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: March 22, 2023

Dear Administrator:

On April 24, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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Electronically delivered

July 13, 2023

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

Re: Reinspection Results
Event ID: 6FUK12

Dear Administrator:

On April 24, 2023 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 March 22, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any 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

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March 28, 2023

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

RE: CCN: 245200
Cycle Start Date: March 22, 2023

Dear Administrator:

On March 22, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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)).

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 22, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 22, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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 electronic 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 6FUK11

Dear Administrator:

The above facility was surveyed on March 21, 2023 through March 22, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@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 03/22/2023

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 On 3/21/23 - 3/22/23, 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 following complaints were reviewed. H52009655C (MN92008), H52009701C (MN89809) with a deficiency issued at F686 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		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		4/21/23

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

Electronically Signed | 04/06/2023

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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F 686	Continued From page 1 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive assessment of pressure ulcers was completed; ensure appropriate interventions were developed and implemented; along with timely weekly pressure ulcer assessments were completed for 2 of 3 residents (R2, R3) reviewed for pressure ulcers. Findings include: R2's Admission Record indicated she admitted to the facility on 2/23/23, following a femur fracture. R2's admission Minimum Data Set (MDS) identified intact cognition and indicated she did not display rejection of care behaviors. The MDS indicated R2 required extensive assistance from two staff for bed mobility, transfers and toileting, had an indwelling Foley catheter and frequent bowel incontinence. R2's MDS further indicated no pressure ulcers were present on admission. R2's care plan dated 2/23/23, identified a self care deficit and directed staff to provide assistance with bed mobility, transfers and toileting. The care plan identified a potential/actual impairment to skin integrity and directed staff to observe skin during cares and report changes to the nurse, encourage reposition/position changes during rounds and observe/document location, size and treatment of skin injury and report abnormalities to the medical practitioner. A nursing assistant care sheet dated 3/21/23,	F 686	F686 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. With respect to R2 and R3, body audits, comprehensive risk assessments and comprehensive wound assessments have been completed. The care plan and NAR care sheets have been updated with indicated risks and interventions as appropriate. 2. Body audits were completed on all residents. All observed open areas were comprehensively assessed weekly and care plans and NAR care sheets were updated as indicated. 3. The skin management program policy was reviewed, and no changes were indicated. Licensed staff are now alerted to scheduled body audits via eMAR to increase compliance. A new skin	

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F 686	Continued From page 2 identified the use of "foot boots" and directed staff to float heel lying flat in bed and side to side repositioning due to wounds. R2's Treatment Administration Record (TAR) dated February 2023, identified the following orders: 2/23/23, Comprehensive Skin and Positioning Evaluation. Within the first four hours of admission then weekly for four weeks. The TAR indicated the assessment had not been completed. 2/27/23, Body audit and vital signs weekly. Document body audit in Point Click Care (PCC). 2/27/23, Comprehensive Skin and Positioning Evaluation. Within the first four hours of admission then weekly for four weeks. Both audits were documented as completed on 2/27/23, however, the medical record lacked evidence of the assessment. R2's Treatment Administration Record (TAR) dated March 2023, identified the following orders: 2/27/23, Body audit and vital signs weekly. Document body audit in Point Click Care (PCC). 2/27/23, Comprehensive Skin and Positioning Evaluation. Within the first four hours of admission then weekly for four weeks. Both audits were documented as completed each week, however, the medical record lacked evidence of a completed skin assessment until 3/16/23. R2's Skin and Wound Evaluation dated 3/16/23, identified a new stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) on her coccyx that measure 2.9 centimeters (cm) x 6.7 cm. Surrounding tissue	F 686	alteration checklist has been developed for licensed nurses to ensure assessment, interventions and care planning for new skin alterations are comprehensive and timely. All items will be completed by April 21, 2023. 4. All nursing and health information staff will receive education on timely and accurate body audit completion, review of new skin alteration checklist, and types of skin alterations by April 21, 2023. 5. The Director of Nursing and/or designee will complete audits to ensure all scheduled body audits are completed timely, identified alterations are comprehensively assessed and care plans updated. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 686	Continued From page 3 was described as denuded (loss of epidermis caused by exposure to urine, feces, body fluids, wound drainage or friction). A Body Audit dated 3/20/23, indicated R2 did not have any alterations in skin integrity. During observation on 3/22/23, at 9:03 a.m. nursing assistant (NA)-A and NA-B assisted R2 to the bathroom using a mechanical stand. NA-B stated R2 had "sores on her butt" and said the sores were present when R2 admitted to the facility. NA-B stated the sores were the size of nickels and had bandages on them. During interview on 3/22/23, at 9:10 a.m. licensed practical nurse (LPN)-A stated R2 had a "couple of skin issues" on her coccyx and said "I believe it came with her" upon admission to the facility. LPN-A stated wounds should be documented in the wound section of the medical record and on the TAR. LPN-A stated in depth documentation was completed on bath days. During observation on 3/22/23, at 9:13 a.m. LPN-A assessed R2's skin and described two dime sized open areas on R2's left buttock and one healing wound on the right buttock. During interview on 3/22/23, at 9:17 a.m. NA-B stated R2 usually sat in her wheel chair after she got up in the morning until therapy. NA-B stated staff tried to reposition R2 every couple of hours. During interview on 3/22/23, at 9:39 a.m. the director of nursing (DON) reviewed R2's medical record and stated it looked like R2 had a stage II pressure ulcer on her buttocks and part of her sacrum. The Regional Clinical Consultant (RCC)	F 686		

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F 686	Continued From page 4 also reviewed R2's medical record and said R2 did not have any record of pressure ulcers present on admission and it was noted first on 3/16/23, and assessed. The RCC further stated the first body audit was completed on admission and no further audits were completed until 3/20/23. The RCC said the body audits should be done weekly as directed on the TAR. The RCC reviewed the NA care sheet and said the care sheet directed staff to reposition R2 from side to side due to wounds but acknowledged the care sheet lacked direction of how often. During interview on 3/22/23, at 11:06 a.m. R2 stated she had sores on her bottom and said they were "pretty sore." R2 stated the sores had been there for about a month. R3's Admission Record indicated she admitted to the facility on 4/11/22, with hemiplegia (paralysis) and hemiparesis (weakness) following a cerebral infarction. R3's significant change Minimum Data Set (MDS) dated 2/12/23, identified severe cognitive impairment and indicated she required extensive assistance from two staff for bed mobility, transfers and toileting. The MDS indicated R3 was always incontinent of bowel and bladder and identified no skin impairments. R3's care plan dated 7/4/22, identified a self care deficit related to impaired mobility due to hemiplegia/hemiparesis affecting the left dominant side and incontinence. The care plan further identified a potential for skin impairment related to immobility and directed staff to encourage reposition/position changes during rounds, observe skin during cares and report changes to the nurse along with weekly and as needed skin inspection.	F 686		

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F 686	Continued From page 5 R3's Body Audits identified the following: 2/11/23, Inner butt blanchable redness, scab also noted. 2/18/23, Coccyx, pink blanchable areas. R3's medical record lacked evidence of skin assessments from 2/18/23 - 3/22/23. R3's Treatment Administration Records (TAR) dated February 2023, and March 2023, identified the following orders: 2/11/23, Body audit and vital signs weekly. Document body audit in Point Click Care (PCC). The assessments were documented as complete, however the medical record lacked evidence of assessments after 2/18/23. 2/11/23, Comprehensive Skin and Positioning Evaluation. Within the first four hours of admission then weekly for four weeks. The assessments were documented as completed except on 3/4/23. The record lacked evidence of the completed assessments. During observation on 3/22/23, at 1:37 p.m. nursing assistant (NA)-C and NA-D assisted R3 to lay down in bed. NA-C stated R3's buttocks was a little red. NA-D stated "it looks much better than last week." R3's buttocks was observed to be red and blanchable with a few small open areas. Surrounding tissue was denuded (loss of epidermis caused by exposure to urine, feces, body fluids, wound drainage or friction). When NA-C pushed on R3's bottom, R3 flinched indicating discomfort. NA-C stated the previous week R3's buttocks had "big sores." During interview on 3/22/23, at 1:54 p.m. registered nurse (RN)-A stated R3's skin was	F 686		

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F 686	Continued From page 6 improving. RN-A stated most of R3's skin assessments were performed on the PM shift and said a head to toe skin assessment was supposed to be completed weekly on bath day. RN-A stated the skin assessment should be documented in the TAR and was done "most of the time." RN-A stated the person giving the bath would tell her if they noticed any areas of concern. RN-A stated R3's skin had some open areas. During interview on 3/22/23, at 9:39 a.m. The regional clinical consultant (RCC) said the body audits should be done weekly as directed on the TAR. At 2:02 p.m. the RCC reviewed R3's medical record and said no skin concerns were "popping up right now." The RCC stated staff were directed to encourage repositioning on rounds which occurred hourly. The RCC stated interventions should be addressed in the care plan. Facility policy Skin Management Program dated 9/2022, indicated the following purpose: Promote the prevention of alterations in skin integrity: promote healing of current skin alteration and to prevent further loss of skin integrity. The policy indicated documentation of the skin integrity, risk factors and evaluation of individualized interventions shall be done in clear and concise manner per the resident plan of care. Body Audit is completed: Upon admission and weekly by licensed staff, preferable on bath day, and as needed for changes in skin integrity. Comprehensive Skin and Positioning Evaluation will be completed: upon admission, quarterly, annually, and with significant change in status or with new alteration in skin integrity excluding bruises.	F 686		

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

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F 686	Continued From page 7 Weekly skin integrity evaluation completed in PCC for all alterations in skin integrity. Individualized care plan will reflect approaches to stabilize reduce or remove risk for pressure injury development and or promoting healing of existing alterations in skin. Daily skin/Wound monitoring will be completed for all residents on a daily basis that have any alterations in skin integrity until resolved.	F 686		

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	00853	A. BUILDING: _____ B. WING _____	C 03/22/2023

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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 3/21/23 - 3/22/23, 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(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H52009655C (MN92008), H52009701C (MN89809) with a licensing order issued at 0830 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive assessment of pressure ulcers was completed; ensure appropriate interventions were developed and implemented; along with timely weekly pressure ulcer assessments were completed for 2 of 3 residents (R2, R3) reviewed for pressure ulcers. Findings include:	2 830	Corrected	4/21/23

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2 830	Continued From page 3 R2's Admission Record indicated she admitted to the facility on 2/23/23, following a femur fracture. R2's admission Minimum Data Set (MDS) identified intact cognition and indicated she did not display rejection of care behaviors. The MDS indicated R2 required extensive assistance from two staff for bed mobility, transfers and toileting, had an indwelling Foley catheter and frequent bowel incontinence. R2's MDS further indicated no pressure ulcers were present on admission. R2's care plan dated 2/23/23, identified a self care deficit and directed staff to provide assistance with bed mobility, transfers and toileting. The care plan identified a potential/actual impairment to skin integrity and directed staff to observe skin during cares and report changes to the nurse, encourage reposition/position changes during rounds and observe/document location, size and treatment of skin injury and report abnormalities to the medical practitioner. A nursing assistant care sheet dated 3/21/23, identified the use of "foot boots" and directed staff to float heel lying flat in bed and side to side repositioning due to wounds. R2's Treatment Administration Record (TAR) dated February 2023, identified the following orders: 2/23/23, Comprehensive Skin and Positioning Evaluation. Within the first four hours of admission then weekly for four weeks. The TAR indicated the assessment had not been completed. 2/27/23, Body audit and vital signs weekly. Document body audit in Point Click Care (PCC). 2/27/23, Comprehensive Skin and Positioning Evaluation. Within the first four hours of	2 830		

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2 830	Continued From page 4 admission then weekly for four weeks. Both audits were documented as completed on 2/27/23, however, the medical record lacked evidence of the assessment. R2's Treatment Administration Record (TAR) dated March 2023, identified the following orders: 2/27/23, Body audit and vital signs weekly. Document body audit in Point Click Care (PCC). 2/27/23, Comprehensive Skin and Positioning Evaluation. Within the first four hours of admission then weekly for four weeks. Both audits were documented as completed each week, however, the medical record lacked evidence of a completed skin assessment until 3/16/23. R2's Skin and Wound Evaluation dated 3/16/23, identified a new stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) on her coccyx that measure 2.9 centimeters (cm) x 6.7 cm. Surrounding tissue was described as denuded (loss of epidermis caused by exposure to urine, feces, body fluids, wound drainage or friction). A Body Audit dated 3/20/23, indicated R2 did not have any alterations in skin integrity. During observation on 3/22/23, at 9:03 a.m. nursing assistant (NA)-A and NA-B assisted R2 to the bathroom using a mechanical stand. NA-B stated R2 had "sores on her butt" and said the sores were present when R2 admitted to the facility. NA-B stated the sores were the size of nickels and had bandages on them. During interview on 3/22/23, at 9:10 a.m. licensed practical nurse (LPN)-A stated R2 had a "couple	2 830		

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2 830	Continued From page 5 of skin issues" on her coccyx and said "I believe it came with her" upon admission to the facility. LPN-A stated wounds should be documented in the wound section of the medical record and on the TAR. LPN-A stated in depth documentation was completed on bath days. During observation on 3/22/23, at 9:13 a.m. LPN-A assessed R2's skin and described two dime sized open areas on R2's left buttock and one healing wound on the right buttock. During interview on 3/22/23, at 9:17 a.m. NA-B stated R2 usually sat in her wheel chair after she got up in the morning until therapy. NA-B stated staff tried to reposition R2 every couple of hours. During interview on 3/22/23, at 9:39 a.m. the director of nursing (DON) reviewed R2's medical record and stated it looked like R2 had a stage II pressure ulcer on her buttocks and part of her sacrum. The Regional Clinical Consultant (RCC) also reviewed R2's medical record and said R2 did not have any record of pressure ulcers present on admission and it was noted first on 3/16/23, and assessed. The RCC further stated the first body audit was completed on admission and no further audits were completed until 3/20/23. The RCC said the body audits should be done weekly as directed on the TAR. The RCC reviewed the NA care sheet and said the care sheet directed staff to reposition R2 from side to side due to wounds but acknowledged the care sheet lacked direction of how often. During interview on 3/22/23, at 11:06 a.m. R2 stated she had sores on her bottom and said they were "pretty sore." R2 stated the sores had been there for about a month.	2 830		

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2 830	Continued From page 6 R3's Admission Record indicated she admitted to the facility on 4/11/22, with hemiplegia (paralysis) and hemiparesis (weakness) following a cerebral infarction. R3's significant change Minimum Data Set (MDS) dated 2/12/23, identified severe cognitive impairment and indicated she required extensive assistance from two staff for bed mobility, transfers and toileting. The MDS indicated R3 was always incontinent of bowel and bladder and identified no skin impairments. R3's care plan dated 7/4/22, identified a self care deficit related to impaired mobility due to hemiplegia/hemiparesis affecting the left dominant side and incontinence. The care plan further identified a potential for skin impairment related to immobility and directed staff to encourage reposition/position changes during rounds, observe skin during cares and report changes to the nurse along with weekly and as needed skin inspection. R3's Body Audits identified the following: 2/11/23, Inner butt blanchable redness, scab also noted. 2/18/23, Coccyx, pink blanchable areas. R3's medical record lacked evidence of skin assessments from 2/18/23 - 3/22/23. R3's Treatment Administration Records (TAR) dated February 2023, and March 2023, identified the following orders: 2/11/23, Body audit and vital signs weekly. Document body audit in Point Click Care (PCC). The assessments were documented as complete, however the medical record lacked evidence of assessments after 2/18/23. 2/11/23, Comprehensive Skin and Positioning Evaluation. Within the first four hours of	2 830		

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2 830	Continued From page 7 admission then weekly for four weeks. The assessments were documented as completed except on 3/4/23. The record lacked evidence of the completed assessments. During observation on 3/22/23, at 1:37 p.m. nursing assistant (NA)-C and NA-D assisted R3 to lay down in bed. NA-C stated R3's buttocks was a little red. NA-D stated "it looks much better than last week." R3's buttocks was observed to be red and blanchable with a few small open areas. Surrounding tissue was denuded (loss of epidermis caused by exposure to urine, feces, body fluids, wound drainage or friction). When NA-C pushed on R3's bottom, R3 flinched indicating discomfort. NA-C stated the previous week R3's buttocks had "big sores." During interview on 3/22/23, at 1:54 p.m. registered nurse (RN)-A stated R3's skin was improving. RN-A stated most of R3's skin assessments were performed on the PM shift and said a head to toe skin assessment was supposed to be completed weekly on bath day. RN-A stated the skin assessment should be documented in the TAR and was done "most of the time." RN-A stated the person giving the bath would tell her if they noticed any areas of concern. RN-A stated R3's skin had some open areas. During interview on 3/22/23, at 9:39 a.m. The regional clinical consultant (RCC) said the body audits should be done weekly as directed on the TAR. At 2:02 p.m. the RCC reviewed R3's medical record and said no skin concerns were "popping up right now." The RCC stated staff were directed to encourage repositioning on rounds which occurred hourly. The RCC stated interventions should be addressed in the care	2 830		

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2 830	Continued From page 8 plan. Facility policy Skin Management Program dated 9/2022, indicated the following purpose: Promote the prevention of alterations in skin integrity: promote healing of current skin alteration and to prevent further loss of skin integrity. The policy indicated documentation of the skin integrity, risk factors and evaluation of individualized interventions shall be done in clear and concise manner per the resident plan of care. Body Audit is completed: Upon admission and weekly by licensed staff, preferable on bath day, and as needed for changes in skin integrity. Comprehensive Skin and Positioning Evaluation will be completed: upon admission, quarterly, annually, and with significant change in status or with new alteration in skin integrity excluding bruises. Weekly skin integrity evaluation completed in PCC for all alterations in skin integrity. Individualized care plan will reflect approaches to stabilize reduce or remove risk for pressure injury development and or promoting healing of existing alterations in skin. Daily skin/Wound monitoring will be completed for all residents on a daily basis that have any alterations in skin integrity until resolved. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate	2 830		

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2 830	Continued From page 9 care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		