Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 10, 2025

Administrator
Birchwood Care Home
715 WEST 31ST STREET
MINNEAPOLIS, MN 55408

RE: CCN: 24E166
Cycle Start Date: July 29, 2025

Dear Administrator:

On September 9, 2025, 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

September 10, 2025

Administrator
Birchwood Care Home
715 WEST 31ST STREET
MINNEAPOLIS, MN 55408

Re: Reinspection Results
Event ID: 1D2281-H2

Dear Administrator:

On September 9, 2025 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 July 29, 2025. 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 1, 2025

Administrator
Birchwood Care Home

715 WEST 31ST STREET
MINNEAPOLIS, MN 55408

RE: CCN:24E166
Cycle Start Date: July 29, 2025

Dear Administrator:

On July 29, 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 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:

LeAnn Huseth, RN, Regional Operations Supervisor, Rapid Response
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 October 29, 2025 (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 January 29, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies. A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E166	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Care Home	715 WEST 31ST STREET , MINNEAPOLIS, Minnesota, 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/29/25, an abbreviated survey was completed by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: HE1669969C (2565495); with non-compliance cited at F689. 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.	F0000		08/15/2025
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure episodes of leaving the building unsupervised were evaluated or assessed to determine what, if any, additional supervision or monitoring was needed to help prevent subsequent exits from the building for 1 of 3 residents (R1) reviewed	F0689	Resident R1 was discharged on July 21, 2025, after leaving the facility unsupervised and requiring a secure setting. R1 was discharged on July 21, 2025. The incident was immediately reviewed by the Interdisciplinary Team (IDT). Documentation of the incident, interventions, and follow-up actions were completed within the same shift. A root cause analysis was conducted to identify contributing factors. A facility-wide review of all residents was initiated to identify individuals at risk for elopement. Residents identified as potential elopement risks will be reassessed using a standardized Elopement Risk Assessment Tool. Care plans will be updated accordingly to reflect supervision needs and safety interventions. The findings of the resident's elopement risk assessment will be brought to IDT to verify findings. The facility’s Elopement Prevention Policy was revised to include:	08/15/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E166	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

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Birchwood Care Home	715 WEST 31ST STREET , MINNEAPOLIS, Minnesota, 55408

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F0689 SS = D	Continued from page 1 for elopement and whom had cognitive impairment. R1 left the care center without staff knowledge was found outside in an adjacent alleyway. Findings include: R1's quarterly Minimum Data Set (MDS), dated 6/6/25, identified R1 had moderate cognitive impairment but demonstrated no delusional thinking. The MDS outlined R1 demonstrated no wandering behaviors, however, did have dementia and Alzheimer's Disease. Further, the MDS recorded R1 as being independent with most mobility tasks (i.e., walking, transferring). R1's Wander Risk Assessment, dated 3/6/25, identified R1 had been in the care center for less than 30 days, was un-familiar with the surrounding area(s), and had both short and long-term memory loss. The evaluation identified R1 was unable to safely cross streets and did not have the skills to navigate independently in the community. The evaluation added these points and others for a combined score which read, "25 pts [points]," with dictation adjacent, "High Risk." A summary was listed which read, "Resident high risk, she is unable to leave facility unsupervised." The evaluation outlined R1's care plan was updated with this information on 3/13/25. R1's care plan, printed 7/29/25, identified R1's actual or potential problems as of that date along with each' respective initiation and revision date. The care plan outlined a section labeled, "ASSESSMENT OF RESIDENT'S ABILITY TO LEAVE THE FACILITY SAFELY," which dictated R1 was deemed unsafe to leave the facility unsupervised. The care plan outlined, "5/22/25 Deemed unable to sit outside unsupervised." The care plan listed several interventions to help ensure R1 didn't leave the facility unsupervised including having social services provide reminders to R1, working to find a memory care setting and, "SS [social services] and TR [therapeutic recreation] will do Wandering Risk Assessment Annually [sic] and/or as needed. IDT [interdisciplinary team] will determine if resident is able to leave the facility unsupervised." This section was last revised on 6/11/25; with no interventions being revised since 3/13/25. The care plan continued and outlined a section labeled, "VULNERABLE ADULT STATUS," which dictated, "7/17/25: Resident found coming out of alley off facility property by SSD [social services director]. Brought to nurses station." The interventions listed outlined R1 as being on hourly checks and reminders since 4/10/25 and reporting incidents to the common entry point (CEP)	F0689	Continued from page 1 Immediate action upon identification of elopement risk (within the same shift). Same-shift implementation of safety interventions (e.g., increased supervision, room relocation). Immediate documentation in progress notes and notification of the IDT. IDT follow-up within 24 hours on weekdays and 48 hours on weekends. Follow-up review within 7 days to evaluate intervention effectiveness. Defined elopement protocol, including: Use of risk assessment tools Notification procedures for staff, family, and providers Tailored interventions based on resident needs Documentation and escalation procedures All IDT members, nursing staff, CNAs, and direct care staff will receive training on: Recognizing elopement risks Immediate response procedures Documentation requirements Roles and responsibilities in elopement prevention Revised IDT policy All staff will be trained within 14 days of policy revision. New hires will receive training during onboarding. The Social Services Director or designee will audit progress notes daily to: Identify unresolved IDT issues Confirm timely implementation of safety interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E166	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Care Home	715 WEST 31ST STREET , MINNEAPOLIS, Minnesota, 55408

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F0689 SS = D	Continued from page 2 as required. On 7/17/25, an intervention which read, "Staff will stay with resident at all times when door is unlocked," was initiated. On 7/29/25 at 9:12 a.m., a tour of the second floor of the care center was completed. The unit consisted of a single, long hallway with resident' rooms on each side and a central commons area. The North side of the hallway opened into an open stairwell which lead to the main entrance of the care center. The main entrance had signage posted which directed residents to sign out before leaving, and about hours which the door would best be used for safety reasons. The South side of the unit had a closed, un-alarmed door which opened to another stairwell. This lead down to an exterior door which opened to a back alleyway with cars parked outside. The exterior door had a red-colored, alarm-type stop sign placed which was deactivated at this time. An unidentified male resident was seen walking through the door to outside and the door did not alarm. R1's progress notes, dated 3/1/25 to 7/21/25, identified the following: On 3/1/25, R1 admitted to the care center and presented as confused and/or forgetful. The note outlined R1 was placed on hourly checks. On 3/13/25, the IDT met to review R1's Wandering Risk Assessment. R1 was determined to be unsafe to leave the facility unsupervised. On 3/17/25, R1 was found sitting outside the facility on a bench around 6:25 a.m. without staff present. The note outlined R1 was looking for a lighter and added, " ... was reminded that she cannot be out smoking without staff ... came into building with staff." On 4/3/25, R1 was " ... up a number of times going into other rooms looking for cigarettes ... was redirected to go back in her room." On 5/22/25, the IDT reviewed R1's ability to leave the facility unsupervised or sit outside without staff present. The note outlined, " ... in consensus that she would not be safe unsupervised ... will incorporate supervised times to sit outside and encourage to participate in TR activities and walking." On 6/10/25, R1 was again found outside in front of the building. The note outlined, " ... reminded [R1] that she is unable to sit outside unsupervised ... redirected and came inside of the building right away."	F0689	Continued from page 2 Ensure documentation is complete and accurate Audit results will be reviewed monthly and quarterly during QAPI meetings. Trends, compliance gaps, and corrective actions will be documented and tracked. Additional training or policy adjustments will be implemented as needed.	

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F0689 SS = D	Continued from page 3 On 7/17/25, R1 was seen outside without staff coming out of the alley way onto the sidewalk next to an adjacent building. R1 stated she was going for a walk. A subsequent note, dated 7/17/25, identified the IDT discussed R1 leaving the facility unsupervised to go for a walk adding, "SS director will follow up with [R1] family about placement and will continue looking for placement." On 7/24/25, R1 was discharged from the care center to another venue. However, R1's medical record was reviewed and lacked evidence R1 had been comprehensively reassessed or evaluated for what, if any, additional interventions had been needed or discussed after R1 was found outside on 6/10/25. There was no evidence documented in the record to support the IDT had reviewed this incident; nor any rationale for what, if any, changes to the interventions in place were considered to reduce the risk of subsequent incidents despite R1 being found unsupervised outside again. When interviewed on 7/29/25 at 9:23 a.m., nursing assistant (NA)-A stated they had worked with R1 multiple times and described her as having "a memory problem," adding R1 would likely not have known how to find her way back if she'd ever have left the campus unsupervised. NA-A explained when a resident was on hourly checks, then staff would "pop in" and check on them just to ensure they were onsite, and these were tracked on a paper flow sheet which were saved by the care team. NA-A stated the building was not locked and there was no full-time wander/exit alarms to secure it (i.e., Wander-guard System). NA-A recalled the care team trying to find new placement for R1 as Birchwood was not a "memory ward unit." NA-A stated they were aware R1 had been found outside in the alleyway (7/17/25), however, was unaware of the other incidents adding, "I think it was only one time [found outside]." NA-A stated after R1 was found outside on 7/17/25, the activities staff then got more directly involved with R1. When interviewed on 7/29/25 10:05 a.m., activities aide (AA)-A stated they had worked at the campus only a few weeks, but recalled working with R1. AA-A stated R1 would repeatedly want to go outside and smoke adding, "She [kept] wanting to go smoke outside." AA-A stated they often tried to keep R1 entertained with card games but, again, would often ask about smoking. AA-A stated they were not working when R1 was found outside on 7/17/25, however, expressed they did not recall any	F0689		

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F0689 SS = D	Continued from page 4 changes to their (activities) approach with R1 for the duration of her stay. At 10:11 a.m., the activities director (AD) joined the interview and expressed it was "just that last week" R1 was there when activities increased their one-to-one and oversight of R1. Prior to 7/17/25, AD stated activities staff would go outside to smoke with R1 but didn't always remain with her. AD verified the one-to-ones were added due to R1 being found outside on 7/17/25, as they determined they "gotta do something here." On 7/29/25 at 10:32 a.m., licensed practical nurse (LPN)-A and LPN-B were interviewed, and LPN-A verified they helped to oversee the entire building. LPN-A explained residents were evaluated upon admission to determine if they could leave the building unsupervised. LPN-A stated the 'Wandering Risk Assessment' would be completed by social services and then reviewed by the IDT and, from there, the care plan would be developed. LPN-A recalled R1 had "memory issues" and the IDT had determined "in the very beginning" that she was unable to safely leave the building or campus without supervision. LPN-A verified the building was not locked or armed with a wandering system, and explained R1 had been placed on hourly checks for "a long time" prior to 7/17/25 due to her cognition. LPN-A acknowledged R1 as being found outside multiple times unsupervised and expressed social services had been actively working to get other placement for R1 in addition to the ongoing hourly checks being done. LPN-A reviewed the medical record and verified the progress note (6/10/25) which R1 was found outside the building unsupervised. LPN-A and LPN-B both expressed that would have been reviewed by the IDT. However, LPN-A verified there was no documented progress note in the record to support that had happened. LPN-B reviewed the collected IDT meeting minutes which were contained in a white-colored binder, and expressed they were unable to locate evidence R1's incident of being found outside unsupervised was discussed or reviewed by the IDT. LPN-A and LPN-B both felt it had been discussed in the IDT; however, LPN-A confirmed the IDT discussion and/or review would typically be recorded in the progress notes, too. The interview continued and LPN-A stated on 7/17/25, the social worker (SW)-A was coming into work and found R1 outside in the alleyway. LPN-A stated it was "at that point" the IDT determined R1 needed more one-to-one oversight so they had AA-A coming in to just sit more with R1 and keep closer supervision on her. At 10:57 a.m., SW-A joined the interview. SW-A explained R1 had been on hourly checks since she admitted to the care center, and they had been attempting to find	F0689		

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F0689 SS = D	Continued from page 5 better placement throughout her stay. SW-A expressed re-doing the Wandering Risk Assessment after the 6/10/25 incident likely wouldn't have changed their approach or interventions. SW-A stated after the 7/17/25 incident is when they decided a more secured unit was needed and accelerated R1's discharge planning process. SW-A stated the incidents prior to the 7/17/25 incident would have triggered new interventions as R1 "wasn't leaving the grounds." SW-A verified the incidents of being found outside were something that would typically be reviewed by the IDT, and they expressed they thought such had been done. However, SW-A and LPN-A both verified the lack of medical record documentation to support this had happened, and LPN-A added aloud, "I think something got missed." SW-A stated the incident on 7/17/25 triggered a more immediate response as R1 was then attempting to leave the physical grounds instead of just sitting outside unsupervised. LPN-A reiterated the interventions already in place throughout R1's admission but acknowledged, "Maybe we did not get everything we should have in there [record], but we did do it." Further, SW-A stated ensuring residents were properly supervised was important "to keep them safe." On 7/29/25 at 11:18 a.m., the director of nursing (DON) was interviewed. DON stated any incident, including elopements, were reviewed by the IDT and a progress note was typically entered into the medical record with their evaluation or decision-making on it. DON reviewed R1's medical record and verified it lacked such evidence about the 6/10/25 incident when R1 was found outside unsupervised adding aloud, "I don't see anything." DON stated it was important to ensure the IDT reviewed incidents and recorded them in the record as it was "all part of keeping her safe." DON added, "It's the process we have in place to make sure we're addressing it [incident]." A facility-provided Elopement Risk Assessment Policy, dated 1/2025, identified the facility would assess upon admission, quarterly and as needed for this risk adding, "Elopement is wandering away from the facility and is dangerous for the resident." The policy outlined any resident with a score of 7 or higher would have a safety plan incorporated into their care plan adding, "IDT will meet during weekly meeting to discuss ability to keep safe and determine if the resident needs a higher level of care if they score greater than 7 on the Wandering Elopement Risk Assessment." In addition, a facility-provided Birchwood/Grand Avenue IDT Policy, dated 4/2025, identified the team would meet daily (Mon-Fri) and discuss falls or behaviors. The policy directed, "6. A progress note will be put in the	F0689		

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F0689 SS = D	Continued from page 6 residents chart with interventions put in place."	F0689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 1, 2025

Administrator
Birchwood Care Home
715 WEST 31ST STREET
MINNEAPOLIS, MN 55408

Re: State Nursing Home Licensing Orders
Event ID: 1D2281-H1

Dear Administrator:

The above facility was surveyed on July 29, 2025 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:

LeAnn Huseth, RN, Regional Operations Supervisor, Rapid Response
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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.

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

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 **07/29/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Care Home	**715 WEST 31ST STREET , MINNEAPOLIS, Minnesota, 55408**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/29/25, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: HE1669969C	20000		08/15/2025

Office of Primary Care and Health Systems Management

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

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 **07/29/2025**

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20000	Continued from page 1 (2565495); order cited 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 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 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.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 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.	20830	Corrected	08/15/2025

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20830	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure episodes of leaving the building unsupervised were evaluated or assessed to determine what, if any, additional supervision or monitoring was needed to help prevent subsequent exits from the building for 1 of 3 residents (R1) reviewed for elopement and whom had cognitive impairment. R1 left the care center without staff knowledge was found outside in an adjacent alleyway. Findings include: R1's quarterly Minimum Data Set (MDS), dated 6/6/25, identified R1 had moderate cognitive impairment but demonstrated no delusional thinking. The MDS outlined R1 demonstrated no wandering behaviors, however, did have dementia and Alzheimer's Disease. Further, the MDS recorded R1 as being independent with most mobility tasks (i.e., walking, transferring). R1's Wander Risk Assessment, dated 3/6/25, identified R1 had been in the care center for less than 30 days, was un-familiar with the surrounding area(s), and had both short and long-term memory loss. The evaluation identified R1 was unable to safely cross streets and did not have the skills to navigate independently in the community. The evaluation added these points and others for a combined score which read, "25 pts [points]," with dictation adjacent, "High Risk." A summary was listed which read, "Resident high risk, she is unable to leave facility unsupervised." The evaluation outlined R1's care plan was updated with this information on 3/13/25. R1's care plan, printed 7/29/25, identified R1's actual or potential problems as of that date along with each' respective initiation and revision date. The care plan outlined a section labeled, "ASSESSMENT OF RESIDENT'S ABILITY TO LEAVE THE FACILITY SAFELY," which dictated R1 was deemed unsafe to leave the facility unsupervised. The care plan outlined, "5/22/25 Deemed unable to sit outside unsupervised." The care plan listed several interventions to help ensure R1 didn't leave the facility unsupervised including having social services provide reminders to R1, working to find a memory care setting and, "SS [social services] and TR [therapeutic recreation] will do Wandering Risk Assessment Annually [sic] and/or as needed. IDT [interdisciplinary team] will determine if resident is able to leave the facility unsupervised." This section was last revised on 6/11/25; with no interventions being revised since 3/13/25.	20830		

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20830	Continued from page 3 The care plan continued and outlined a section labeled, "VULNERABLE ADULT STATUS," which dictated, "7/17/25: Resident found coming out of alley off facility property by SSD [social services director]. Brought to nurses station." The interventions listed outlined R1 as being on hourly checks and reminders since 4/10/25 and reporting incidents to the common entry point (CEP) as required. On 7/17/25, an intervention which read, "Staff will stay with resident at all times when door is unlocked," was initiated. On 7/29/25 at 9:12 a.m., a tour of the second floor of the care center was completed. The unit consisted of a single, long hallway with resident' rooms on each side and a central commons area. The North side of the hallway opened into an open stairwell which lead to the main entrance of the care center. The main entrance had signage posted which directed residents to sign out before leaving, and about hours which the door would best be used for safety reasons. The South side of the unit had a closed, un-alarmed door which opened to another stairwell. This lead down to an exterior door which opened to a back alleyway with cars parked outside. The exterior door had a red-colored, alarm-type stop sign placed which was deactivated at this time. An unidentified male resident was seen walking through the door to outside and the door did not alarm. R1's progress notes, dated 3/1/25 to 7/21/25, identified the following: On 3/1/25, R1 admitted to the care center and presented as confused and/or forgetful. The note outlined R1 was placed on hourly checks. On 3/13/25, the IDT met to review R1's Wandering Risk Assessment. R1 was determined to be unsafe to leave the facility unsupervised. On 3/17/25, R1 was found sitting outside the facility on a bench around 6:25 a.m. without staff present. The note outlined R1 was looking for a lighter and added, " ... was reminded that she cannot be out smoking without staff ... came into building with staff." On 4/3/25, R1 was " ... up a number of times going into other rooms looking for cigarettes ... was redirected to go back in her room." On 5/22/25, the IDT reviewed R1's ability to leave the facility unsupervised or sit outside without staff present. The note outlined, " ... in consensus that she	20830		

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20830	Continued from page 4 would not be safe unsupervised ... will incorporate supervised times to sit outside and encourage to participate in TR activities and walking." On 6/10/25, R1 was again found outside in front of the building. The note outlined, " ... reminded [R1] that she is unable to sit outside unsupervised ... redirected and came inside of the building right away." On 7/17/25, R1 was seen outside without staff coming out of the alley way onto the sidewalk next to an adjacent building. R1 stated she was going for a walk. A subsequent note, dated 7/17/25, identified the IDT discussed R1 leaving the facility unsupervised to go for a walk adding, "SS director will follow up with [R1] family about placement and will continue looking for placement." On 7/24/25, R1 was discharged from the care center to another venue. However, R1's medical record was reviewed and lacked evidence R1 had been comprehensively reassessed or evaluated for what, if any, additional interventions had been needed or discussed after R1 was found outside on 6/10/25. There was no evidence documented in the record to support the IDT had reviewed this incident; nor any rationale for what, if any, changes to the interventions in place were considered to reduce the risk of subsequent incidents despite R1 being found unsupervised outside again. When interviewed on 7/29/25 at 9:23 a.m., nursing assistant (NA)-A stated they had worked with R1 multiple times and described her as having "a memory problem," adding R1 would likely not have known how to find her way back if she'd ever have left the campus unsupervised. NA-A explained when a resident was on hourly checks, then staff would "pop in" and check on them just to ensure they were onsite, and these were tracked on a paper flow sheet which were saved by the care team. NA-A stated the building was not locked and there was no full-time wander/exit alarms to secure it (i.e., Wander-guard System). NA-A recalled the care team trying to find new placement for R1 as Birchwood was not a "memory ward unit." NA-A stated they were aware R1 had been found outside in the alleyway (7/17/25), however, was unaware of the other incidents adding, "I think it was only one time [found outside]." NA-A stated after R1 was found outside on 7/17/25, the activities staff then got more directly involved with R1. When interviewed on 7/29/25 10:05 a.m., activities aide	20830		

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20830	Continued from page 5 (AA)-A stated they had worked at the campus only a few weeks, but recalled working with R1. AA-A stated R1 would repeatedly want to go outside and smoke adding, "She [kept] wanting to go smoke outside." AA-A stated they often tried to keep R1 entertained with card games but, again, would often ask about smoking. AA-A stated they were not working when R1 was found outside on 7/17/25, however, expressed they did not recall any changes to their (activities) approach with R1 for the duration of her stay. At 10:11 a.m., the activities director (AD) joined the interview and expressed it was "just that last week" R1 was there when activities increased their one-to-one and oversight of R1. Prior to 7/17/25, AD stated activities staff would go outside to smoke with R1 but didn't always remain with her. AD verified the one-to-ones were added due to R1 being found outside on 7/17/25, as they determined they "gotta do something here." On 7/29/25 at 10:32 a.m., licensed practical nurse (LPN)-A and LPN-B were interviewed, and LPN-A verified they helped to oversee the entire building. LPN-A explained residents were evaluated upon admission to determine if they could leave the building unsupervised. LPN-A stated the 'Wandering Risk Assessment' would be completed by social services and then reviewed by the IDT and, from there, the care plan would be developed. LPN-A recalled R1 had "memory issues" and the IDT had determined "in the very beginning" that she was unable to safely leave the building or campus without supervision. LPN-A verified the building was not locked or armed with a wandering system, and explained R1 had been placed on hourly checks for "a long time" prior to 7/17/25 due to her cognition. LPN-A acknowledged R1 as being found outside multiple times unsupervised and expressed social services had been actively working to get other placement for R1 in addition to the ongoing hourly checks being done. LPN-A reviewed the medical record and verified the progress note (6/10/25) which R1 was found outside the building unsupervised. LPN-A and LPN-B both expressed that would have been reviewed by the IDT. However, LPN-A verified there was no documented progress note in the record to support that had happened. LPN-B reviewed the collected IDT meeting minutes which were contained in a white-colored binder, and expressed they were unable to locate evidence R1's incident of being found outside unsupervised was discussed or reviewed by the IDT. LPN-A and LPN-B both felt it had been discussed in the IDT; however, LPN-A confirmed the IDT discussion and/or review would typically be recorded in the progress notes, too. The interview continued and LPN-A stated on 7/17/25,	20830		

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20830	Continued from page 6 the social worker (SW)-A was coming into work and found R1 outside in the alleyway. LPN-A stated it was "at that point" the IDT determined R1 needed more one-to-one oversight so they had AA-A coming in to just sit more with R1 and keep closer supervision on her. At 10:57 a.m., SW-A joined the interview. SW-A explained R1 had been on hourly checks since she admitted to the care center, and they had been attempting to find better placement throughout her stay. SW-A expressed re-doing the Wandering Risk Assessment after the 6/10/25 incident likely wouldn't have changed their approach or interventions. SW-A stated after the 7/17/25 incident is when they decided a more secured unit was needed and accelerated R1's discharge planning process. SW-A stated the incidents prior to the 7/17/25 incident would have triggered new interventions as R1 "wasn't leaving the grounds." SW-A verified the incidents of being found outside were something that would typically be reviewed by the IDT, and they expressed they thought such had been done. However, SW-A and LPN-A both verified the lack of medical record documentation to support this had happened, and LPN-A added aloud, "I think something got missed." SW-A stated the incident on 7/17/25 triggered a more immediate response as R1 was then attempting to leave the physical grounds instead of just sitting outside unsupervised. LPN-A reiterated the interventions already in place throughout R1's admission but acknowledged, "Maybe we did not get everything we should have in there [record], but we did do it." Further, SW-A stated ensuring residents were properly supervised was important "to keep them safe." On 7/29/25 at 11:18 a.m., the director of nursing (DON) was interviewed. DON stated any incident, including elopements, were reviewed by the IDT and a progress note was typically entered into the medical record with their evaluation or decision-making on it. DON reviewed R1's medical record and verified it lacked such evidence about the 6/10/25 incident when R1 was found outside unsupervised adding aloud, "I don't see anything." DON stated it was important to ensure the IDT reviewed incidents and recorded them in the record as it was "all part of keeping her safe." DON added, "It's the process we have in place to make sure we're addressing it [incident]." A facility-provided Elopement Risk Assessment Policy, dated 1/2025, identified the facility would assess upon admission, quarterly and as needed for this risk adding, "Elopement is wandering away from the facility and is dangerous for the resident." The policy outlined any resident with a score of 7 or higher would have a safety plan incorporated into their care plan adding,	20830		

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20830	Continued from page 7 "IDT will meet during weekly meeting to discuss ability to keep safe and determine if the resident needs a higher level of care if they score greater than 7 on the Wandering Elopement Risk Assessment." In addition, a facility-provided Birchwood/Grand Avenue IDT Policy, dated 4/2025, identified the team would meet daily (Mon-Fri) and discuss falls or behaviors. The policy directed, "6. A progress note will be put in the residents chart with interventions put in place." SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review applicable policies and procedures on potential elopements, including review of them with the IDT, to ensure accuracy; then educate staff involved and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	20830		