DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 6, 2022

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

RE: CCN: 245200
Cycle Start Date: August 4, 2022

Dear Administrator:

On August 30, 2022, the Minnesota Department(s) of Health and Public Safety 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

Electronically delivered
August 15, 2022

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

RE: CCN: 245200
Cycle Start Date: August 4, 2022

Dear Administrator:

On August 4, 2022, 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:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

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 November 4, 2022 (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 February 4, 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING _____ B. WING _____	C 08/04/2022

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
E 000	Initial Comments On 8/1/22 - 8/4/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/1/22 - 8/4/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H52003480C (MN84917) and H52003481C (MN84605). 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 substantial compliance with the regulations has been attained.	F 000		
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		8/25/22

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

Electronically Signed | 08/25/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695 SS=D	Continued From page 1 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure respiratory equipment was maintained according to facility policies and standards of practice and failed to consistently implement oxygen (O2) weaning per the practitioner's order for 1 of 2 residents (R41) reviewed for respiratory care. Findings include: RESPIRATORY EQUIPMENT R41's admission Minimum Data Set (MDS) dated 6/9/22, identified he had intact cognition. R41 required extensive assist of one with hygiene. R41's diagnoses included acute respiratory failure, personal history of COVID-19 and pneumonia. R41 also received O2 therapy. R41's care plan dated 6/3/22, indicated he had a history of acute respiratory failure due to COVID-19 and he required O2 therapy via nasal cannula (nc) at 2.5 liters per minute (lpm), rate of flow). Staff were directed to observe/document and report to nurse/medical practitioner any signs or symptoms of respiratory distress. The care	F 695	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 R42, a new humidifier bottle was placed on his stationary unit on 8/1/2022. R41 has since discharged from the facility on supplemental oxygen per providers order. Provider discontinued order to wean oxygen. 2) All residents on supplemental oxygen were reviewed for orders to wean and none were identified. All oxygen equipment was audited, and all humidifier bottles were exchanged for new ones.	

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	245200	A. BUILDING _____ B. WING _____	C 08/04/2022

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

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F 695	Continued From page 2 plan lacked direction for weaning from O2 therapy or for maintenance of respiratory equipment. R41's treatment administration record (TAR) dated 7/1/22 - 8/3/22, included orders to change O2 tubing and "set up" weekly and to record date and time on tubing. The TAR showed the order was initialed as being completed weekly. The orders lacked specification of maintenance such as cleaning or replacement for the oxygen humidifier bottle. During an observation and interview on 8/1/22, at 1:47 p.m. R41 was in bed with O2 on 3 lpm via nc. R41's nc was connected to a liquid oxygen base unit which had a partially filled humidifier bottle attached dated "6/4" indicating the bottle was last changed almost two months ago. During an interview 8/1/22, at 6:01 p.m. nursing assistant (NA)-A stated the nurses took care of resident O2 equipment and she was not sure how often anything was maintained. During an observation and interview on 8/1/22, at 7:31 p.m. registered nurse (RN)-A stated she was not sure how often the O2 equipment was maintained. RN-A entered R41's room and verified the humidifier bottle was dated 6/4. RN-A replaced the O2 tubing and humidifier bottle and dated the bottle with the current date. RN-A reviewed the TAR and stated the TAR indicated the humidifier bottle should have been replaced weekly with the O2 tubing and had not been. O2 WEANING R41's active, prescriber written orders included the following:	F 695	3) Supplemental oxygen batch orders in the electronic medical record were updated to include weekly replacement of humidifier bottles for all new oxygen orders. 4) All licensed staff will receive education on updated batch orders and needing to clarify oxygen weaning orders to include rate, route, frequency, and specific parameters by August 25th, 2022. 5) The Director of Nursing and/or Designee will complete oxygen equipment and oxygen weaning audits weekly for one month and every other week for 2 months to ensure all residents on supplemental oxygen receive their cares as ordered. The data collected from these audits will be reviewed/discussed at the facility monthly Quality Assurance Committee Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 3 -6/14/22, wean O2 as able to maintain O2 saturation (a reading of the amount of oxygen you have circulating in your blood) greater than 90% every shift -6/27/22, provide continuous O2 at 2 lpm via nc -6/28/22, provide continuous O2 at 1-4 lpm via nc. R41's TAR dated 7/1/22 - 8/3/22, identified nurses had initialed the orders for O2 weaning the majority of the shifts acknowledging the orders and the O2 saturations were documented as consistently above 90%. The TAR lacked indication of rate of flow. R41's nursing progress notes for dated 7/1/22 - 8/3/22, lacked consistent documentation of R41's tolerance of O2 weaning. There were five progress notes that mentioned O2 lpm and saturations: -7/31/22, at 10:43 a.m. continues on 02 at 3 lpm 96% and tolerated well -7/30/22, at 12:22 p.m. on O2 3 lpm 93% stable no concerns today -7/26/22, 11:08 a.m. O2 at 2 lpm 90% seems winded with cares -7/7/22, at 23:05 (11:05 p.m.) O2 sats 60% on 3 lpm. Increased to 4 lpm with no improvement. On-call notified and R41 declined to go to the hospital -7/4/22, at 10:06 a.m. O2 sats 98% on 3 lpm. During an observation and interview on 8/1/22, at 1:47 p.m. R41 was laying in bed on 3 lpm O2 via nc. R41 stated as far as he knew, he was always on 3 lpm. R41 stated before he was in the hospital he was not dependent on supplemental O2.	F 695		

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 08/04/2022

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 695	Continued From page 4 During an interview 8/1/22, at 6:01 p.m. NA-A stated R41 was always at 3 lpm. During an interview on 8/1/22, at 7:31 p.m. RN-A stated R41 was always at 3 lpm and she was not aware of any routine O2 weaning being performed. RN-A stated she was not aware of a specific protocol to follow and the TAR did not specify one either. During an interview on 8/2/22, at 1:09 p.m. RN-B stated she did not do any O2 weaning with R41 today and his O2 saturations were within normal limits. RN-B stated she did not think O2 weaning was something the nurses needed to do routinely. During a follow up interview on 8/3/22, at 1:14 p.m. R41 stated he was agreeable to weaning off his O2 but no one had the discussion with him on the process. R41 stated he felt like he was breathing fine today. During an interview on 8/3/22, at 1:18 p.m. licensed practical nurse (LPN)-A stated she had not done any O2 weaning with R41 today even though he was 97% on 3 lpm and had not heard if she was supposed to be even though there was an order on the TAR to do so. During an interview on 8/4/22, at 8:41 a.m. the medical doctor (MD) stated he would expect the facility to wean off O2 as ordered, follow a weaning protocol, and provide education to the resident about the process. During an interview on 8/4/22, at 11:03 a.m. the occupational therapist (OT) stated R41 occasionally felt sick during therapy when his O2 was at 2.5 lpm, even if his O2 sats were within	F 695		

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 08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 5 normal limits, so they typically kept him at 3 lpm. During an interview on 8/4/22, at 9:51 a.m. the director of nursing stated they did not have a specific protocol for weaning a resident off O2. The DON stated they would follow the MD order. The DON stated she would expect supplemental documentation from the nurses on the resident's tolerance. The DON also stated the bubbler should be changed out weekly in accordance with the orders on the TAR . Policies or procedures for O2 weaning and physician's orders was requested during survey and not provided. Facility provided policy and procedures titled Northwest Respiratory Handbook dated 2/20, identified the humidifier bottle must be cleaned between fills of distilled/filtered water or once per week using the following process: soak all parts in warm soapy water for 15 minutes, rinse and shake dry. To disinfect put all parts in a basin with one part white vinegar to three parts water and soak for 20 minutes. Rinse all parts and air dry. Additionally, the humidifier bottle should be replaced once per month.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2022**

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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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/03/2022. At the time of this survey, Birchwood Senior Living was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Birchwood Health Care Center is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(111)construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 100 beds and had a census of 80 at the time of the survey. The facility has a capacity of 100 beds and had a census of 78 at time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2022**

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2022

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

Re: Event ID: XNEH11

Dear Administrator:

The above facility survey was completed on August 4, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 08/04/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 8/1/22 - 8/4/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be IN compliance with MN State Licensure. The following complaints were found to be UNSUBSTANTIATED: H52003480C (MN84917)	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 08/04/2022

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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2 000	Continued From page 1 and H52003481C (MN84605). The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		