



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 14, 2022

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

RE: CCN: 245200
Cycle Start Date: March 16, 2022

Dear Administrator:

On April 8, 2022, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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
March 18, 2022

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

RE: CCN: 245200
Cycle Start Date: March 16, 2022

Dear Administrator:

On March 16, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 16, 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).

Birchwood Health Care Center

March 18, 2022

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In addition, if substantial compliance with the regulations is not verified by September 16, 2022 (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,



Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/06/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/16/2022
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 3/16/22, a standard abbreviated survey was conducted at your facility. 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: H5200062C (MN81365) & H5200063C (MN80957) however, related deficiencies were cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684			4/4/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/25/2022

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.

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F 684	<p>Continued From page 1</p> <p>Based on observation, interview and document review the facility failed to assist 1 of 1 resident (R1) with severe hearing impairment the use of a hearing device as stated on the care plan and resident's choice.</p> <p>Findings include:</p> <p>Upon observation on 3/16/21, at 10:41 a.m. R1 was in bed and nursing assistant (NA)-A was going to assist R1 with her activities of daily living. NA-A was shouting the instructions repetitively of the cares she would be performing into R1's right ear. R1's roommate stated from across the room "You know she has a device to help her hear." A pocket talker (a device that amplifies the sound for people who are heard of hearing) was tangled around R1's bed side rails. Upon interview on 3/16/21, at 10:58 a.m. NA-A reported knowing of the pocket talker. NA-A stated she thought it was broken and that it was only for R1 to use when visiting with her son. NA-A verified use of pocket talker was on the daily sheet; however, reported she did not know how to use it and that she hasn't seen other staff use it. "She can sometimes hear us when we get very close to her ear and speak loudly."</p> <p>R1's daily nursing assistant sheet undated, indicated under the activities of daily living (ADL's) that R1 has a pocket talker. The sheet also indicated under wellness/interests to use pocket talker.</p> <p>R1's care plan dated 1/2/20 indicated an intervention for all staff to use pocket talker in room to communicate what they are doing to meet R1's needs.</p>	F 684	<p>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:</p> <ol style="list-style-type: none"> 1) Facility assessed R1 for pocket talker accessibility and ensured its functioning state. 2) Facility reviewed all residents' assistive devices for use and function. There were no identified areas of concern. 3) All Residents care plans were reviewed and updated to reflect assistive devices. 4) Facility's QAPI committee completed a root cause analysis on March 24, 2022, regarding area of concern. Reviewed and updated facility guidelines for adaptive equipment 5) All staff will be re-educated on facility guidelines for assistive devices by April 4, 2022. The training included a return demonstration to ensure staff competency. 6) The Director of Nursing or designee will complete assistive device audits four times per week for one month, then twice weekly for one month or once 100% compliance is reached. This includes Staff audited for expectations of utilization and efficacy on use of assistive devices. 7) The Director of Nursing or designee will 		

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NAME OF PROVIDER OR SUPPLIER BIRCHWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 604 - 1ST STREET NE FOREST LAKE, 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 684	<p>Continued From page 2</p> <p>R1's care plan dated 9/7/21, indicated an intention that all staff have a slow, friendly approach. Establish eye contact. Encourage the use of pocket talker when speaking to R1 to encourage her understanding of information shared.</p> <p>R1's quarterly MDS dated 3/3/22, indicated R2 needed extensive assistance with bed mobility and assistance of daily living and needed total dependence for transfers. R1's Brief Interview for Mental Status (BIMs) score was 9 indicating moderate impairment</p> <p>Upon interview on 3/16/22, at 11:16 a.m. registered nurse (RN)-A verified the use of the pocket talker was on nursing assistant daily assignment sheet. (RN)-A reported not knowing if it worked or not. LPN-A untangled the cords and hooked up the pocket talker, tried it on the resident and resident was able to hear the conversation. (RN)-A reported having used the pocket talker, but most of the time does not.</p> <p>Upon interview on 3/16/22, at 11:40 a.m. R1 reported feeling like staff were always yelling at her and they sound "crabby" because of her hearing impairment. R1 stated staff does not use the pocket talker. When asked if she preferred the use of the pocket talker, her response was "of course I would, it would be life changing for me."</p> <p>Upon interview on 3/16/22, at 1:06 p.m. Family (FA) reported that family has always wanted the pocket used and that family makes sure it is visible to the staff whenever they visit. FA reported having asked staff to the pocket talker but has not witnessed staff use. "The entire building can hear the staff talking to my mother."</p>	F 684	review the results of the audits and monitoring with the facility's QAPI program.		

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F 684	<p>Continued From page 3</p> <p>Upon interview on 3/16/22, at 1:38 p.m. registered nurse (RN)- B reported not knowing how to use a pocket talker. RN-B stated she doesn't work on R1's unit often and was aware that R1 did have the device but denied using the device when completing cares. "I felt she could understand me well enough."</p> <p>Upon interview on 3/16/22, at 1:59 p.m. activity aide (AA)-A reported knowledge of R1's pocket talker and stated she could figure out how to use, but unsure if it was on the care plan and who was to be using it.</p> <p>Upon interview on 3/16/22, at 3:27 p.m. RN-A verified that the use of the pocket talker was on R1's care plan and on the nursing assistant daily assignment sheet. RN-A's expectation was that all departments follow the care plan and the assignment sheet and if they don't understand something to reach out and ask.</p> <p>A facility guideline dated 2011, indicated all residents receive care based on assessment of their needs. The date is used to determine and prioritize the plan of care. The purpose of the NAR care plan is to provide resident cares consistent with, and according to the plan of care. The NAR care plan is a tool that briefly identifies specific care needs for each individual resident. The NAR care plan is reviewed daily and revised as change occurs. The NAR care plan is printed off and copied after any revisions have been made.</p>			F 684			



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Electronically delivered
March 18, 2022

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

Re: Event ID: Y5I011

Dear Administrator:

The above facility survey was completed on March 16, 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,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00853	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/16/2022
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 604 - 1ST STREET NE FOREST LAKE, MN 55025		
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On 3/16/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaint was found to be</p>	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/25/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00853	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/16/2022
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2 000	Continued From page 1 UNSUBSTANTIATED: H5200062C (MN81365) & H5200063C (MN80957). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			