

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  12/19/2025
NAME OF PROVIDER OR SUPPLIER  Birchwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  604 1st Street NE Forest Lake, MN 55025	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide and implement an infection prevention and control program.  (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure proper use of personal protective equipment (PPE) for 2 of 3 (R2, R3) residents who were on enhanced barrier precautions (EBP), required personal cares and ordered treatments and staff did not maintain proper hand hygiene practices or use of gowns while performing cares and treatments. Findings include: R2's Face Sheet dated 2/16/25, indicated R2 had neuromuscular dysfunction of bladder and was a carrier or suspected carrier of methicillin resistant staphylococcus aureus (MRSA). R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 was cognitively intact, had a suprapubic catheter in place, and was on EBPs. R3's Face Sheet dated 10/18/25, indicated R1 had retention of urine and was a carrier or suspected carrier of MRSA. R3's admission Minimum Data Set (MDS) dated [DATE], indicated R3 had memory problems, had an indwelling catheter, had a feeding tube was dependent on staff for hygiene, and was on EBPs. Enhanced Barrier Precautions signage on R2 and R3's door undated, indicated providers and staff would wear gloves and gown for the following High-Contact Resident Care Activities: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toilet use, and when caring for wounds or device cares. During an observation on 12/18/25 at 9:54 a.m., registered nurse (RN)-A sanitized her hands, applied gloves, and entered R2's room. RN-A told R2 she was going to change her suprapubic catheter dressing. RN-A did not have a gown on, she removed the drainage sponge from R2's abdomen and indicated purulent tan medium amount of drainage, and discarded the soiled dressing in the garbage. RN-A removed her gloves, applied new gloves without performing hand hygiene, and cleansed the catheter site. RN-A applied a clean dressing to catheter site with same gloves she cleansed site with. RN-A removed her gloves and sanitized her hands. During an interview on 12/18/25 at 10:13 a.m., RN-A stated it was expected that staff wear personal protective equipment for residents on EBPs when they come into contact with the resident. RN-A stated she forgot to wear a gown when completing R2's treatment. RN-A stated staff were expected to wash or sanitize hands after removing soiled gloves and when going from dirty to clean areas. RN-A stated she should have sanitized her hands after removed her gloves and after cleansing R2's suprapubic site but the sanitizer and gloves were on the other side of the room so she did not do either step. During an observation on 12/18/25 at 11:18 a.m., nursing assistant (NA)-A and NA-B sanitized hands applied gown and gloves and entered R3's room. NA-A and NA-B assisted R3 to bed and lowered his pants. NA-B held R3 on his right side and NA-A cleansed bowel from R3's buttocks with wipes. NA-A removed the bowel soiled brief and placed it in the garbage and removed her gloves. NA-A applied clean gloves without sanitizing hands, applied barrier cream to R3's buttocks, applied a clean brief on R3, and placed clothes back on. NA-A emptied urine out of R3's catheter bag, removed her gloves, and applied clean gloves without sanitizing hands. NA-A and NA-B assisted R3 back to his wheelchair, took off gown and gloves, and sanitized hands. During an interview on 12/18/25 at 1:14 p.m., NA-A stated staff were expected to sanitize hands when taking gloves off. NA-A stated she did not sanitize her hands because she got nervous. During an observation on 12/18/25 at 3:48 p.m., licensed practical nurse (LPN)-A and NA-A sanitized hands, applied gown and gloves, and entered R3's room. LPN-A gathered supplies and explained to R3 that she was going to change his feeding tube dressing. LPN-A removed her gloves, washed her hands, and applied clean gloves. LPN-A removed R3's dressing with no drainage on it and placed it in the garbage, removed her gloves, sanitized her hands, and applied clean gloves. LPN-A cleansed the insertion site and applied a clean dressing without changing her gloves or sanitizing her hands. LPN-A removed her gloves, dated a piece of tape, sanitized her hands, applied a clean pair of gloves, and put the tape on the clean dressing. During an interview on 12/18/25 at 4:01 p.m., LPN-A stated she should have changed her gloves and sanitized her hands after cleansing R3's feeding tube insertion site but she did not because she was nervous. On 12/19/25 at 11:55 a.m., the director of nursing (DON) stated staff were expected to perform hand hygiene per policy. When residents are on EBPs staff were expected to wear a gown and gloves with cares and when completing dressing changes. On 12/19/25 at 11:57 a.m., the administrator stated staff were expected to follow the hand hygiene policy. Staff were expected to follow EBP guidelines when performing dressing changes on a resident on EBPs. The facility Hand Hygiene policy revised 8/2025, indicated staff would cleanse hands before putting on gloves, after removal of gloves, and before moving from a soiled body site to a clean body site. The facility Personal Protective Equipment Selection and Use policy revised 9/2023, indicated staff would apply a gown and</p>		