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	06/12/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to verify and obtain on admission a resident's need for bipap (bilevel positive airway pressure machine which delivers pressurized air through a mask over the nose or mouth to provide improvement in breathing) equipment and failed to notify the provider after prescribed breathing interventions were ineffective for 1 of 1 resident (R90) reviewed for hospitalization. This resulted in an Immediate Jeopardy situation when R90 continued to have respiratory decompensation leading to the need for transfer to the emergency room, intubation, and admission to the intensive care unit. The IJ began on 6/4/26, when R90 was hospitalized , intubated, and admitted to the intensive care unit. Administration was notified of the IJ on 6/11/26, at 3:40 p.m. The IJ was removed on 6/11/26 at 8:38 p.m., however non-compliance remained at a lower scope and severity, level 2, isolated scope, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:R90's admission Record dated 6/12/26, identified R90 was admitted on [DATE] and had diagnoses of chronic obstructive pulmonary disease (COPD, a condition where lung tissue is damaged), acute and chronic respiratory failure with hypercapnia (too much carbon dioxide in the bloodstream) and hypoxia (not enough oxygen in the bloodstream), malignant neoplasm (cancer) of bronchus or lung, pulmonary hypertension, dependence on supplemental oxygen, and heart failure.R90's care plan dated 6/3/26 identified a focus statement for altered respiratory status with difficulty breathing and shortness of breath (SOB) and included interventions to observe, document, and report any signs or symptoms of SOB, provide oxygen as ordered, observe and record pulse oximeter (SpO2) readings, and report abnormalities to provider.R90's provider orders dated 6/3/26 identified: Facility standing orders without exception. Standing orders identified to initiate and titrate supplemental oxygen from one to four liters per minute (LPM) via nasal cannula for dyspnea, hypoxia (oxygen saturation less than 90% or less than 88% for COPD) or acute angina to keep oxygen saturations (a measurement of blood oxygen gases quantified in a percentage) less than 90%; immediately update provider with nursing assessment. May wean supplemental oxygen per nursing judgment to maintain oxygen saturation greater than 90%; monitor SaO2 three times per day for three days after oxygen is discontinued, including once during night-time sleep.Budesonide inhalation suspension 0.5 MG/2M, inhale 2 milliliters (mL) by inhalation in the morning.Formoterol fumarate inhalation nebulization solution 20 MCG/2ML, inhale 2 mL via nebulizer two times per day.Sodium chloride inhalation nebulization solution 3%, inhale 4 mL via nebulizer two times per day.Ipratropium-albuterol inhalation solution 3MG/3ML, inhale 3 mL orally as needed (PRN) four times per day for wheezing or SOB. Use second after albuterol inhaler.Ventolin (albuterol) inhalation aerosol solution 108 micrograms per actuation (MCG/ACT), give two puffs by inhalation as needed for wheezing or SOB. Use first prior to ipratropium-albuterol. Continuous oxygen at 1 LPM via nasal cannula or mask to keep Sa02 greater than 90%. Ensure tubing patency and proper flow rate.Obtain and record SaO2 every shift.R90's progress notes identified the following:6/3/26 at 2:37 a.m., a respiratory status note: A respiratory evaluation was performed 06/03/2026 for R90. Resident currently sleeps in recliner. Resident currently sleeps with HOB elevated when lying in bed. Resident has needed rest breaks d/t shortness of breath with ADLs (activities of daily living) and/or (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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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Mobility. Resident uses oxygen. Lung sounds with wheezes. Respirations were shallow. Dry, non-productive cough present.6/3/26 at 4:15 p.m., a social services note: Met with resident's wife regarding her concern that the resident did not have a bipap in the facility. The wife expressed concerned with his breathing. SS reviewed resident's orders and hospital notes. SS followed up with the wife informing her that there were no orders for a bipap, just oxygen. SS informed that that the nursing team will work with the doctor here to see if a bipap can be ordered. SS directed the nurses to monitor the resident's breathing.6/4/26 at 2:15 a.m., progress note: R90 having a difficult time breathing, SpO2 mid-80's on 3 LPM oxygen. Lung sounds diminished on left with crackles and wheezes on right. PRN albuterol inhaler utilized with little effect. Nebulizer then utilized. SpO2 remaining in upper 80's. Oxygen turned up to 4 LPM and head of bed (HOB) at 65 degrees to maintain SpO2 above 90% at this time. SpO2 92% upon completion of interventions. R4 remains uncomfortable and SOB.6/4/26 2:20 a.m., a medication administration note: Ipratropium-Albuterol Inhalation Solution 3 MG/3ML, 3 ml inhale orally as needed for wheezing or SOB. Use 2nd after Albuterol inhaler. PRN Administration was: Ineffective R90's SpO2 88-89% on 3 LPM. Turned oxygen up to 4 LPM at this time.6/4/26 at 2:58 a.m., vital signs: oxygen saturation 85%, blood pressure 164/89, pulse 78, respirations 246/4/26 at 3:10 a.m., a medication administration note: Ventolin inhalation aerosol solution 108 MCG/ACT, 2 puffs every 4 hours as needed for wheezing or SOB. Use first prior to duoneb. PRN administration was ineffective R90's SpO2 remains in upper 80s.6/4/26 at 3:46 a.m., an oxygen administration note: R90 cannot tolerate one LPM, patient on four LPMs oxygen at this time to maintain saturations above 90%. 6/4/26 at 8:13 a.m., greeted resident for morning and R90 was sitting on the edge of bed. Nurse asked if resident was alright, resident shook head, indicating no. Checked SpO2, and was 80 percent. Got resident sitting up in bed and checked other vitals. Respirations were 50 (typical rate 12 to 20). Provided both scheduled nebulizer treatments, but no improvement. Called 911, after emergency medical system (EMS) arrived, R90 became nonresponsive to all stimuli. EMS transported R90 to the emergency department.R90's Discharge summary dated [DATE], identified during cardiology course of care dated 5/16 to 5/19/26, R90 had become increasingly somnolent (sleepy) and tachypneic (fast breathing) when bipap had not been worn consistently overnight. During the pulmonary course of care dated 5/26/26 to 6/1/26, R90 was seen by sleep medicine for a bipap prescription with settings of inspiratory positive airway pressure (IPAP) of 22, expiratory positive airway pressure (EPAP) of 10, and a backup rate of 16. A sleep medicine follow-up visit was arranged in three to six months. Referrals were sent for a skilled nursing facility which accepted 6/1. A discharge medication list included line items for disposable medical equipment (DME) oxygen with the message to see Order Report for details.R90's electronic medical record (EMR) included an ExuCare Summary Report (an AI-powered platform designed to analyze full admission packets) for R90, identified the hospital referral source was the same hospital as the discharge summary and included equipment and assistive devices to include nighttime bipap with settings documented in hospital discharge.During an interview on 6/11/26 at 8:27 a.m., licensed practical nurse (LPN)-B, who identified as the clinical coordinator for R90, stated she would have expected the provider to be updated or call 911 if interventions were not helping him improve. The risk of not doing so was respiratory failure and up to death. Raising the oxygen flow on someone with COPD could be detrimental to the patient and would expect nursing staff to have that knowledge.During an interview on 6/11/26 at 9:06 a.m. social services staff (SS)-A stated R90's wife had come to her on 6/3 asking why R90 didn't have a bipap. At the hospital she was told a bipap was important for his care. SS-A stated she talked to the administrator at that point, and he reached out to the admissions team, and it was found there were no orders for R90 to have bipap here, just oxygen. SS-A stated she then talked with R90's wife and explained they would try get orders for a bipap. SS-A didn't know if the provider was notified, but she did tell nursing staff to keep an eye on his breathing and let them know of his wife's concern.During an interview on 6/11/26 at 10:44 a.m., LPN-C, who identified as a long-term care clinical coordinator, stated their process was to have an outside admissions team receive the (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	referral, the history and physical, discharge orders and any other pertinent orders and then accept or deny the referral. Before the residents came to the facility, they received finalized admit orders, looked into equipment needs, any oxygen or bipap needs, and they confirmed Northwest Respiratory has received the orders. LPN-C further stated they also review the ExuCare report that summarizes the care and equipment used in the hospital course and what the resident may need for care and equipment here. LPN-C pulled up R90's report in the EMR and a bipap was identified on the report.During an interview on 6/11/25 at 10:59, registered nurse (RN)-B stated he worked the morning shift of 6/4/26 and noted R90 to be in respiratory distress, he initiated help from an LPN, so that he could stay with the resident while the LPN called 911 and started to get the paperwork ready.During an interview on 6/11/26 at 11:29 a.m., customer service lead (CS)-D at Northwest Respiratory stated they had received orders for oxygen for R90 on 6/1/26, but they hadn't received an order for a bipap until yesterday when he was discharged from the hospital to a different facility.During an interview on 6/11/26 at 11:35 a.m., RN-A identified as the nurse caring for R90 on the night of 6/3 to 6/4/26, stated she hadn't updated another RN, DON, or provider that R90 continued to decompensate after provided interventions.During an interview on 6/11/26 at 12:23 p.m., the director of nursing (DON) stated when oxygen needs required increasing oxygen, or if the initial treatments were not helping, then the staff should notify the provider.During an interview on 6/11/26 at 12:37 p.m., corporate admissions coordinator (AC)-E stated there wasn't anything that indicated R90 needed a bipap but did remember the facility administrator asking her if R90 was supposed to have a bipap, and she had told them it didn't flag on the discharge note from the provider. AC-E stated she sent the paperwork to the respiratory company to get a machine delivered after talking with the facility.During an interview on 6/11/26 at 12:42 p.m., LPN-A stated she remembered working the morning of 6/4/26 and helping RN-B with R90. LPN-A stated that she and RN-B both felt that R90 needed to be sent in when they assessed the resident on the morning of 6/4/26.R90's hospital record dated 6/4/26 at 9:32 a.m., identified patient was obtunded and in respiratory failure on arrival requiring intubation to protect airway. Provider noted they suspected patient developed increasing carbon dioxide retention since discharging as he does not have home bipap machine that was recommended. During an interview on 6/11/26 at 1:40 p.m., the medical director stated he would have expected the nurse to call a provider if the patient didn't look good and interventions were not successful. This patient really needed a BIPAP to wash out the carbon dioxide, all the oxygen wouldn't help. With sooner intervention, he may have avoided intubation. The facility needs more education for nursing staff about when to call the provider.The immediate jeopardy was removed on 6/11/26 at 8:38 p.m., when it was determined the facility had completed the following:-Identified any residents that had unmet respiratory needs-Implemented education to licensed nursing staff regarding the admission process, assessments, and how to utilize oxygen administration orders in conjunction with oxygen standing orders-Implemented education on when to notify the provider and other nursing staff when a resident is experiencing a change of condition-Reviewed and revised necessary policies pertaining to admission process and assessments, oxygen or equipment needs, provider notification, management of COPD for residents with hypercapnia Policies regarding oxygen use and respiratory equipment needs, and the admission process were requested but not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and document review the facility failed to ensure residents were given an opportunity to wash their hands prior to eating. This had the potential to affect any resident who chose to eat in the main dining room.Findings include:During an observation on 6/8/26 at 12:06 p.m., dining was in progress in the main dining room. Tables had hand wipes on the tables. Staff were not observed to offer residents an opportunity to clean their hands as they were brought in and seated at the tables.During an observation on 6/9/26 at 4:13 p.m., in the main dining room staff were bringing residents to the tables, staff were not observed offering any residents hand wipes to clean their hands. There were hand wipes on each table.During an observation on 6/9/26 at 4:25 p.m., in the main dining room staff were bringing residents into the dining room, staff were not observed offering hand wipes to residents as they brought them in.During an observation on 6/9/26 at 4:40 p.m., another resident was brought into the dining room and placed at a table, they were not offered a hand wipe to clean their hands.During an observation on 6/11/26 at 7:17 a.m., a resident was brought into the dining room and situated at the table she was not offered an opportunity for handwashing, she was however offered something to drink.During an observation on 6/11/26 at 7:19 a.m., R24 was brought into the main floor dining room and was assisted to her table, she was not offered an opportunity to wash her hands but was brought some juice.During an observation on 6/11/26 at 7:22 a.m., R47 was brought into the dining room and seated by R12, he was not offered an opportunity to wash his hands but was brought some juice.During an observation on 6/11/26 at 7:26 a.m., R69 and R51 were seated at a table in the dining room coloring and looking at magazines at the table where they eat.During an observation on 6/11/26 at 7:26 a.m., R12 was observed getting juice on his own.During an observation on 6/11/26 at 7:31 a.m., R69 was brought her breakfast, no handwashing was offered. R51 had not been offered handwashing and she was eating toast with her hands.During an observation on 6/11/26 at 7:44 a.m., R13 was brought into the dining room, they were not offered hand washing but they were offered a beverage.During an observation on 6/11/26 at 7:45 a.m., R24 was observed eating peanut butter toast with her hands.During an observation on 6/11/26 at 7:51 a.m., R16 was brought to a table, no offer was made for handwashing.During an observation on 6/11/26 at 7:51 a.m., R13 entered and did not perform handwashing but helped herself to items from the counter. During an observation on 6/11/26 at 7:57 a.m., R34 was brought into the dining room, she was given a clothing protector but not offered handwashing.During an interview on 6/11/26 at 10:23 a.m., nursing assistant (NA)-F stated it was the nursing assistants' job to make sure residents received assistance to wash their hands prior to eating. During an interview on 6/11/26 at 10:25 a.m., NA-E stated they should be offering residents a chance to use the hand wipes before meals.During an interview on 6/11/26 at 10:31 a.m., registered nurse (RN)-F stated all staff should be helping residents with hand washing before meals. RN-F stated it was important to do this to prevent the spread of germs.During an interview on 6/1/26 at 10:43 a.m., the director of nursing (DON) stated when the NAs brought residents into the dining room they should be offering them the hand wipes to clean their hands. The DON stated this would be important to prevent the spread of germs. The DON further qualified any staff who brought a resident to the dining room should be offering handwashing. Hand Hygiene dated 8/2025, identified proper hand washing should be used to protect the spread of infection. The policy did not address hand hygiene related to residents and meals.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a resident's call light was answered timely to prevent a bladder accident for 1 of 1 resident (R53) reviewed for bowel and bladder. Findings include:R53 was admitted on [DATE], his admission Minimum Data Set (MDS) was in progress. R53's Face Sheet dated 6/11/26, identified R53 had diagnoses which included post-polio syndrome (a progressive neurological condition that causes new or worsening muscle weakness, fatigue, and pain decades after an initial polio infection), benign prostatic hyperplasia without lower urinary tract symptoms (non-cancerous enlargement of the prostate gland that commonly occurs as men age, obstructing urine flow and causing bothersome lower urinary tract symptoms like frequent urination, weak flow, and the inability to fully empty the bladder).R53's care plan dated 6/9/26, identified R53 was at risk for falls, interventions included to have his call light accessible and within reach. R53's care plan identified incontinence and interventions included to have urinal available.R53's admission note dated 6/8/26, identified R53 was oriented to time, place, and person. His speech was clear and he was able to make himself understood and usually understood others. In addition, R53 was identified as continent of bladder.On 6/8/26 at 2:32 p.m., someone was heard shouting and saying, quickly I need the urinal. The call light was on for R53's room.On 6/8/26 at 2:32 p.m., therapy staff were observed outside of R53's room, no actions were taken for R53 by therapy staff.On 6/8/26 at 2:34 p.m., the call light banner was scrolling and flashing for R53's room.On 6/8/26 at 2:41 p.m., R53's call light remained on, a staff member walked past R53's room but no actions were taken.On 6/8/26 at 2:42 p.m., a staff member from activities found a nursing staff and informed them R53's call light was on. The staff member knocked and went into R53's room and shut the door.On 6/8/26 at 2:49 p.m., nursing assistant (NA)- B left R53's room and returned with a urinal for R53.During an interview on 6/8/26 at 2:51 p.m., R53 stated his call light had been on for a h*** of a long time, he stated he'd had an accident waiting for someone to answer his call light. R53 stated after the call light had been on for 20 minutes he started calling out loud for help. He said he had been in the facility for about an hour. R53 stated he was not given a urinal when he was admitted and stated he'd had to use drinking cups to urinate in. He stated his clothes had gotten wet and also the floor got wet. He pointed to two bags on the floor as evidence of the accident and the long wait for help.On 6/8/26 at 3:10 p.m., R53 wanted the administrator to come to the room, R53 told the administrator his chair was not working and pointed out the two bags on the floor, the drinking cups were visible in the bag. The administrator stated he was aware that R53's motorized wheelchair was not working when he arrived, and he then took a picture of the control screen.During an interview on 6/8/26 at 3:27 p.m., NA-C stated when she entered R53's room he had urinated in the drinking cups, she stated there was also urine on the floor, the overbed table, and the bed. She stated she cleaned it all up and sanitized the table. NA-C stated R53 would not allow her to remove the bags with the linen and the garbage.During an interview on 6/10/26 at 2:41 p.m., NA-D stated when a new admission arrived it was nursing's job to ensure they had supplies which for some residents would include a urinal.During an interview on 6/10/26 at 3:42 p.m., the unit coordinator (UC)- F stated she had heard later that when R53 arrived his motorized wheelchair was not working. UC-F stated the hospital had not communicated anything about his wheelchair not working.During an interview on 6/11/26 at 8:29 a.m., the social service director (SS)-A stated they found out the day he arrived that his motorized wheelchair wasn't working but had heard registered nurse (RN)-E and the administrator had figured out how to fix it (it had been in a manual mode setting).During an interview on 6/11/26 at 9:15 a.m., the administrator verified when R53 arrived his motorized wheelchair was not working properly, and it took three staff to get the motorized wheelchair out of the van. He stated RN-E figured out the problem and corrected it. The administrator volunteered R53's call light had been on 14 minutes (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before it was answered.During an interview on 6/11/26 at 10:26 a.m., NA-E stated part of getting a new resident settled would include asking a male resident if they needed a urinal.During an interview on 6/11/26 at 10:41 a.m., the director of nursing (DON) stated it would be important to ensure a resident was provided with items they needed upon admission, including a urinal for male resident to prevent accidents and to promote dignity.Call Lights Accessibility and Timely Response Policy dated 4/2025, identified the purpose of the call light was to allow residents to call for assistance. The policy included the call light would be relayed directly to a staff member. The policy also included All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to meet the requirements for a bed hold notification for 1 of 2 residents (R90) reviewed for hospitalization.Findings include:R90's admission Record dated 6/12/26, identified R90 was admitted on [DATE] and had diagnoses of chronic obstructive pulmonary disease (COPD, a condition where lung tissue is damaged), acute and chronic respiratory failure with hypercapnia (too much carbon dioxide in the bloodstream) and hypoxia (not enough oxygen in the bloodstream), malignant neoplasm (cancer) of bronchus or lung, pulmonary hypertension, dependence on supplemental oxygen, and heart failure.R90's electronic medical record (EMR) didn't contain evidence of a bed hold offered to R90 or his spouse when he was transferred to the hospital.During an interview on 6/11/26 at 8:27 a.m., licensed practical nurse (LPN)-A stated the usual process for bed hold was when they go out ask if they want to hold the bed and provide them with bed hold policy at the time of their need to transfer or if the resident was unable to say, they will call the family. LPN-A stated she saw social work had put in a note this morning, stating bed hold policy was sent with resident to the hospital on 6/4. LPN-A's expectation would be the resident or family were asked if they wanted to hold the bed and that it is documented at that time, which was important because there could be a private pay responsibility and the hospital needs to know if they have a bed hold.During an interview on 6/11/26 at 9:06 a.m. social services person (SS)-A stated when a resident was sent out, they were sent with a copy of the bed hold and transfer form and then she would follow up with the family and find out if they want to hold the bed. SS-A stated she attempted to call R90's wife on 6/9, who then called SS-A back on 6/10 stating they didn't wish to hold the bed. SS-A further stated she usually would want to make that call the next day or once they knew if the resident had been admitted , unfortunately time got away from her on this one.A bed hold policy was requested but not received.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure staff was properly educated on how to monitor a dialysis access site for 1 of 1 resident (R1) reviewed for dialysis.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, with diagnoses that included end stage renal disease (ESRD), and required dialysis.R1's care plan dated 6/9/26, indicated R1 required hemodialysis with potential for (arteriovenous) AV fistula malfunction. Instructions included to check for a thrill/bruit at the AV fistula/graft left arm access site every shift and as needed.R1's orders dated 6/11/26, indicated hemodialysis three times weekly, and instructed:Monitor hemodialysis vascular access AV fistula on left arm for signs and symptoms of infection every shift.Dialysis -Thrill/Bruit: Check Thrill (palpate) & Bruit (listen with stethoscope) every shift.Dialysis Post Run: Obtain full vital signs (VS) post dialysis run every evening shift every Tuesday, Thursday, Saturday.During an observation on 6/9/26 at 3:12 p.m., R1 returned from dialysis and licensed practical nurse (LPN)-D checked R1's vitals and AV fistula site. LPN-D looked at the AV fistula dressing and placed a gloved hand at the site. LPN-D did not use a stethoscope to auscultate the AV fistula site.During an interview on 6/9/26 at 3:38 p.m., LPN-D stated they did not know what a thrill or bruit was but indicated it was related to the AV fistula. They stated they thought the thrill and bruit should be checked when a resident returned from dialysis, but they needed to look it up. During an interview on 6/9/26 at 3:41 p.m., LPN-D returned and stated the thrill was what they felt at the AV fistula when they rested their hand on the site, and the bruit was a sound to listen for at the site. LPN-D confirmed they had not listened for the bruit and stated they would grab their stethoscope to listen now.During an interview on 6/11/26 at 8:37 a.m., director of nursing (DON) stated that when a resident returns from dialysis, nurses were to obtain vitals, check port site for bleeding, thrill and bruit, and monitor for lethargy. They stated they expected nurses to know how to check for a thrill and a bruit and stated it was important to auscultate for a bruit to ensure patency of the AV fistula. If it were not patent, they would have concern for a possible blood clot.Dialysis Care Plan and Treatment Sheet guideline instructed staff to monitor for complications following dialysis and monitor the shunt site by checking for the bruit and thrill.

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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Health Care Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that assessments and orders were in place for self-administration of medication and bedside storage for 1 of 1 resident (R40) who was reviewed for safe self-administration and storage of medications. Findings include: R40's quarterly Minimum Data Set (MDS) dated [DATE], indicated R40 was cognitively intact with diagnoses of diabetes, chronic kidney disease, and peripheral vascular disease.R40's care plan last reviewed 3/22/26, included Focus area Med Self Administration dated 9/30/25, which indicated R40 was able to keep at besides, and self-administer Voltaren gel. The associated intervention section instructed: (9/30/25) facility to administer medications as resident is not safe to independently administer medications at this time.R40's Order Summary Report, Active Orders as of 6/11/26, included okay to have over the counter medications for nerve pain in room. The order summary lacked administration parameter orders and/or orders to keep at bedside for the following medication/supplements: Amala super fruit extract, aged garlic extract, Alphacure, total pain relief supplement, Lymphavive, vision supplement, triple complex magnesium, coq10 complex, Antartic [NAME] oil, and Moringa.A medication assessment completed on 7/17/25, indicated R40 was safe to keep at bedside and self-administer the medication Nerve Renew Supplement two times a day. The chart lacked evidence of completion of subsequent self-administration assessments for oral medication administration.During an interview on 6/8/26 at 12:40 p.m., it was noted R40's bedside table in their room had multiple over the counter medication bottles on it.During an observation on 6/9/26 at 4:29 p.m., multiple over the counter bottles of medications remained on R40's bedside table in their room.During an interview on 6/10/26 at 2:50 p.m., R40 stated they had ordered the bottles of medication from advertisements they had seen. R40 confirmed the following medication/supplement bottles were located on their room bedside table: Amala super fruit extract, aged garlic extract, Alphacure, total pain relief supplement, Lymphavive, vision supplement, triple complex magnesium, coq10 complex, Antartic [NAME] oil, and Moringa. R40 confirmed they had been keeping the bottles on their bedside table. R40 did not think that any of the nursing staff had taken a list of the bottles for the doctor or the pharmacist to review. R40 did not think they had been tested on taking the pills either.During an observation on 6/11/26 at 7:27 a.m., R40 was in bed with eyes closed. Multiple over the counter medication bottles remained on R40's bedside table.During an interview on 6/11/26 at 9:08 a.m., the bottles of over-the-counter medication were present on R40's bedside table.During an interview on 6/11/26 at 10:22 a.m., the director of nursing stated (DON) if a resident would like to self-administer medications or supplements, nursing would do an assessment to see if they could safely do so. If safe, an order from the doctor for the resident to be able to self-administer the medications would be requested. Most medications kept at bedside should have an order and a completed assessment to ensure the medication(s) could be safely kept at bedside. When staff become aware a resident has medications at bedside, they should notify the nurse so the nurse can make sure the resident has orders and an assessment in place for the medications. If nothing is in place the nurse should initiate the process.The facility policy Medication Self Administration Safety Screen and /or Self Administration dated 9/2023, included evaluation and approval of self-administration will be based on the medication self-administration safety screen which is to be completed prior to a resident self-administering medication. A physician order will be obtained with indication of which medications the resident may self-administer with or without staff supervision. Repeat self-administration safety assessments will be completed at minimum quarterly and with medication changes, changes in function/condition that might impact ability to self-administer.

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	06/12/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and document review the facility failed to provide residents the Skilled Nursing Facility Advance Beneficiary notice of Non-coverage (SNF ABN) CMS-10055 when Medicare part A services were being discontinued and the resident stayed in the facility. This affected 4 of 4 (R1, R5, R8, R11) residents reviewed for beneficiary notices. Findings include:R1's Notice of Medicare Non-Coverage (CMS-10123) dated 4/21/26, indicated R1's last covered day of Medicare A would be 4/23/26. R1's electronic medical record (EMR) lacked indication the SNF ABN was provided.R1's Census list and progress notes indicated R1 remained at the facility after 4/21/26 (Medicare Part A discharge date).R5's CMS-10123 dated 3/12/26, indicated R5's last covered day of Medicare A would be 3/13/26. R5's electronic medical record (EMR) lacked indication the SNF ABN was provided.R5's Census list and progress notes indicated R5 remained at the facility after 3/12/26 (Medicare Part A discharge date).R8's CMS-10123 dated 2/2/26, indicated R8's last covered day of Medicare A would be 2/5/26. R8's electronic medical record (EMR) lacked indication the SNF ABN was provided.R8's Census list and progress notes indicated R8 remained at the facility after 2/5/26 (Medicare Part A discharge date).R11's CMS-10123 dated 5/14/26, indicated R11's last covered day of Medicare A would be 5/23/26. R11's electronic medical record (EMR) lacked indication the SNF ABN was provided.R11's Census list and progress notes indicated R11 remained at the facility after 5/23/26 (Medicare Part A discharge date).During an interview on 6/9/26 at 5:21 p.m., the licensed social worker (LSW) stated she was not aware the SNF ABN needed to be given to residents. The facility had been using from CMS-R-131 (the ABN form for home health and hospices) instead. The LSW reviewed all medical records and confirmed R1, R5, R8, and R11 remained in the facility after discharge from Medicare-A. During an interview on 6/9/26 at 5:34 p.m., the administrator stated the facility had been told by corporate staff to use CMS-R-131 when all residents were discharged from Medicare-A and stayed in the facility. Facility policy Advanced Beneficiary Notices dated 4/1/26, indicated residents would receive form CMS-10055 when residents were discharged from Medicare-A services. Form CMS-R-131 would be utilized for residents under Medicare-B services.