

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  24E166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/18/2024
NAME OF PROVIDER OR SUPPLIER  Birchwood Care Home		STREET ADDRESS, CITY, STATE, ZIP CODE 715 West 31st Street Minneapolis, MN 55408	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49618</p> <p>Based on interview and record review, the facility failed to develop a comprehensive care plan for one of one resident (R1) when reviewed for care plans. R1 did not have adequate interventions in place after a history of eloping/wandering from the facility.</p> <p>Findings include:</p> <p>R1's Admission Record printed on 6/17/24 indicated R1 was admitted to the facility on [DATE]. The Admission Record stated R1's medical diagnosis included schizoaffective disorder.</p> <p>R1's minimum data set (MDS) dated [DATE] indicated R1 had a brief interview for mental status (BIMS) score of 15, which indicated R1 was cognitively intact.</p> <p>R1's care plan dated 2/14/24 indicated R1 has command voices that are loud, whispers that can be intense that tell him things to do and if he is decompensating, he will act on those commands. Interventions indicated staff to ask questions to bring R1 back to reality such as 1. Are you having whispers, intense, or screaming voices? And 2. What are the voices telling you? The intervention indicated to remind R1 that it is not ok to take off his clothing and that he is not going to hell if he does throw away his clothing. Another intervention indicated staff will ask R1 on every shift if he hears voices. The care plan does not indicate what staff are to do when R1 is hearing command voices.</p> <p>R1's care plan dated 2/14/24 indicated R1 is not safe leaving the facility unsupervised when command voices are present. The indicated goals were R1 would be safe when in the community, R1 will notify charge nurse when leaving building and when returning, and R1 will use the sign out book when leaving the facility. The intervention indicated staff would provide hourly checks on R1 as needed when R1 has increased symptoms of hearing command voices related to the diagnosis of schizophrenia, staff would assess resident psychotic symptoms every shift, and staff would remind R1 to notify nurse when leaving building and when he returns. The care plan does not indicate what staff are to do when R1 is hearing command voices or how to assess if R1 is hearing command voices.</p> <p>R1's care plan dated 2/14/24 indicated R1 self-isolates and does not ask for as-needed medications when he hears command voices. The care plan indicated R1 decompensates rapidly if R1 does not take his as-needed medication when he is hearing command voices. The care plan does not indicate signs to look for when R1 is decompensating or interventions when R1 is decompensating.</p> <p>(continued on next page)</p>		

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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NAME OF PROVIDER OR SUPPLIER  Birchwood Care Home		STREET ADDRESS, CITY, STATE, ZIP CODE  715 West 31st Street Minneapolis, MN 55408	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's care plan dated 2/14/24 indicated R1 currently uses a GPS tracker to monitor R1's whereabouts. The care plan stated R1 gets the tracker from the charge nurse and the charge nurse will turn on the GPS tracker. The care plan stated R1 confirms he has his cell phone on. The care plan stated R1 left the facility due to his command voices telling him to leave on 3/9/24 and 3/11/24 without the GPS tracker. The care plan indicated R1 returned both of those instances with no injury. The interventions included R1 seeing Associated Clinic of Psychology (ACP) therapist weekly or bi-weekly, the staff would call R1's cell phone if he does not return to the facility when he stated he would, staff would follow the missing person/wandering resident policy and procedure, staff would monitor resident whereabouts hourly and document on hourly monitoring sheets whereabouts and visible symptoms of increased command voices, and when R1 went to the nurse to request a tracking device the nurse would have R1 fill out a worksheet that asked: 1. Do you have a specific destination in mind? If yes, where? 2. Are your voices telling you not to return? 3. Do you feel like you have to listen to the voices? 4. Do you feel safe? and if R1 indicated a yes to any of those questions the nurse would complete flow chart for elopement risk assessment and management and follow interventions as listed. The care plan does not indicate what staff should do if R1 has high intensity command voices.</p> <p>An interview was attempted with R1 on 6/17/24 at 11:08 a.m. and R1 declined to be interviewed.</p> <p>During an interview on 6/17/24 at 11:31 a.m., the director of social services stated when there is more activity going on in the facility, is when R1 starts to hear more command voices and he gets overwhelmed. The director of social services stated if R1 gets overwhelmed, he will not sign out in the sign out book and he will not grab his GPS tracker. The director of social services stated there is nothing the facility can do to stop R1 from leaving.</p> <p>During an interview with registered nurse (RN)-A on 6/18/24 at 9:16 a.m., RN-A stated the facility needs to be able to help him control his command voices when his command voices are too loud because that is when he gets overwhelmed and leaves the facility without signing out in the sign out book or getting his GPS tracker from the nurse's station.</p> <p>During an interview with the certified nursing assistant (CNA)-A on 6/18/24 at 9:29 a.m., CNA-A stated she was not sure what she should do if she found R1 in a distressed state. CNA-A stated she was unaware of interventions to be done when R1 is in a distressed state.</p> <p>An interview was attempted with R1 on 6/18/24 at 9:26 a.m. and R1 declined to be interviewed.</p> <p>During an interview with the director of nursing (DON)-A on 6/18/24 at 10:12 a.m., the DON stated R1's intervention for a GPS tracker was placed on his care plan about a year ago and does not think there has been any new interventions since his last elopement. The DON stated he has done so many elopements that it is hard to keep track on them.</p> <p>During an interview with the DON on 6/18/24 at 11:24 a.m., the DON stated if staff is noticing R1 having more anxious or overwhelmed behaviors, they chart those behaviors and based on those behaviors staff should figure out what to do to help R1.</p> <p>The facility procedure titled Missing Resident Reporting Procedure, not dated, indicated find out why the resident was missing, where they were, then document in nursing notes. The procedure did not identify the development of resident interventions to prevent future missing person incidents.</p>		