Electronically Delivered

October 6, 2023

Licensee
Birchwood Cottages
1845 Austin Road
Owatonna, MN 55060

RE: Project Number(s) SL33374015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

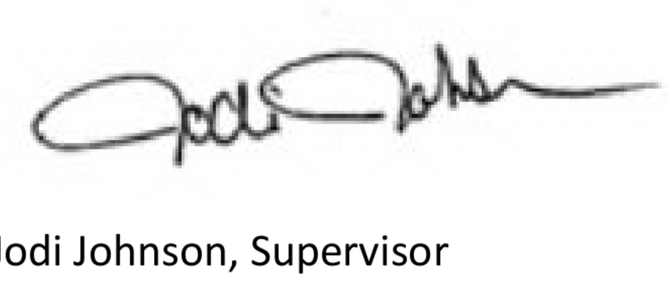
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33374	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1845 AUSTIN ROAD OWATONNA, MN 55060

(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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33374015 On September 11, 2023, through September 13, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 21 active residents; 21 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 1 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On facility tour with Licensed Assisted Living Director (LALD)-A, Maintenance Director (MD)-F, and Vice President (VP)-G, on September 12, 2023, between approximately 8:30 a.m. and 11:30 a.m., it was observed that the kitchen area contained unsecured utensils that were accessible to anyone. The utensils were contained within a drawer, but this drawer was not adequately secured to ensure safety to the residents of the facility.	0 800		

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0 800	Continued From page 2 This deficient condition was verified by LALD-A, MD-F, and VP-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 3 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation; and failed to complete required employee evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on September 12, 2023, between approximately 11:15 a.m. and 12:00 p.m. with the Licensed Assisted Living Director (LALD)-A, Maintenance Director (MD)-F, and the Vice President (VP)-G on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that the employees did not receive training twice per year after initial hire;	0 810		

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0 810	Continued From page 4 residents capable of self-evacuation were not provided training on proper actions to take in the event of a fire at least once per year; and evacuation drills for employees had not been performed twice per year per shift with one drill every other month as required. During interview, LALD-A stated that training for fire evacuation and safety is completed for all new residents and new hires but could not provide records that showed this. Residents also met at resident council meetings every three months, but no record of resident training was kept. Fire evacuation drills were conducted with all shifts together and did not meet the number per shift or the every-other-month requirements. MD-F explained that there was confusion on the amount and frequency of the drills and would fix the issue in the future. These deficient conditions were verified by LALD-A, MD-F, and VP-G during interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability	01440		

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01440	Continued From page 5 to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 calendar days of providing services for two of two unlicensed personnel (ULP-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was no likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C began working for the licensee on	01440		

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01440	Continued From page 6 February 15, 2023, to provide direct care services to residents. On September 12, 2023, at 7:02 a.m. ULP-C was observed to administer medications to R2. ULP-C's record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide services. ULP-D ULP-D began working for the licensee on June 5, 2023, to provide direct care services to residents. On September 12, 2023, at 8:10 a.m. ULP-D was observed providing a female resident with standby assistance with use of a gait belt while ambulating to the dining room. ULP-D's record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide services. On September 13, 2023, at 10:29 a.m. RN-B stated ULP-C and ULP-D's employee records lacked documentation of direct supervision completed by RN within 30 days of providing services to a resident. The licensee's delegation of nursing tasks to unlicensed personnel dated January 20, 2022, indicated the RN would conduct 30 day supervisions per statue for ULP.	01440		

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01440	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments	01620		

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01620	Continued From page 8 not to exceed 14 days from admission for two of two residents (R1, R2), and failed to conduct ongoing nursing assessments not to exceed 90 days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on November 7, 2022, with diagnoses that included depression, anxiety, diabetes, chronic obstructive pulmonary disease (condition involving constriction of the airways), thrombophlebitis (inflammation of the wall of a vein with associated the formation of a blood clot), hyperlipidemia (high cholesterol), and hypertension (high blood pressure). R1's service plan signed on August 23, 2023, indicated R1 received services to include assistance with bedtime cares, toileting, showers, transfers, meals, laundry, and medication management. R1's ongoing nursing assessments were requested. Assessments dated November 28, 2022, February 27, 2023, May 28, 2023, and August 26, 2023, were provided. The November 28, 2022, assessment was 21	01620		

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01620	Continued From page 9 days after the date of admission, exceeding 14 calendar days. The February 27, 2023, assessment was done 91 days after the date of the previous assessment, exceeding 90 calendar days. R2 R2 was admitted for services on January 26, 2023, with diagnoses that included dementia, diabetes, chest pain, abnormal gait, weakness, hypotension (low blood pressure), insomnia, repeated falls, and pain. R2's service plan signed on September 6, 2023, indicated R2 received services to include assistance with morning and bedtime cares, showers, toileting, transfers, alarm checks, behavior monitoring, fall prevention safety checks, meals, laundry, and medication management. R2's ongoing nursing assessments were requested. Assessments dated February 13, 2023, May 10, 2023, and August 7, 2023, were provided. The February 13, 2023, assessment was 18 days after the date of admission, exceeding 14 calendar days. On September 13, 2023, at 10:14 a.m. RN-B stated R1 and R2's assessments were not completed within the required time frame. RN-B stated a previous RN had completed both R1 and R2's assessment and was unsure why they were not completed on time. The licensee's Initial and On-going Nursing Assessments of Residents policy dated January 22, 2022, indicated an RN would complete	01620		

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01620	Continued From page 10 comprehensive nursing assessments of resident's physical, mental, and cognitive needs as required up to 14- days after start of services, periodically but no less than every 90-days and with change in resident condition. No further information was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940		

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01940	Continued From page 11 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include on the service plan a written statement of the treatment or therapy services provided for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 11, 2023, at 10:57 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents as prescribed. R1's physician orders dated August 9, 2023, included blood glucose check once daily before breakfast. Notify provider if less than 70 or greater than 500. On September 12, 2023, at 7:49 a.m. unlicensed personnel (ULP)-C was observed administering	01940		

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01940	Continued From page 12 medications to R1 which included a blood glucose check and insulin administration. R1's service plan dated August 23, 2023, did not include blood glucose check daily. On September 13, 2023, at 10:14 a.m. registered nurse (RN)-B stated R1 had an order for blood glucose check once daily before breakfast. RN-B reviewed R1's service plan and stated the blood glucose check had not been added to it. The licensee's Treatment and Therapy Services policy dated February 1, 2022, indicated based on the nursing assessment, the CNS or designated RN would develop an individualized service plan for each resident receiving any type of treatment and/or therapy services, consistent with current practice standards and guidelines, and will develop specific procedures for the services that staff would provide. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33374	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1845 AUSTIN ROAD OWATONNA, MN 55060

(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
02170	Continued From page 13 participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for three of three residents (R1, R2, R3) who resided in an assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33374	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1845 AUSTIN ROAD OWATONNA, MN 55060

(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
02170	Continued From page 14 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective April 1, 2023. R1 R1 was admitted for services on November 7, 2022. R1's diagnoses included depression, anxiety, diabetes, chronic obstructive pulmonary disease (condition involving constriction of the airways), thrombophlebitis (inflammation of the wall of a vein with associated the formation of a blood clot), hyperlipidemia (high cholesterol), and hypertension (high blood pressure). R1's undated, Memorable Experience Profile lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R1's undated, Life Enrichment Evaluation lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations;	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33374	A. BUILDING: _____ B. WING _____	09/13/2023

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BIRCHWOOD COTTAGES	1845 AUSTIN ROAD OWATONNA, MN 55060

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02170	Continued From page 15 - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R1's record did not include evidence of an individualized activity plan based on the resident's activity assessment. R2 R2 was admitted for services on January 26, 2023. R2's diagnoses included dementia, diabetes, chest pain, abnormal gait, weakness, hypotension (low blood pressure), insomnia, repeated falls, and pain. R2's undated, Memorable Experience Profile lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R2's undated, Life Enrichment Evaluation lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R2's record did not include evidence of an individualized activity plan based on the resident's	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33374	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1845 AUSTIN ROAD OWATONNA, MN 55060

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02170	Continued From page 16 activity assessment. R3 R2 was admitted for services on May 22, 2023 R3's diagnoses included frontal temporal dementia (a group of brain disorders that primarily affect the frontal and temporal lobes of the brain generally associated with personality, behavior and language), hallucinations, primary progressive aphasia (a brain disorder where a person has trouble speaking or understanding other people speaking), major depressive disorder, and vision loss. On September 12, 2023, at 8:45 a.m. unlicensed personnel (ULP)-C was observed administering medications to R3 in the resident's room. R3 accepted and took the medications without incident though was unable to carry on a sensical conversation with ULP-C. When ULP-C exited R3's room, another resident asked for assistance with the window in her room. ULP-C entered the other resident's room; R3 followed her into the room and wandered about until ULP-C had finished assisting the other resident. ULP-C then took R3 by the hand and walked her out of the other resident's room and assisted her with sitting at the dining room table for breakfast. R3's undated, Memorable Experience Profile lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33374	A. BUILDING: _____ B. WING _____	09/13/2023

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02170	Continued From page 17 R3's undated, Life Enrichment Evaluation lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R3's record did not include evidence of an individualized activity plan based on the resident's activity assessment. On September 13, 2023, at 11:23 a.m. activity director (AD)-E reviewed the required criteria needed for the activity assessment and stated her current assessments did not include the above required components. AD-E further stated the activity plan included in the Life Enrichment Evaluation was not individualized for each resident. The licensee's Life Enrichment Programming policy dated January 25, 2022, indicated the licensee would complete an activity evaluation for each resident and develop an individual activity plan for the resident based on that evaluation that reflects their preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/12/23*
Time: 07:56:01
Report: 8044231332

Food and Beverage Establishment Inspection Report

Location:
Birchwood Cottages
1845 Austin Road
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0037809
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074136800
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 174.4 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Spray bottlr
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36.2 Degrees Fahrenheit - Location: Milk in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35.0 Degrees Fahrenheit - Location: Upright 1
Violation Issued: No

Process/Item: Hot Holding
Temperature: 168.2 Degrees Fahrenheit - Location: Oatmeal
Violation Issued: No

Process/Item: Cold Holding
Temperature: 32.6 Degrees Fahrenheit - Location: Milk in Coastal fridge
Violation Issued: No

Process/Item: Cold Holding
Temperature: 33.0 Degrees Fahrenheit - Location: Coastal fridge
Violation Issued: No

Type: Full
Date: *09/12/23*
Time: 07:56:01
Report: 8044231332
Birchwood Cottages

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 36.0 Degrees Fahrenheit - Location: Farm fridge
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

HRD inspection conducted with nurse evaluator Wendy Buckholz and Kassie Marking. Inspection report reviewed on site with Laura Kaiser.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044231332 of 09/12/23.

Certified Food Protection Manager: Susan K. Polasek

Certification Number: FM38648 Expires: 05/11/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Laura

Signed: _____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us