Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 16, 2024

Administrator
Bigfork Valley Communities
258 Pine Tree Drive
Bigfork, MN 56628

RE: CCN: 245529
Cycle Start Date: November 15, 2023

Dear Administrator:

On December 19, 2023, the Minnesota Departments of Health and Public Safety, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
November 30, 2023

Administrator
Bigfork Valley Communities
258 Pine Tree Drive
Bigfork, MN 56628

RE: CCN: 245529
Cycle Start Date: November 15, 2023

Dear Administrator:

On November 15, 2023, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 February 15, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by May 15, 2024 (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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. BUILDING ______ B. WING ______	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIGFORK VALLEY COMMUNITIES	**258 PINE TREE DRIVE BIGFORK, MN 56628**

(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
E 000	Initial Comments On 11/13/23 - 11/15/23, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements at 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/13/23 - 11/15/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H55297003C (MN92023). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/04/2023

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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure proper placement of a full mechanical lift sling to ensure a safe transfer for 1 of 2 (R2) observed during full mechanical lift transfers. Findings include: R2's quarterly Minimum Data Set (MDS) dated 9/15/23, identified R2 was severely cognitively impaired, and diagnoses included hemiplegia, hemiparesis, and aphasia. R2's care plan dated 10/3/23, identified staff used the full mechanical lift for transfers to and from the bed. During observation on 11/14/23 at 3:13 p.m., nursing assistant (NA)-A and NA-B were assisting R2 from wheelchair to bed. NA-A and NA-B placed the full mechanical lift sling behind R2's back and buttocks. NA-A stated the lift sheet did not slide behind R2's back and under legs very well and was sticking to R2's clothing. NA-A reached for the strap and pulled hard on the sling under R2's leg. NA-B fastened the sling loops to the mechanical lift. NA-A attempted but was	F 689	1 The staff working with R2 have been reeducated on proper placement of a full mechanical lift sling to ensure a safe transfer and have performed return demos. 2 All residents who use a mechanical lift may have the potential for improper placement of the full lift apron. 3 All staff to be reeducated on positioning of the lift apron and how to check for proper use of sling prior to transferring the residents. Return demos will be completed and documented. Policies and procedures to be reviewed and revised. Staff to be educated on policy changes. 4 Audits will be completed randomly on all 3 shifts by DON, ADON or their designee to ensure proper placement of lift aprons prior to transfer. We will do 2 random audits a day and will report findings to QAPI to determine further need for audits	12/18/23

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F 689	Continued From page 2	F 689		

unable to fasten the sling loops to the mechanical lift clips. NA-B used the remote control to lower the lift closer to R2 until NA-A was able to fasten the loops to the sling clips. Using the remote control NA-B elevated R2 approximately six inches above the wheelchair. R2's buttocks was hanging through the opening of the lift sheet. NA-A stated R2 was sliding down out of the sling, NA-B lowered R2 back down into the wheelchair.

-R2 was seated in the wheelchair in a slouched position with his buttocks at the front edge and hanging off of the wheelchair cushion. R2's buttocks started slowly slipping forward, off the wheelchair cushion and out of the wheelchair. Staff did not immediately assist R2. Surveyor intervened and reported to NA-A and NA-B that R2 was slipping out of the wheelchair. NA-B then used the remote control and slightly elevated the lift to tightened the sling around R2. R2 stopped sliding out of the wheelchair.

During interview on 11/14/23 3:34 p.m., NA-B stated staff used the full mechanical lift to transfer R2 in/out of bed and did not usually have problems. R2 has never slipped out of the sling or the wheelchair. The transfer observed was not a good transfer because the sling was not under R2 far enough and R2 started slipping out of the sling. NA-B was trained to use the full mechanical lift by the assistant director of nursing (ADON).

During interview on 11/14/23 at 4:48 p.m., NA-A stated the full mechanical lift was new to the facility and the ADON trained staff on correct placement of the sling and use of the lift. It was hard to place the sling under R2 because the sling stuck to the residents clothing and staff had a hard time getting the sling under the resident far

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F 689	Continued From page 3	F 689		

enough. Transfers usually went well with the full mechanical lift. This transfer of R2 did not go well because the sling was not properly placed under the resident to safely transfer R2 and staff had to lower the resident back down to the wheelchair.

During interview on 11/15/23 at 8:25 a.m., the ADON stated she received a call from NA-A regarding R2's transfer on 11/14/23. NA-A reported the transfer had not gone well and R2 nearly slid out of the lift sling. Both NA-A and NA-B received training for placement of the sling and use of the full mechanical lift. The ADON stated she expected staff to follow the education provided to ensure residents would not fall or slip out of the sling.

During interview on 11/15/23 at 12:59 p.m., the director of nursing (DON) stated staff were expected to follow the education provided for proper sling placement and use of the full mechanical lift. If a transfer didn't go well, the staff were expected to notify one of the nurses who would follow up by sending a referral to therapy for an evaluation of the residents transfers and to see if there was a better way to transfer the resident.

The Safe Patient Handling: Mechanical and Non-Mechanical Lifts policy review date 4/20, identified the purpose of the policy was to ensure proper use of Safe Patient Handling equipment. The policy directed staff on how to place the sling under and lift the resident while seated in a chair/wheelchair. The directions included staff to tuck the end of the sling at the coccyx or against the seat.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 883 SS=E	Influenza and Pneumococcal Immunizations	F 883		12/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 4	F 883		

CFR(s): 483.80(d)(1)(2)

§483.80(d) Influenza and pneumococcal immunizations
§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 5 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer and provide education regarding the pneumococcal conjugate vaccine 20 variant (PVC20) education for those elegible as directed by the Centers for Disease Control (CDC) for 5 of 5 residents (R2, R4, R16, R17, R71) reviewed for immunizations. Findings include: R2's quarterly Minimum Data Set (MDS) dated 9/15/23, identified R2 had diagnoses including chronic obstructive pulmonary disease (COPD). R2's undated, Minnesota Immunization Information Connection (MIIC) report identified R2 received the pneumococcal polysaccharide vaccine (PPSV23) on 4/19/18, and the pneumococcal conjugate vaccine 13 variant (PCV13) on 5/20/05. R2's medical record lacked evidence the PCV20	F 883	1 Residents, R2, R4, R16, R17 and R 71 or their Resident Representative have been provided with the education related to PVC 15 and PVC 20, via mail and email. A consent form for PVC 20 was also provided to them, after following the new algorithm from March 2023. 2 All residents could be affected by this practice. 3 All residents immunization history has been reviewed and all eligible residents or their representatives have been educated on the PVC 15 and PVC 20, via mail and email. Consent forms for the PVC 20 were also provided after following the new algorithm from March 2023. Policy, Standing Orders and algorithm were reviewed and revised with the most up to date information. All new residents	

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F 883	Continued From page 6 was offered and/or education was provided in conjunction with the provider to R2/R2's representative. R4's quarterly MDS dated 8/30/23, identified diagnoses of diabetes and atrial fibrillation. R4's undated Minnesota Immunization Information Connection (MIIC) report identified R4 received PPSV23 on 10/13/04, and the PCV13 on 3/29/17. R4's medical record lacked evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R4/R4's representative. R16's admission MDS dated 6/26/23, identified diagnoses including diabetes, and multiple sclerosis. R16's undated MIIC identified R16 received PPSV23, on 9/27/12 and PCV13 on 7/21/15. R16's medical record lacked evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R16/R16's representative. R17's admission MDS dated 10/18/23, identified diagnoses including asthma and thyroid disease. R17's undated MIIC report identified R17 received PPV23, on 9/21/15 and PCV13 on 4/22/19. R17's medical record lacked evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R17/R17's representative. R71's quarterly MDS dated 8/16/23, identified diagnoses including coronary artery disease,	F 883	will have their immunization history reviewed upon admit and using the algorithm and MD input, if necessary, the vaccines will be educated to and offered. 4 A full house audit has been completed by DON/IP and education was sent to resident or their representative. All immunizations will be reviewed quarterly to ensure all vaccines have been educated to. Audits to be performed by DON/IP or designee. Audits will be completed on 4 residents a week and results reviewed with QAPI to determine continuance of audits. All nurses will be educated on the regulation for education and usage of PSV15 and PSV 20.	

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	245529	A. BUILDING ______ B. WING ______	C **11/15/2023**

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F 883	Continued From page 7	F 883		

heart failure and asthma. R71's pneumococcal immunization standing orders dated 5/17/23, identified R71 refused the PPSV23 and PCV13 vaccinations. The declination failed to identify if the PCV20 risk and benefits was discussed or offered.

During interview on 11/15/2023 at 1:15 p.m., the director of nursing stated she was unaware of the new CDC guidance and had not completed education or offered the PCV20 vaccination to residents/resident representatives.

The facilities Pneumococcal Vaccine Standing Orders revised 10/22, identified all adults who met the criteria established by the CDC Advisory Committee would be vaccinated to reduce morbidity and mortality. The standing orders enabled appropriately qualified personnel (e.g. nurses or pharmacist) to assess the need for vaccination and to vaccinate adults equal to or older than 19 years of age who met any of the procedural criteria, without a physicians order. The appropriate personnel would determine the need for vaccination, screen the individuals, provide a vaccine information statement (VIS), administer and document the vaccine information.

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	245529	A. BUILDING **01 - NURSING HOME** B. WING ___	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/15/2023. At the time of this survey, Bigfork Valley Communities was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/07/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. BUILDING **01 - NURSING HOME** B. WING ______	**11/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIGFORK VALLEY COMMUNITIES	**258 PINE TREE DRIVE** **BIGFORK, MN 56628**

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Bigfork Valley Communities Nursing Home was built in three stages. The original building was constructed in 1972 and is a 1-story building without a basement of Type II (111) construction. In 1985 a 1-story addition was constructed to the north of the original building and was determined to be Type II (111) construction. In 1999, a 1-story addition with a basement was constructed off the	K 000		

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K 000	Continued From page 2 east wing of the original building and was determined to be type II (000) construction. In 2014 1 story addition was added that was determined to be of Type II(000) construction. The building is divided into 4 smoke zones with 30 minute and 2-hour fire barriers. The original building has a common 2-hour fire barrier between the nursing home and the Bigfork Valley Hospital. The entire building has an automatic fire sprinkler system installed and also has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building Type II (000) construction. The facility has a capacity of 70 beds and had a census of 20 at the time of the survey.	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.	K 321		12/18/23

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K 321	Continued From page 3 Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/15/2023 between 09:30 AM and 12:30 PM, it was revealed by observation that the following storage rooms did not have a self-closing device. 1) Storage Room B-3 2) Storage Room B-2 3) Storage Room B-1 Tamarack Lodge Hallway 4) Patient Room 11	K 321	1 Maintenance has addressed all the rooms listed in the tag. 2 Proper closures are in place and function tested. 3 Plant Operations Manager or designee will conduct routine audits monthly. Results will be reviewed at QAPI to determine further audits. 4 Responsible person for corrective actions and monitoring compliance: Plant Operations Manager or designee.	

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K 321	Continued From page 4 5) Patient Room 12 6) Patient Room 15 7) Patient Room 21 8) Patient Room 22 9) Patient Room 26 10) Patient Room 27 11) Patient Room 28 12) Patient Room 29 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/15/2023 between 09:30 AM and 12:30 PM, during documentation review it was revealed that the facility was without a fire watch policy or fire	K 346	1 Facility does have a fire watch policy which will be attached to our inspection logs , retrained maintenance staff. 2 Monitoring system: Audits monthly, results will be reviewed at QAPI to determine further audits. 3 Responsible person : Plant Operations Manager. Manager or designee	12/18/23

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K 346	Continued From page 5 watch documentation for a fire alarm system outage. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________ b) Who provided system test _____________ c) Water system supply source _____________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These	K 353	1 High storage was reorganized 2 Education to be provided to departments utilizing the storage space. Indication line will be added to the walls. 3 audits monthly , will be reviewed at QAPI to determine further audits 4 Plant Operations Manager or designee will do the audits	12/18/23

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K 353	Continued From page 6 deficient findings could a patterned impact on the residents within the facility. Findings include: On 11/15/2023 between 09:30 AM and 12:30 PM, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in Cedar Storage room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/15/2023 between 09:30 AM and 12:30 PM, it was revealed by documentation review that the	K 355	1 An annual fire extinguisher inspection log was created. Will have both contracted inspecting staff and maintenance team sign off on it. All Maintenance staff will be educated on new process. 3 Audits will be performed monthly results will be reviewed at QAPI to determine further audits 3 Plant Operations Manager or designee will be responsible for audits	12/18/23

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K 355	Continued From page 7 fire extinguishers annual inspection documentation could not be provided. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/15/2023 between 09:30 AM and 12:30 PM, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following areas: 1) Nursing home to Assisted Living	K 372	1 Areas missing fire caulking were immediately addressed and corrected after survey. 2 Checklist created to monitor areas to ensure there is no missing fire caulking. 3 Plant Operations Manager or designee will do monthly audits, results will be reviewed at QAPI for further audits.	12/18/23

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K 372	Continued From page 8 2) Activities Room 3) Hospital to Nursing Home 4) Tamarack Wing by Time Clock Door 5) Memory Care - by Health Unit Coordinators Office An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 372		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. These deficient findings could have a widespread impact on the residents within the facility.	K 511	1 Cabinet was locked immediately after survey. 2 Staff reeducated on need to keep cabinets locked when not in use. 3 Plant operations Manager or designee will perform monthly audits. Results of audits will be reviewed at QAPI for further audits needed.	12/18/23

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K 511	Continued From page 9 Findings include: On 11/15/2023 between 09:30 AM and 12:30 PM, it was revealed by observation that the electrical panel located ion Tamarack Lodge Wing was not locked. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 511		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/15/2023 between 09:30 AM and 12:30 PM, it was revealed by a review of available	K 521	1 Plant Operations Manager will be contacting facility used contractor to make sure fire dampers will be inspected on next inspections. 2 Audits will be completed by Plant Operations Manager or designee monthly. Results to be reviewed at QAPI to determine further audits.	12/18/23

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K 521	Continued From page 10 documentation that the facility could not provide a fire damper inspection report. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/15/2023, between 9:30am and 12:30pm, it was revealed by a review of available documentation that the facility missed the December 2022 for the fourth quarter. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	1 Facility Plant Operations Staff will readjust fire drills schedule. 2 Education will be provided to Plant Operations Staff. 3 Plant Operations Manager or designee will audit fire drill times monthly moving forward. Audits will be reviewed at QAPI for further audits.	12/18/23

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