Electronically delivered
July 8, 2022

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

RE: CCN: 245529
Cycle Start Date: June 23, 2022

Dear Administrator:

On June 23, 2022, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 7, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 7, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 7, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.
This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 7, 2022 the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Bigfork Valley Communities will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 7, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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, MN 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 23, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 06/23/2022

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
F 000	INITIAL COMMENTS On 6/21/22 through 6/23/22, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H55292299C (MN84336) H55292377C (MN83390) H55292528C (MN83489) 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		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility comprehensively assess safety	F 554	1 R5 has been assessed related to ability to self administer her medications once	7/19/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/13/2022

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 554

Continued From page 1

with self- administration of medication for 1 of 1 residents (R5) observed to have medications left in their room unsupervised by staff after staff set-up.

Findings include:

R5's quarterly Minimum Data Set (MDS) dated 4/29/22, identified R5 was cognitively intact and required assistance of one staff for activities of daily living (ADLs).

On 6/21/22, at 1:34 p.m. R5 was observed seated in a wheelchair in her room with no staff present; and there were three pills and one capsule in a medication cup on R5's bedside table. R5 stated the four medications in the med cup were left by the nurse about 30 minutes earlier and the staff always left her medications for her to take unsupervised.

R5's medical record lacked a self- adminstration of medication assessment.

- At 1:53 p.m. registered nurse (RN)-A stated when dispensing medications to a resident she would verify med orders, place them in a med cup, give the medications to the resident and then sign the medication administration record (MAR) after observing the resident swallowed the medication. RN-A stated R5 would not swallow the medications in front staff so she always left the medications for R5 to take on her own. RN-A checked back after about 30 minutes to be sure R5 took the medications. RN-A signed R5's MAR at 12:15 p.m. on 6/21/22.

- At 2:11 p.m. RN-A stated she could not find anything in R5's care plan directing staff to leave

F 554

nursing has set them up for her. She is able to self administer. MD order has been obtained and Care Plan updated along with EMR.
2 All residents who self administer their medications will be audited to ensure an assessment has been completed, a MD order is in place and the care plan is up to date.
3 Nursing staff to be educated as to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff will also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. Nurses to be educated on self administration policy and procedures. Policies and procedures reviewed and revised.
4 Audits will be completed weekly by DON or designee on 5 residents per week for 4 weeks to ensure compliance related to timely and accurate self medication assessments have been completed to ensure appropriate medication administration, MD order and care plan are in place. Audit results will be reviewed at QAPI for further recommendations.

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F 554	Continued From page 2 R5's medication's to take unsupervised. - At 2:30 p.m. RN-B stated she defined self-administration of medication as when a nurse sets up a residents medication and allows the resident to take the med's unsupervised. The facility policy directed staff to complete an assessment, obtain an MD order and add an item to the care plan before a resident was able to self-administer med's. R5's medical record lacked any assessment, MD orders and was not on the care plan to take medications without nurse supervision. During interview on 6/23/22, at 1:50 p.m. the director of nursing (DON) stated if a resident was deemed unable to administer their own medications, the medications shouldn't be left in their room unsupervised by staff. An assessment must be completed indicating the resident was capable of taking the medications unsupervised and the nurse would need to follow-up with the resident within 15 minutes. If a resident is capable of administering their own medications and there was not an assessment, they would be responsible to notify RN-B to complete an assessment. The facilities Self-Administration of Medications LTC policy last approved 6/22, identified residents were able to self-administer medication if they were evaluated to do so. The evaluation would include assessments of the resident's mental and physical abilities, their decision-making capacity and an order from the MD identifying the resident is clinically appropriate to self-administer medications.	F 554		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs	F 790		7/25/22

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F 790	Continued From page 3 CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental	F 790		

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F 790	Continued From page 4 services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 1 residents (R10) reviewed who had broken/chipped teeth in poor condition. Findings include: R10's quarterly Minimum Data Set (MDS) dated 4/22/22, identified R10 had moderate cognitive impairment and diagnosis of Alzheimer's disease. R10 required set up for eating. However, the R10's dental/oral status was not required to be assessed during the MDS assessment period. During an observation on 6/21/22, at 2:34 p.m. R10 had missing and broken teeth along the upper right side of R10's mouth that were visible while she was speaking. R10's nursing progress note dated 5/29/21, at 4:56 p.m. identified R10 voiced a complaint of a loose tooth. Staff identified an upper incisor tooth was observed to be loose and wiggling on the left side. R10 did not state she hit the tooth and there was no apparent bruising to R10's lips or gums. R10 stated stated she would just chew to either side. R10 denied pain unless she bit down with the broken tooth and staff encouraged her to not wiggle the tooth manually. A message to contact hospice and/or the dentist during the following business week. R10's nursing progress noted dated 6/12/21, at 1:20 p.m. identified R10's loose tooth had cracked and a piece of the tooth had fallen out	F 790	1 R10 has a dental appointment set up for her on 7/18/22 and transportation has been arranged. 2 All residents who have issues with their teeth/dentures could be effected by this practice and their needs may not be met. All residents have been assessed to ensure there are no residents with unmet dental needs. 3 Policies, procedures have been reviewed /or revised to ensure dental care services and follow up dental care is provided to all residents in accordance with individual needs. All licensed nursing staff, Social Worker and HUC will be educated. 4 Audits will be completed daily of the EMR by DON or designee times 4 weeks to ensure all residents who are having problems with their teeth/dentures have dental appointments made promptly or have an assessment completed within 3 days to ensure they are able to chew and eat their meals as usual or be provided an alternative until an appointment can be made if resident and family do chose. 5 residents a week to be assessed and audited to ensure if they do need an appointment, one will be obtained. After 4 weeks, audits will be presented at QAPI and additional follow up audits will be determined by QAPI team.	

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F 790	Continued From page 5	F 790		

during lunch. A small amount of blood was surrounding the tooth at the base of the gums. There was no swelling or signs of infections. R10 was encouraged to not wiggle the tooth. R10 did not complain of any increased pain at the site, continued to eat, and forgot the tooth had fallen out. Nursing communicated the broken tooth to hospice in regards to making a dental appointment and hospice agreed with this plan. A reminder was placed on the message board in the electronic medical record to make an appointment and arrange transportation during the following business week.

During an interview on 6/23/22, at 7:56 a.m. registered nurse (RN)-A stated she reviewed R10's chart and found notes which stated a dental appointment should have been made. However, there was no documentation or notes which identified the facility attempted to make a dental appointment for R10. RN-A stated an attempt to make a dental appointment after a resident had broken a tooth was expected.

During an interview on 6/23/22, at 1:07 p.m. the health unit coordinator (HUC) stated she was out of the facility on leave when R10 broke her tooth and was not notified to schedule an appointment for R10 when she returned to work.

During an interview on 6/23/22, at 1:58 p.m. the director of nursing (DON) stated all the nurses and/or the social worker were able to make medical and/or dental appointments for the residents and the responsibility did not rest solely on the HUC. R10's dental appointment should have been scheduled timely or at least an attempt to do so with documentation reflecting what had occurred.

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F 790	Continued From page 6 The facility policy Dental Services revised 12/21, identified the facility would assist elders to obtain routine and 24-hour emergency dental care. Each elder was encouraged to choose a dentist who was ale to provide dental care to meet the elder's needs. The nursing staf would assist elders, as necessary in making appointment and arranging transportation to and from the dentist's office if services were not provided in the facility.	F 790		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		7/19/22

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F 880	Continued From page 7	F 880		

but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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 06/23/2022

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
F 880	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standard infection control practices when handling and sorting soiled and potentially infectious resident laundry. This practice had the potential to affect all 20 residents residing in the facility and who had their personal laundry laundered at the facility. Findings include: On 6/23/22, at 10:57 a.m. the facility's laundry room was observed with housekeeper (HK)-A. There were two protective gowns and gloves in the laundry room. HK-A stated after he gathered each residents soiled laundry he sorted through it examining each item for stains, checking pockets and separating whites from darks, before putting the clothing into the facility washer. HK-A did the quarantined (infectious) resident's laundry last to keep from contaminating other's clothing. HK-A stated he sorted the quarantined laundry in the same manner as the other laundry. HK-A also stated he took the large, waterproof isolation bag and turned it inside out and put in with the wash. - HK-A demonstrated how he sorted and inspected the soiled clothing (included quarantined laundry) and handled the clothing isolation bag to wash. HK-A put on gloves to handle the soiled laundry, but did not put on a protective gown over his uniform. HK-A stated there was a potential for the soiled laundry to come into contact with his bare arms or uniform, and only used a protective gown when adding bleach to the washer to disinfect it at the end of the shift. Further, HK-A stated the facility	F 880	1 All residents could be effected by this practice. 2 Policies, procedures were reviewed, revised and implemented related to infection control practices in the laundry to ensure they comply with CDC guidance to prevent cross contamination. RCA was completed and will be reviewed at QAPI on 7/14/22 3 Education provided to all laundry personnel. competencies completed after the training. 4 Audits will be completed by DON, Plant Manager or designee on all shifts that laundry is working daily to ensure compliance times one week, then will be reviewed with QAPI to determine frequency of further audits.	

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F 880	Continued From page 9 completed all 20 residents personal laundry. During interview on 6/23/22, at 11:28 a.m. housekeeping supervisor (HKS)-B stated all staff were to wear a washable protective gown when sorting through resident's soiled laundry and the gowns were to be washed each time it was worn. When quarantined laundry was handled, the staff were to wear a disposable gown and discard it immediately after use. The facility policy Clarification of Interpretive Guidance Laundry and Infection Control from the Center For Medicare and Medicaid Services dated 1/25/13, identified it was important all potentially contaminated linen be handled with appropriate measures to prevent cross-transmission. It was important laundry areas had appropriate personal protective equipment such as gloves and gowns for workers to wear when sorting linens.	F 880		

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	245529	A. BUILDING **01 - NURSING HOME** B. WING ______	06/22/2022

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BIGFORK VALLEY COMMUNITIES	**258 PINE TREE DRIVE** **BIGFORK, MN 56628**

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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 06/22/2022. 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 CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU 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 IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 07/18/2022

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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	245529	A. BUILDING 01 - NURSING HOME B. WING ______	06/22/2022

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K 000	Continued From page 1	K 000		

Continued From page 1

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail 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 east wing of the original building and was determined to be type II (000) construction. In 2014 1 story addition was added that was

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	245529	A. BUILDING **01 - NURSING HOME** B. WING ____	**06/22/2022**

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K 000	Continued From page 2 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. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=D	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		7/19/22

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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. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/22/2022 between 09:30 AM and 12:30 PM, it was revealed by observation that lower level maintenance storage room did not have a self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	1 Self closing hinges will be installed to assure door meets life safety code. 2 Checklist for door inspection will now have a space for checking operation of automatic door closure and if area is equipped with correct equipment. 3 Training on F321 tag and what areas need to meet requirements. 4 Maintenance Manager will be responsible for corrective action and monitoring of compliance	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101	K 324		7/19/22

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K 324	Continued From page 4 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		
	This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility.		1 Up to date inspection logs were sent to previous Maintenance manager. Provider updated email for future use. 2 Monthly checks of inspection logs/tags will be conducted to ensure we are in compliance. 3 Maintenance Manager will conduct audits of inspection logs/tags to ensure inspections are scheduled and completed before due date. Responsible person: Maintenance	

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K 324	Continued From page 5 Findings Include: On 06/22/2022, between 9:30am and 12:30pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	Manager.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		7/19/22

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K 351	Continued From page 6 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. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/22/2022, between 9:30am and 12:30pm, 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 Records Storage Room, basement level. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 351	1 Affected area was reorganized so high storage was not present. 2 All staff informed of high storage guidelines, to help prevent and avoid future storage issues. 3Maintanance Manager will monitor all storage areas to prevent/correct improper storage tendencies, lines may be improved. 4 Maintenance manager other staff as needed will be responsible.	
K 353 SS=F	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.	K 353		7/19/22

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K 353	Continued From page 7 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 a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/22/2022, between 9:30 am and 12:30 pm, it was revealed by a review of available documentation the facility failed to perform quarterly sprinkler system testing. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 353	1 up to date inspection logs were sent to previous Maintenance Manager , provider updated to correct managers information for future use. 2 Monthly checks of inspection logs will be conducted to ensure we are in compliance. 3 Maintenance Manager will conduct audits of inspection logs/tags to ensure inspections are scheduled and completed before due date. 4 Maintenance Manager is responsible.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING	K 372		7/19/22

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K 372	Continued From page 8 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. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/22/2022 between 9:30am and 12:30pm, it was revealed by observation that there was a penetration running from one smoke compartment to another in the main hallway to the Aspen Wing. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 372	1 Effected area was corrected by filling penetration with fire caulking. 2 All fire barriers will be inspected and effected areas will be fixed if needed. 3 Annual inspections of fire barriers will be put into place to ensure we are in compliance 4 Maintenance Manager will be responsible.	
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	K 712		7/19/22

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K 712	Continued From page 9 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: 1. On 06/22/2022, between 9:30am and 12:30pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift 05/25/2022 at 4:12 PM, 08/25/2021 at 4:12 PM, and 11/26/2021 at 3:32 PM. 2. On 06/22/2022, between 9:30am and 12:30pm, it was revealed by a review of available documentation that fire drills were not completed: third shift missing first quarter (January - March) and third quarter (July - September) drills completely. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	1 Training to Maintenance staff conducting fire drills will be provided. 2 Facility shift times provided with fire drill checklist to ensure drills are ran in correct time frame and in compliance. 3 Maintenance Manager will audit and oversee fire drill process and paperwork, to ensure we are in compliance. 4 Maintenance Manager and Maintenance staff are responsible.	

Electronically delivered
July 8, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 4J6V11

Dear Administrator:

The above facility was surveyed on June 21, 2022 through June 23, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00834	A. BUILDING: ______ B. WING ______	C **06/23/2022**

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) COMPLETE DATE
2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 6/21/22 through 6/23/22, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure.

The following complaints were found to be

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UNSUBSTANTIATED:
H55292299C (MN84336)
H55292377C (MN83390)
H55292528C (MN83489)

Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21335	MN Rule 4658.0725 Subp. 3 A&B Providing Routine & Emergency Oral Health Ser Subp. 3. Emergency dental services. A. A nursing home must provide, or obtain from an outside resource, emergency dental services to meet the needs of each resident. Emergency dental services include services needed to treat: an episode of acute pain in teeth, gums, or palate; broken or otherwise damaged teeth; or any other problem of the oral cavity, appropriately treated by a dentist, that requires immediate attention. B. When emergency dental problems arise, a nursing home must contact a dentist within 24 hours, describe the dental problem, and document and implement the dentist's plans and orders. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 1 residents (R10) reviewed who had broken/chipped teeth in poor condition.	21335	corrected	7/18/22

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Findings include:

R10's quarterly Minimum Data Set (MDS) dated 4/22/22, identified R10 had moderate cognitive impairment and diagnosis of Alzheimer's disease. R10 required set up for eating. However, the R10's dental/oral status was not required to be assessed during the MDS assessment period.

During an observation on 6/21/22, at 2:34 p.m. R10 had missing and broken teeth along the upper right side of R10's mouth that were visible while she was speaking.

R10's nursing progress note dated 5/29/21, at 4:56 p.m. identified R10 voiced a complaint of a loose tooth. Staff identified an upper incisor tooth was observed to be loose and wiggling on the left side. R10 did not state she hit the tooth and there was no apparent bruising to R10's lips or gums. R10 stated stated she would just chew to either side. R10 denied pain unless she bit down with the broken tooth and staff encouraged her to not wiggle the tooth manually. A message to contact hospice and/or the dentist during the following business week.

R10's nursing progress noted dated 6/12/21, at 1:20 p.m. identified R10's loose tooth had cracked and a piece of the tooth had fallen out during lunch. A small amount of blood was surrounding the tooth at the base of the gums. There was no swelling or signs of infections. R10 was encouraged to not wiggle the tooth. R10 did not complain of any increased pain at the site, continued to eat, and forgot the tooth had fallen out. Nursing communicated the broken tooth to hospice in regards to making a dental appointment and hospice agreed with this plan. A reminder was placed on the message board in

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the electronic medical record to make an appointment and arrange transportation during the following business week.

During an interview on 6/23/22, at 7:56 a.m. registered nurse (RN)-A stated she reviewed R10's chart and found notes which stated a dental appointment should have been made. However, there was no documentation or notes which identified the facility attempted to make a dental appointment for R10. RN-A stated an attempt to make a dental appointment after a resident had broken a tooth was expected.

During an interview on 6/23/22, at 1:07 p.m. the health unit coordinator (HUC) stated she was out of the facility on leave when R10 broke her tooth and was not notified to schedule an appointment for R10 when she returned to work.

During an interview on 6/23/22, at 1:58 p.m. the director of nursing (DON) stated all the nurses and/or the social worker were able to make medical and/or dental appointments for the residents and the responsibility did not rest solely on the HUC. R10's dental appointment should have been scheduled timely or at least an attempt to do so with documentation reflecting what had occurred.

The facility policy Dental Services revised 12/21, identified the facility would assist elders to obtain routine and 24-hour emergency dental care. Each elder was encouraged to choose a dentist who was ale to provide dental care to meet the elder's needs. The nursing staf would assist elders, as necessary in making appointment and arranging transportation to and from the dentist's office if services were not provided in the facility.

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21335	Continued From page 5 SUGGESTED METHODS OF CORRECTION: The DON or designee could develop, review, and /or revise policies and procedures to ensure dental care services and follow up dental care is provided to all residents in accordance with individual needs. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21335		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility comprehensively assess safety with self- administration of medication for 1 of 1 residents (R5) observed to have medications left in their room unsupervised by staff after staff set-up. Findings include: R5's quarterly Minimum Data Set (MDS) dated 4/29/22, identified R5 was cognitively intact and required assistance of one staff for activities of	21565	corrected	7/18/22

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daily living (ADLs).

On 6/21/22, at 1:34 p.m. R5 was observed seated in a wheelchair in her room with no staff present; and there were three pills and one capsule in a medication cup on R5's bedside table. R5 stated the four medications in the med cup were left by the nurse about 30 minutes earlier and the staff always left her medications for her to take unsupervised.

R5's medical record lacked a self- adminstration of medication assessment.

- At 1:53 p.m. registered nurse (RN)-A stated when dispensing medications to a resident she would verify med orders, place them in a med cup, give the medications to the resident and then sign the medication administration record (MAR) after observing the resident swallowed the medication. RN-A stated R5 would not swallow the medications in front staff so she always left the medications for R5 to take on her own. RN-A checked back after about 30 minutes to be sure R5 took the medications. RN-A signed R5's MAR at 12:15 p.m. on 6/21/22.

- At 2:11 p.m. RN-A stated she could not find anything in R5's care plan directing staff to leave R5's medication's to take unsupervised.

- At 2:30 p.m. RN-B stated she defined self-administration of medication as when a nurse sets up a residents medication and allows the resident to take the med's unsupervised. The facility policy directed staff to complete an assessment, obtain an MD order and add an item to the care plan before a resident was able to self-administer med's. R5's medical record lacked any assessment, MD orders and was not on the

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care plan to take medications without nurse supervision.

During interview on 6/23/22, at 1:50 p.m. the director of nursing (DON) stated if a resident was deemed unable to administer their own medications, the medications shouldn't be left in their room unsupervised by staff. An assessment must be completed indicating the resident was capable of taking the medications unsupervised and the nurse would need to follow-up with the resident within 15 minutes. If a resident is capable of administering their own medications and there was not an assessment, they would be responsible to notify RN-B to complete an assessment.

The facilities Self-Administration of Medications LTC policy last approved 6/22, identified residents were able to self-administer medication if they were evaluated to do so. The evaluation would include assessments of the resident's mental and physical abilities, their decision-making capacity and an order from the MD identifying the resident is clinically appropriate to self-administer medications.

SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies for self administration of medication. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance

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21565	Continued From page 8 with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standard infection control practices when handling and sorting soiled and potentially infectious resident laundry. This practice had the potential to affect all 20 residents residing in the facility and who had their personal laundry laundered at the facility. Findings include: On 6/23/22, at 10:57 a.m. the facility's laundry room was observed with housekeeper (HK)-A. There were two protective gowns and gloves in the laundry room. HK-A stated after he gathered	21675	corrected	7/19/22

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each residents soiled laundry he sorted through it examining each item for stains, checking pockets and separating whites from darks, before putting the clothing into the facility washer. HK-A did the quarantined (infectious) resident's laundry last to keep from contaminating other's clothing. HK-A stated he sorted the quarantined laundry in the same manner as the other laundry. HK-A also stated he took the large, waterproof isolation bag and turned it inside out and put in with the wash.

- HK-A demonstrated how he sorted and inspected the soiled clothing (included quarantined laundry) and handled the clothing isolation bag to wash. HK-A put on gloves to handle the soiled laundry, but did not put on a protective gown over his uniform. HK-A stated there was a potential for the soiled laundry to come into contact with his bare arms or uniform, and only used a protective gown when adding bleach to the washer to disinfect it at the end of the shift. Further, HK-A stated the facility completed all 20 residents personal laundry.

During interview on 6/23/22, at 11:28 a.m. housekeeping supervisor (HKS)-B stated all staff were to wear a washable protective gown when sorting through resident's soiled laundry and the gowns were to be washed each time it was worn. When quarantined laundry was handled, the staff were to wear a disposable gown and discard it immediately after use.

The facility policy Clarification of Interpretive Guidance Laundry and Infection Control from the Center For Medicare and Medicaid Services dated 1/25/13, identified it was important all potentially contaminated linen be handled with appropriate measures to prevent cross-transmission. It was important laundry

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21675	Continued From page 10 areas had appropriate personal protective equipment such as gloves and gowns for workers to wear when sorting linens. A SUGGESTED METHOD FOR CORRECTION: The housekeeping supervisor or designee could review and revise the policies and procedures related to linen handling. The designee could provide education to all involved staff abd develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21675		