DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CNPS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00834

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245529**

2.STATE VENDOR OR MEDICAID NO.
(L2) **048545405**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIGFORK VALLEY COMMUNITIES**
(L4) **258 PINE TREE DRIVE, PO BOX 258**
(L5) **BIGFORK, MN** (L6) **56628**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/23/2020** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Brenda Waltz, HFE - NE II 04/28/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/28/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 28, 2020

CMS Certification Number (CCN): 245529

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 26, 2020 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 28, 2020

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

RE: CCN: 245529
Cycle Start Date: January 23, 2020

Dear Administrator:

On March 16, 2020, we notified you a remedy was imposed. On April 23, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 26, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 13, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 13, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 13, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 26, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CNPS

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(L5) **BIGFORK, MN** (L6) **56628**

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3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/11/2020** (L34)

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12/31

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And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

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18 SNF	18/19 SNF	19 SNF	ICF	IID
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(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date :
Becky Haberle HFE - NE II 03/25/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/27/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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3. Both of the Above :

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05/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
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05-Fail to Meet Health/Safety
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00-Active

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03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 16, 2020

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

RE: CCN: 245529
Cycle Start Date: January 23, 2020

Dear Administrator:

On February 13, 2020, we informed you of imposed enforcement remedies.

On February 26, 2020, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 13, 2020.

- Civil money penalty. (42 CFR 488.430 through 488.444)

On March 11, 2020, the Minnesota Department(s) of Health and Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 13, 2020, will remain in effect.

This Department continues to recommend that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 13, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 13, 2020.

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.

As we notified you in our letter of February 13, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 13, 2020.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 July 23, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

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/ 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 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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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 _____	R 03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIGFORK VALLEY COMMUNITIES	**258 PINE TREE DRIVE, PO BOX 258 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 An onsite post certification revisit (PCR) was completed on 3/10/20 - 3/11/20, to follow up on deficiencies issued as a result of a recertifcation survey exited 1/23/20. The facility was found NOT to have corrected one or more deficiencies. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	{F 686}		3/26/20

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

Electronically Signed | 03/18/2020

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 _____	R 03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIGFORK VALLEY COMMUNITIES	**258 PINE TREE DRIVE, PO BOX 258 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 686}	Continued From page 1 Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning for 2 of 3 residents (R18, R31) assessed to be at risk for the development of pressure ulcers. Findings include: R18's quarterly Minimum Data Set (MDS) dated 3/5/20, identified R18 with moderate cognitive impairment and diagnoses including dementia and a stroke with left sided weakness. The MDS indicated R18 required extensive assistance with bed mobility, transfers and was unable to walk. The MDS also indicated R18 was occasionally incontinent of bowel and bladder and identified R18 at risk for the development of pressure ulcers. R18's Pressure Ulcer Care Area Assessment (CAA) dated 9/11/19, indicated R18 had sustained a stroke with hemiparesis (muscle weakness or partial paralysis on one side of the body) and was unable to move sufficiently to reduce pressure. R18's Braden Scale for Predicting Pressure Ulcer Risk (an assessment tool for predicting the risk of pressure ulcers) dated 3/5/20, identified R18 at high risk for the development of pressure ulcers. R18's Care Plan dated 8/30/19, indicated R18 was unable to reposition himself and directed the staff to assist with repositioning every two hours. On 3/10/20, from 3:40 p.m. to 7:17 p.m. R18 was continuously observed. -At 3:40 p.m. R18 was wheeled from his room to the Aspen unit nurse's station	{F 686}	R18 and R 31 have had new tissue tolerances completed. All care plans for residents at risk for pressure ulcers were reviewed and revised to accurately reflect needs according to current tissue tolerance, Kardex's were updated. All staff have been reeducated on the necessity to follow care plan for turning and repositioning and the rationale behind it to prevent skin breakdown. Nursing has been educated to make sure the care plan is accurate according to the latest tissue tolerance. Policy related to LTC Skin Breakdown and LTC Care Plan has been reviewed and revised. Groups sheets were created, and staff have been assigned a group to create more accountability and an easy tool for them to keep track of positioning times. Audits will be completed daily at random times and shifts for 5 weeks for all residents who have a turn and repositioning program to ensure the Turn and Reposition Program is being followed. The group sheets are to be signed and turned in daily so they can be audited. Then audits will be completed on residents with turn and repositioning programs, 5 times a week on random shifts. Audits will be reviewed at monthly QAPI and further audits will be determined by the QAPI team.	

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 _____	R 03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIGFORK VALLEY COMMUNITIES	**258 PINE TREE DRIVE, PO BOX 258 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 686}	Continued From page 2 -At 5:00 p.m. nursing assistant (NA)-G wheeled R18 into the dining room for the evening meal. -At 5:40 p.m. activity aid (AA)-A wheeled R18 to the evening activity (card bingo) and remained there until 7:01 p.m. at which time NA-G confirmed R18 had not been assisted with repositioning since 3:40 p.m. -At 7:12 p.m. R18 was wheeled to the Aspen nurses station. -At 7:17 p.m. R18 was assisted to the rest room by NA-H. R18's buttocks were observed to be pink and intact and his wheelchair was noted to have a pressure redistribution seat cushion. R18 had not received assistance with repositioning for a total of 2 hours and 37 minutes. On 3/11/20, from 7:28 a.m. to 10:36 a.m. R18 was continuously observed. -At 7:28 a.m. NA-I assisted R18 in his room. A wheelchair pressure redistribution cushion remained in his wheelchair. -At 7:31 a.m. R18 was wheeled from his room to the Aspen unit nurse's station. -At 8:29 a.m. R18 was wheeled from the nurse's station to the dining room. -At 9:28 a.m. R18 was wheeled from the dining room to the Aspen unit bird aviary. -At 9:59 a.m. R18 was wheeled from the aviary area to a ball toss activity. -At 10:19 a.m. R18 was wheeled back to the bird aviary. -At 10:32 a.m. NA-J offered R18 assistance with repositioning, R18 refused. -At 10:36 a.m. NA-H assisted R18 to the restroom. R18's skin was observed to be pink and intact. R18 was not offered or provided assistance with repositioning for a total of 3 hours.	{F 686}		

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 _____	R 03/11/2020

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

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{F 686}	Continued From page 3 -At 12:15 p.m. registered nurse (RN)-A stated R18 was to be repositioned every two hours in accordance with the care plan. R31's quarterly MDS dated 1/2/20, identified R31 had severe cognitive impairment and diagnoses which included dementia with behavioral disturbance, heart failure, and anemia. The MDS also indicated R31 required extensive assistance of 1-2 staff for all activities of daily living and was incontinent of bowel and bladder. The MDS further indicated R31 was at risk for skin issues including pressure ulcers due to incontinence, advanced dementia, refusal of cares, immobility and pain. R31's Pressure Ulcer CAA dated 10/7/19, indicated R31 was at risk for skin issues including pressure ulcers due to his incontinence, advanced dementia, refusal of cares, immobility, and pain R31's Braden Scale for Predicting Pressure Ulcer Risk dated 1/2/20, indicated R31 was at high risk for pressure ulcer. R31's Care Plan dated 1/22/20, indicated R31 was at high risk for skin injury and pressure ulcers related to immobility, decreased intake and taking aspirin. The Care Plan directed nursing assistants to assist R31 with repositioning every two hours. On 3/11/20 from 7:04 a.m. to 9:46 a.m. R31 was continuously observed to remain seated in a wheelchair and was not assisted with repositioning. -At 7:04 a.m. R31 was seated in a wheelchair in the lobby.	{F 686}		

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 _____	R 03/11/2020

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

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{F 686}	Continued From page 4 -At 7:06 a.m. NA-I stated R31 had been assisted out of bed around 6:45 a.m. -At 8:33 a.m. NA-J wheeled R31 from the lobby to the dining room. -At 9:38 a.m. R31 was wheeled into the lobby. -At 9:42 a.m. NA-J wheeled R31 to his room. -At 9:46 a.m. NA-J and NA-K transferred R31 from the wheelchair to bed via a full body mechanical lift. R31's buttocks were observed to be pink and the skin was intact. R31's wheelchair was was equipped with a pressure redistribution cushion. NA-J stated he thought R31 was up earlier than 6:45 a.m. and confirmed R31 had not been assisted with repositioning for potentially greater than 3 hours. -At 12:17 p.m. RN-A confirmed R31 was to be assisted with repositioning every two hours as directed by the care plan. -At 12:39 p.m. the director of nursing confirmed R18 and R31 were to be assisted with repositioning every two hours as directed by the care plan. The facility policy titled Care Plan - LTC last revised 10/18, indicated an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. In addition, those residents with skin issues (both real and preventative related to risk level) had been identified with clear interventions in place to prevent breakdown or further breakdown.	{F 686}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CNPS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00834

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245529**

2.STATE VENDOR OR MEDICAID NO.
(L2) **048545405**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIGFORK VALLEY COMMUNITIES**
(L4) **258 PINE TREE DRIVE, PO BOX 258**
(L5) **BIGFORK, MN** (L6) **56628**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/23/2020** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE - NE II 02/21/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 03/10/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
February 13, 2020

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

RE: 245529
Cycle Start Date: January 23, 2020

Dear Administrator:

On January 23, 2020, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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 April 13, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 13, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 13, 2020.

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 a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 $10,483; 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 April 13, 2020, 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 April 13, 2020. 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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag),

i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 July 23, 2020 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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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 _____	01/23/2020

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

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E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on January 21, through January 23, 2020 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS From 1/21-1/23/2020, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		3/4/20

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

Electronically Signed | 02/19/2020

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 609	Continued From page 1 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential resident to resident abuse had been reported to the State Agency (SA) for 1 of 1 resident (R26) who resided on the secured unit and had been involved in resident to resident altercations. Findings include: Review of R26's Progress Notes (PN) from 11/19/20 to 1/22/20, revealed the following: PN dated 11/19/19, at 7:15 p.m. indicated R26 slapped another female resident in the hand out in the lobby/living room area because she would	F 609	Reporting of Alleged Violations Nursing staff have been re-educated on the policy as well as expected timelines for reporting. Policies and Procedures have been reviewed and revised. DON/Designee will audit all resident to resident altercations to ensure they are appropriately addressed and reported if necessary: daily for 1 month and then weekly for 2 months. All issues will be reported to the Administrator or designee immediately for follow up and brought to the QAPI committee monthly.	

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 609	Continued From page 2 not help her to her room after a nursing assistant (NA) stated she would help instead. PN dated 12/20/19, at 7:59 p.m. indicated R26 had been sitting in wheelchair visiting with another resident in the living area when another resident came up and kicked her in the leg. R26 kicked the other resident back and laughed. R26 and the other resident exchanged a couple of kicks at each other. Staff separated residents. During interview with the director of nursing (DON) and administrator on 1/22/20, at 4:07 p.m. the administrator stated the staff are directed to report incidents or potential abuse or injuries of unknown origin immediately, as soon as the resident was safe, to the administrator or DON, who then discussed the situation and determined if the incident required reporting to the SA. DON stated a resident to resident altercation where the residents physically hit each other was required to be reported to the SA. DON verified neither incident involving R26's altercation with other residents involving physical hitting or kicking were reported and stated they had not reported the incidents as neither resident had been upset or aware the incidents had occurred and there had been no bodily harm. The Abuse Prevention Plan policy dated 1/2020, directed if an injury was unexplainable, if suspected or alleged abuse (physical, verbal, sexual, financial exploitation), if there was caregiver neglect or if a therapeutic error resulted in injury, a call must be made to the facility designated State Agency immediately - or no later than two hours after the allegation/suspicion.	F 609		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		3/4/20

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 686 SS=D	Continued From page 3 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning for 3 of 5 residents (R24, R31, and R4) assessed to be at risk for the development of pressure ulcers. Findings include: R24's quarterly Minimum Data Set (MDS) dated 12/19/19, indicated R24 had severe cognitive impairment and diagnoses which included aphasia (A comprehension and communication (reading, speaking, or writing) disorder), and diabetes type II. The MDS also indicated R24 required extensive assistance of 1-2 staff persons for all activities of daily living and was incontinent of bowel and bladder. The MDS further indicated R25 was at risk for pressure ulcers. R24's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 6/24/19, indicated R24	F 686	Treatment to prevent/heal pressure ulcer Resident 24, R31 and R4 have both had a new Tissue Tolerance Test completed. Care plans were reviewed and revised. All Kardex□s have been updated. All staff have been educated on updates to care plans and Kardex□s related to turning and repositioning schedule for R24, R31 and R4. All nursing staff reeducated on the necessity to follow care plan for turning and repositioning for all residents. Policy titled LTC Skin Breakdown and LTC Care Plan have been reviewed and revised. Audits will be completed daily at random times and shifts for 5 weeks for all residents including R24, R31 and R4 who have a turn and repositioning program to ensure the Turn and Reposition Program	

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F 686	Continued From page 4 had the potential for pressure ulcers related to immobility and requiring staff assistance. R24's Braden Scale Assessment (an assessment tool for predicting the risk of pressure ulcers) dated 12/18/19, indicated R24 was at high risk for pressure ulcers. R24's care plan revised 1/10/20, indicated R24 had a pressure ulcer on his lower left buttock and was to have extensive assistance to turning and repositioning every one hour and as needed while in bed, and assistance with toileting every two hours to keep R24's skin dry to allow for prevention of pressure ulcer development. On 1/22/20, at 11:26 a.m. registered nurse (RN)-A verified R24's current pressure ulcer was acquired at the facility. RN-A stated nursing did not document wound measurements, but did document the overall condition of the wound after dressing changes. RN-A further stated he had changed R24's pressure ulcer dressing earlier that morning because R24 had been incontinent of urine and the dressing was saturated. RN-A verified this was typical of R24's dressing upon rising in the morning. On 1/22/20, at 12:30 p.m. two nursing assistants (NA)'s were observed transferring R24 into a wheelchair via a full body mechanical lift. Once in the chair, NA-A assisted R24 to the dining room table for his dinner meal. R24 was continuously observed. At 2:10 p.m. NA-A assisted R24 to his room. NA-A and NA-C transferred R24 back into bed via the full body mechanical lift. At that time, NA-A verified R24 was to be repositioned every one hour because R24 had a pressure ulcer on his buttock, however stated lunch took longer	F 686	is being followed. Then audits will be completed on residents with turn and repositioning programs, including R24, R31 and R4 3 times a week on random shifts. Audits will be reviewed at monthly QAPI and further audits will be determined by the QAPI team.	

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than usual and NA-A was unsure as to how long R24 had sat in his wheelchair without repositioning. NA-A and NA-C both stated they knew R24 had sat in the wheelchair without repositioning longer than an hour. R24's skin surrounding the dressing was noted to be reddened and inflamed. At this time, RN-A assessed R24's pressure ulcer, but would not confirm the reddened and inflamed areas and stated R24's problem with pressure was under the wound dressing. RN-A verified R24 should have been repositioned every one hour as directed by the care plan in order to prevent the worsening of R24's pressure ulcer and to encourage healing.

On 1/22/20, at 4:55 p.m. NA-D was observed to assist R24 from his room to the dining room via the wheelchair. R24 was continuously observed and at 6:31 p.m. R24 was assisted from the dining room and into the common area next to the activity table. NA-D and NA-E proceeded to lift R24 by his shoulders raising his bottom up off of the wheelchair seat approximately 1-2 inches. When asked, NA-E stated R24 was to be repositioned every one and verified it had been more than one hour since he was last repositioned.

- At 6:42 p.m. RN-A stated the lead nursing assistant was in charge of making sure the residents were repositioned timely. RN-A verified R24 had a stage III pressure ulcer (full thickness skin loss) and again had not been repositioned for greater than 1.5 hours.

On 1/22/20, at 8:04 p.m. the director of nursing (DON) stated R24 had a stage III pressure ulcer on his buttock, was followed by the wound

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specialist and the wound had recently been debrided. The DON verified R24's care plan directed every one hour repositioning and stated the staff were expected to implement the interventions, as directed.

R31's quarterly MDS dated 1/2/20, indicated R31 had severe cognitive impairment and diagnoses which included dementia with behavioral disturbance, heart failure, and anemia. The MDS also indicated R31 required extensive assistance of 1-2 staff persons for all activities of daily living and was incontinent of bowel and bladder. The MDS further indicated R31 was at risk for skin issues including pressure ulcers due to incontinence, advanced dementia, refusal of cares, immobility and pain.

Pressure ulcer/injury CAA dated 10/7/19 indicated R31 was at risk for skin issues including pressure ulcers due to his incontinence, advanced dementia, refusal of cares, immobility and pain

R31's Braden Scale Assessment (an assessment tool for predicting the risk of pressure ulcers) dated 1/2/20 indicated R31 was at high risk for pressure ulcer.

R31's Care Plan dated 1/22/20, indicated R31 was at high risk for skin injury and pressure ulcers related to immobility, decreased intake and taking aspirin. The Care Plan directed nursing assistants to check R31's skin nightly and weekly by the nurse.

On 1/23/20, at 7:29 a.m. NA-F and NA-A were observed to provide R31 morning cares. Upon rolling R31 to his left side, NA-A removed R31's soiled brief to provide perineal cares. At that time,

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an area of discoloration was noted on R31's upper left buttock. NA-A stated the nurse had been informed and was unsure if the area was a pressure related. NA-A and NA-F proceeded to complete morning cares and assisted R31 to his wheelchair via a full body lift. At that time, R31 was assisted to the breakfast table.

-At 9:25 a.m. NA-A stated she did not report the area on R31's buttock because another nursing assistant had reported it two days prior and there had also been a paper floating around about the discolored area.

-At 9:28 a.m. NA-F stated she was not aware of the area on R31's buttock until that morning. NA-F stated normally, any skin changes should be reported to the nurse immediately. NA-F further stated staff were instructed to always reposition according to the care plan.

-At 9:43 RN-A assessed R31's area on his left upper buttock. RN-A stated the skin continued to be intact, but verified the area was nonblanchable indicating it was a pressure related area. RN-A measured the area and stated it measured a circular 1.2 cm area. RN-A verified he was unaware of the area and that staff had not reported the change in R31's skin, nor had the area been assessed.

On 1/23/20, at 10:19 a.m. the DON verified she was unaware of R31's change in skin condition and further verified staff were expected to report all changes to the nurse immediately to allow an assessment and investigation in order for immediate implementation of interventions.

The facility policy title Care Plan - LTC last

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F 686	Continued From page 8 revised 10/2018, indicated the facility would create an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. In addition, those residents with skin issues (both real and preventative related to risk level) had been identified with clear interventions in place to prevent breakdown or further breakdown. The facility policy titled LTC Skin Breakdown Prevention Program undated, indicated residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. The policy directed staff to assess resident's skin weekly during resident's scheduled bath and any areas of concern noted during daily cares by the nursing assistant were to be reported to the nurse on shift for assessment. The policy further directed licensed nurses to add residents to weekly wound rounds as applicable by: 1. All active wound were to be charted on a minimum weekly by the nurse performing dressing change and would document in PCC at minimum: A. location of the wound, B. size of wound, C. drainage, and D. appearance of wound bed and surrounding tissue. 2. Signs/symptoms of infection/delay in healing would be monitored every shift for all active wounds in EMAR charting.	F 686		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		3/4/20

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F 688	Continued From page 9 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services in order to maintain and/or prevent loss of ROM ability for 1 of 2 residents (R1) who experienced a decline in ROM of the left hand which was not identified nor assessed. This failure resulted in actual harm for R1. Findings include: R1's annual Minimum Data Set (MDS) dated 1/10/20, indicated R1 had severe cognitive impairment and diagnoses which included dementia, osteoporosis, muscle weakness, and disorder of the brain. The MDS also indicated R1 required extensive assistance to total dependence for all activities of daily living. The MDS further indicated R1 had no impairment in functional range of motion to upper or lower extremities.	F 688	Increase/Prevent Decrease in ROM/Mobility R1 Facility obtained a Therapy evaluation and R1 is receiving ROM with OT and has been placed on a ROM program with nursing staff. All residents with potential ROM needs have been reassessed and their care plans; Kardex have been updated appropriately. Therapy evaluations have been obtained when warranted. A policy and Procedure has been initiated. Nursing staff have been educated on the policy. Nurse Educator has reeducated all nursing staff on ROM, and competencies were completed. The Nurse Educator has educated all Licensed Nurses what changes to look for in residents that could put them at risk for declines and when to contact the MD to obtain a therapy	

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F 688	Continued From page 10 R1's Pain Care Area Assessment (CAA) dated 1/20/20, indicated R1 had had a decline in mobility in the past quarter which could increase her risk for pain and stiffness with her arthritis and osteoarthritis. R1's LTC [Long Term Care] Mobility Assessment dated 1/10/20, indicated R1 had moderate head and trunk range of motion, but poor shoulder, elbow, wrist and fingers, hips, knees and ankle muscle strength and ROM. The assessment also indicated R1 was cooperative and her behavior was non-aggressive. The assessment further indicated R1 had not actively participated in the evaluation and the evaluation was done passively. R1's Care Plan dated 1/23/20, indicated R1 had a self-care deficit related to dementia and required assistance with activities of daily living. The care plan also indicated R1 had limited mobility, and difficulty following directions and processing information, which made it difficult to participate in physical therapy (PT). The care plan further indicated R1 no longer walked and directed staff to stretch R1's arms and legs daily. The care plan lacked further interventions related to ROM for the prevention of contractures. On 1/22/20, at 11:16 a.m. R1 was observed in the community area, seated in an easy chair, watching television. R1 was awake but did not respond when greeted. R1's left hand was clenched tightly into a fist. R1's right hand was also clenched into a fist, however, the right forefinger was extended approximately half way. -At 12:41 p.m. R1 was seated at the dining room, waiting for her meal.	F 688	evaluation to prevent declines. Nurses will also have Train the Trainer education from Nurse Educator in collaboration with Therapists related to Restorative Nursing. All nursing staff will have ROM and Restorative Nursing training upon hire and a refresher yearly with competencies. Administrator and DON are working in collaboration with Therapy and Nurse Educator to initiate a Restorative Nursing Program. Nursing Assistants will be performing ROM on residents who have programs, the DON or designee will oversee the Restorative Programs. All residents with ROM needs will be observed by DON/Designee daily for 4 weeks and then weekly for 2 months to ensure ROM is completed and no declines have been noted. Results of the observations will be reviewed at Monthly QAPI. Ongoing monitoring will be at the recommendation of the QAPI Team.	

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-At 1:30 p.m. NA-A assisted R1 to eat the meal. Throughout the meal, R1's hands remained in clenched fists against her chest. Splints were not in place.
-At 1:32 p.m. NA-A wheeled R1 to the community area, by the television. R1 did not verbally respond to being greeted. R1 loosened her right hand to shake hands, however, the hand did not fully open rather remained in a cupped position.
-At approximately 2:00 p.m. NA-A stated R1 did not wear hand splints of any kind, the facility did not have a restorative nursing program, and the NAs did not provide any type of exercises or ROM services during cares.

On 1/23/20, at 8:40 a.m. NA-B entered R1's room to provide morning cares. NA-B washed R1's face, provided peri cares, and applied a clean brief while rolling R1 from side to side. NA-B applied R1's socks, shoes and pants while R1 remained in bed and then assisted R1 to sit at the side of the bed. R1's elbows were bent close to her chest with both hands clenched into tight fists. NA-B applied a standing lift sling around R1 and struggled to position the sling under R1's arms as they were held tight against her body. NA-F entered the room and assisted R1 to grasp the handle bars of the standing lift. R1 grasped the right bar with her right hand, but only grasped the left bar with her left thumb and forefinger as R1 was unable to fully open the hand. NA-F stated she could open R1's hand, but she would immediately close her fingers again and would only hold the bar with her thumb and forefinger. NA-F stated R1 had no restorative program or exercises in place for her hands, and did not use hand splints or rolls to prevent contractures. NA-B and NA-F proceeded to transfer R1 to a wheelchair via the standing mechanical lift. R1

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was noted to bear own weight throughout the transfer. NA-F left the room with bagged garbage and NA-B removed R1's nightgown, washed her upper body, applied deodorant and assisted R1 to dress. NA-B put R1's shirt over her arms first and lifted the shirt over her head. R1 did not move her arms. NA-B did not offer or provide range of motion exercises for R1's upper extremities. NA-B attempted to put a sweatshirt on R1 using the same process, however, was unable to lift the sweatshirt over R1's head. Therefore, NA-B removed the sweatshirt and obtained a zippered sweatshirt. After several attempts, NA-B was able to pull the sweatshirt over R1's elbows and finish dressing R1. NA-B stated no one had ever talked to her about R1's joints or mobility. NA-B provided R1 her glasses, perfume, dentures, and assisted R1 to the dining room for breakfast.

On 1/23/20, at 9:30 a.m. registered nurse (RN)-A stated he had noticed that today, R1's hands were held more into her chest. RN-A reviewed R1's MDS dated 1/2/20, to determine if she had an identified contracture and verified R1 was dependent upon staff for all activities of daily living but stated, "I don't see where they say she does [have a contracture], but I'm trying to find where they assess for that." RN-A verified the MDS identified R1 had no impairment in range of motion and stated she was able to extend both her arms. RN-A also stated once R1 relaxed more, her arms would straighten out and indicated he found it odd she was positioned with her arms so tight to her body, that morning. RN-A stated the NA's were supposed to provide the residents with ROM exercises with their morning cares and confirmed the facility did not have a formal restorative nursing program which provided those services. RN-A indicated the

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facility assessed residents' ROM abilities quarterly with the MDS assessment. RN-A also verified R1 did not have splints or other interventions identified to prevent contractures.

On 1/23/20, at 10:08 a.m. RN-B stated she did not know if R1 had contractures and stated R1 could open her hands, if R1 wanted to do so. RN-B stated she thought R1 stiffened up all joints due to her disease process and had guarded movement. RN-B indicated R1 had exhibited non-verbal indications of pain including furrowed brows with her last assessment. RN-B indicated interventions to prevent contractures would include exercises; however, verified the facility did not have a restorative nursing program to provide restorative services. RN-B stated the NAs were supposed to provide exercises during resident cares. RN-B stated R1's significant other provided R1 exercises when visiting. RN-B stated her expectation was for the NAs to provide exercises in all planes of motion with 10 repetitions to each joint. RN-B stated when completing R1's last assessment, she had performed five motion repetitions with all joints and R1 had shown no decline in her abilities from the previous assessment. However, it took a while to complete the exercises as R1 would get angry with it. RN-B confirmed R1 did not utilize splints or other physical devices to prevent contractures.

-At 10:13 a.m. RN-B and NA-E were observed to perform ROM exercises for R1. R1's significant other was present during the exercises. RN-B completed ROM to R1's right elbow and shoulder, which revealed some limitations, however, RN-B indicated these limitations were not new and were unchanged from the previous assessment. R1

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made facial grimacing and RN-B stated this indicated R1 was getting mad. At this point, NA-E assisted to complete ROM exercises to R1's right hand/fingers and was able to fully extend R1's fingers. NA-E then assisted R1 to complete ROM of her left elbow and shoulder without difficulty, however, when NA-E attempted to extend R1's left fingers, R1 was only able to extend her fingers approximately 45 degrees. R1's significant other commented, "She is so stiff today." RN-B verified the limitation of extension to R1's left fingers was a new decline and indicated she would get an occupational therapy (OT) assessment for R1.

On 1/23/20, at 11:33 a.m. the director of nursing (DON) verified the facility did not have a designated restorative nursing aid or a restorative nursing program. DON stated she did not know exactly what the facility currently did to provide ROM services for the residents and was unaware of any required exercise routine provided during the provision of cares. The DON also stated she was unaware of R1's decline in ROM and was unsure if this had ever been reported. The DON indicated it was her expectation that any change in a resident's condition be reported to the nurse so it could be assessed. The DON verified R1 should have been provided ROM services in order to maintain her ability and prevent a decline in ROM.

After the completion of the survey, the facility provided an OT Initial Evaluation for R1 dated 1/24/20, which revealed R1 had some upper extremity ROM limitations most noted in left MCP [metacarpophalangeal] extension of digits 3-5, but her ROM was appropriate for proper hygiene and dressing. Presumed arthritis of MCPs noted.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIGFORK VALLEY COMMUNITIES	258 PINE TREE DRIVE, PO BOX 258 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 688	Continued From page 15 OT to continue for ROM, to assist patient with appropriate hand splints to promote ROM of fingers into extension, and staff education as needed. Equipment needs included bilateral hand splints for at night. Recommend wearing splints every other day in order to alternate which hand is wearing brace so both hands are not braced at the same time. The facility policy titled, Quality of Care LTC last revised 12/2016, indicated a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. A resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		3/4/20

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F 756	Continued From page 16 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consulting pharmacist failed to identify and report irregularities related to gradual dose reduction of antidepressant medication (Zoloft) for 1 of 4 residents (R15) reviewed who received antidepressant medication. Findings include: R15's quarterly Minimum Data Set (MDS) dated 11/30/19, indicated R15 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia and anxiety disorder. The MDS indicated R25 required limited assistance with dressing and supervision with all other activities of daily living. The MDS	F 756	Drug Regime Review, Report Irregular, Act on R15 had a trial dose reduction starting 1/27/2020. Staff is observing her shiftly for any adverse effects of the dose reduction, will report to her MD if there are any adverse effects. All BFV residents have the potential to be affected by this practice. Policy for Monitoring for Monthly Medication Regime Review has been reviewed and revised. Nursing and Pharmacy Staff have been educated on revisions to policy. We have hired a Pharmacist Consultant to do a full house review of medications to	

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F 756	Continued From page 17 further indicated R25 had no mood symptoms, psychosis, behavioral symptoms or rejection of care but did exhibit wandering behavior 1-3 days of the assessment period and received antidepressant medication daily. R15's Psychotropic Drug Use Care Area Assessment (CAA) dated 3/7/19, indicated R15 took antidepressant medication for the diagnosis of depression increasing her risk for falls, incontinence, dignity issues, side effects and adverse reactions. The CAA indicated R15's family member was aware of the risks of the medication, however, wanted R15 to remain on the antidepressant. R15's Medication Review Report dated 1/23/20, included a physician order for Zoloft (sertraline HCl) 25 milligrams (mg) by mouth one time a day related to anxiety disorder. The order start date was 12/14/18. R15's Care Plan dated 12/6/19, indicated R15 used antidepressant medication daily and directed staff to complete complete a PHQ-9 [patient health questionnaire] (multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) quarterly and as needed with any changes, an AIMS [abnormal involuntary movement scale] evaluation (scale to assess severity of movement disorders) with any changes in dosing, observe for side effects such as dry mouth, dry eyes, constipation, urinary retention, suicidal ideations, observe for signs and symptoms of depression and complete a monthly review by the Psychotropic Committee. On 1/22/20 at 11:25 a.m. the door to R15's room	F 756	ensure there are no residents who have any irregularities in their drug regime. Pharmacy will complete audits on two random residents at bimonthly Pain and Out of Character IDT meeting who do not have orders for Pain or Psychotropic medications for 2 months then monthly for 2 months. Results of the Audits will be reviewed monthly at QAPI. Ongoing monitoring will be at the recommendation of QAPI Team.	

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F 756	Continued From page 18	F 756		

was partially ajar and a thirteen-gallon garbage can was positioned behind the closed door. R15 was seated in an easy chair with a walker positioned in front of her. The room was dark and R15 rocked in her chair singing and talking to herself.

-At 12:23 p.m. an unidentified staff member entered R15's room and invited her to lunch, reassuring R15 her room would be safe. R15 got up from her chair independently and walked with use of a walker to the dining room with the staff member who provided reassurance and encouragement.

-At 3:57 p.m. R15 rested in bed with her eyes closed.

On 1/23/20, at 7:34 a.m. R15 rested in bed with the lights on. The door was part way open with a large garbage can positioned behind the door.

- At 7:38 a.m. nursing assistant (NA)-B stated R15 had good and bad days and could be moody. NA-B stated R15 liked to keep to herself and preferred to be in her room. NA-B also stated R15 put the can behind her door as the door did not stay shut. NA-B indicated when R15 was having a bad day they provided reassurance, and redirection. NA-B stated R15 didn't like bright lights or loud voices so she didn't really like to be out in the main area but would come out to visit with the ladies occasionally.

Review of R15's Psychotropic Committee Review notes from 1/1/19 to 1/23/20 revealed the following:

-1/30/19: psychotropic committee reviewed

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F 756	Continued From page 19	F 756		

continued use of sertraline 25 mg by mouth daily related to anxiety disorder. GDR [gradual dose education] was unsuccessful in November 2018. She restarted the medication in December 2018. Per committee recommendation, no GDR will be attempted with this medication at this time. MD has ordered the same.
-2/27/19: Restarted on sertraline 25 mg by mouth daily on 12/14/18. Continues to require the use of sertraline for anxiety disorder. Will continue to monitor and review in March.
-4/3/19: March review: R15 failed a GDR in the past year. Medication was restarted in December 2018. No other changes will be made at this time.
-10/8/19: Last GDR in December 2018. R15 failed GDR. Behaviors improved since restarted. No changes will be made at his time.
-11/5/19: R15 continues on antidepressant medications. R15 failed GDR in 2018 and it will be addressed in 2020.

R15's physician notes from 1/9/19 to 12/1/19, lacked documentation regarding R15's use of antidepressant medication and lacked documentation of contraindications for gradual dose reduction of sertraline.

R15's Monthly Medication Reviews from 3/13/19 to 1/21/20 lacked recommendation for gradual dose reduction related to R15's continued use of sertraline and did not identify irregularities related to the medical record's lack of documentation of clinical contraindication for GDR.

On 1/23/20, at 12:53 p.m. the consultant pharmacist (CP) verified R15's last GDR was attempted on 10/22/18. CP indicated R15 failed the dose reduction attempt and the medication

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F 756	Continued From page 20	F 756		

had been restarted on 12/14/18. CP verified no GDR had been attempted in 2019 and stated the psychotropic committee had determined in November they would address it in 2020, so as not to disturb R15 over the holidays.

On 1/23/20, at 1:59 p.m. the director of nursing and administrator verified the facility had a psychotropic medication committee and indicated they were totally revamping the group the following Tuesday. DON indicated they had developed a new form to use to analyze and track current concerns regarding residents' use of psychotropic medications and GDR's. DON verified the facility should have attempted a GDR yearly, as required, or had documention in place regarding contraindications to a dose reduction. DON indicated she would have expected the consultant pharmacist to identify the need for the GDR to be addressed yearly.

The Monitoring of Psychoactive Medications policy dated 11/2019, indicated the use of psychoactive medications would be monitored at least once monthly during the medication regimen review (MRR) and upon request between MRR's to ensure that residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The policy also indicated the pharmacist must report any irregularities such as, lack of rationale identifying why a gradual dose reduction (GDR) is clinically contraindicated, to the attending physician and director of nursing as outlined in the Consultant Pharmacist Services policy.

The Consultant Pharmacist Services Policy dated

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F 756	Continued From page 21 11/2019, indicated the pharmacist must report any irregularities to the director of nursing services , the attending physician, and the facility's medical director and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		3/4/20

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F 758	Continued From page 22 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction of antidepressant medication (Zoloft) was attempted or contraindication to dose reduction was documented for 1 of 4 residents (R15) reviewed who received antidepressant medication. Findings include: R15's quarterly Minimum Data Set (MDS) dated 11/30/19, indicated R15 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia and anxiety disorder. The MDS indicated R25 required limited assistance with dressing and supervision with all other activities of daily living. The MDS further indicated R25 had no mood symptoms, psychosis, behavioral symptoms or rejection of care but did exhibit wandering behavior 1-3 days	F 758	R15 had a dose reduction of her Zoloft starting on 1/27/2020. Staff are observing her shiftly for any adverse effects of the dose reduction, will report to her MD if there are any adverse effects. All BFV residents have the potential to be affected by this practice. Policy for Monitoring of Psychoactive Medications has been reviewed and revised. The IDT meeting : Pain and out of Character meeting has been revised to better track residents who are in need of a medication review to ensure a GDR is completed when necessary or the MD provides adequate documentation as to why the GDR is being declined. We have hired a Pharmacist Consultant to perform a full house review of all residents with psychotropic medications to ensure all residents have had their GDR	

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F 758	Continued From page 23 of the assessment period and received antidepressant medication daily. R15's Psychotropic Drug Use Care Area Assessment (CAA) dated 3/7/19, indicated R15 took antidepressant medication for the diagnosis of depression increasing her risk for falls, incontinence, dignity issues, side effects and adverse reactions. The CAA indicated R15's family member was aware of the risks of the medication, however, wanted R15 to remain on the antidepressant. R15's Medication Review Report dated 1/23/20, included a physician order for Zoloft (sertraline HCl) 25 milligrams (mg) by mouth one time a day related to anxiety disorder. The order start date was 12/14/18. R15's Care Plan dated 12/6/19, indicated R15 used antidepressant medication daily and directed staff to complete complete a PHQ-9 [patient health questionnaire] (multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) quarterly and as needed with any changes, an AIMS [abnormal involuntary movement scale] evaluation (scale to assess severity of movement disorders) with any changes in dosing, observe for side effects such as dry mouth, dry eyes, constipation, urinary retention, suicidal ideations, observe for signs and symptoms of depression and complete a monthly review by the Psychotropic Committee. On 1/22/20 at 11:25 a.m. the door to R15's room was partially ajar and a thirteen-gallon garbage can was positioned behind the closed door. R15 was seated in an easy chair with a walker	F 758	completed or have medical rationale as to why one is not warranted by their physician. All nursing and pharmacy staff have been educated on updated policy and meeting agenda. Pharmacy will complete audits on residents who receive psychotropic medications at bimonthly Pain and out of Character IDT meeting, who have their quarterly review, have been ordered a new psychotropic medication or are having increased Out of Character behaviors., these audits will be ongoing. Results of the Audits will be reviewed monthly at QAPI. Ongoing monitoring will be at the recommendation of QAPI Team.	

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F 758	Continued From page 24	F 758		

positioned in front of her. The room was dark and R15 rocked in her chair singing and talking to herself.

-At 12:23 p.m. an unidentified staff member entered R15's room and invited her to lunch, reassuring R15 her room would be safe. R15 got up from her chair independently and walked with use of a walker to the dining room with the staff member who provided reassurance and encouragement.

-At 3:57 p.m. R15 rested in bed with her eyes closed.

On 1/23/20, at 7:34 a.m. R15 rested in bed with the lights on. The door was part way open with a large garbage can positioned behind the door.

- At 7:38 a.m. nursing assistant (NA)-B stated R15 had good and bad days and could be moody. NA-B stated R15 liked to keep to herself and preferred to be in her room. NA-B also stated R15 put the can behind her door as the door did not stay shut. NA-B indicated when R15 was having a bad day, they provided reassurance, and redirection. NA-B stated R15 did not like bright lights or loud voices so she did not really like to be out in the main area, but would come out to visit with the ladies occasionally.

Review of R15's Psychotropic Committee Review notes from 1/1/19 to 1/23/20, revealed the following:

-1/30/19: psychotropic committee reviewed continued use of sertraline 25 mg by mouth daily related to anxiety disorder. GDR [gradual dose education] was unsuccessful in November 2018.

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F 758	Continued From page 25	F 758		

She restarted the medication in December 2018. Per committee recommendation, no GDR will be attempted with this medication at this time. MD has ordered the same.
-2/27/19: Restarted on sertraline 25 mg by mouth daily on 12/14/18. Continues to require the use of sertraline for anxiety disorder. Will continue to monitor and review in March.
-4/3/19: March review: R15 failed a GDR in the past year. Medication was restarted in December 2018. No other changes will be made at this time.
-10/8/19: Last GDR in December 2018. R15 failed GDR. Behaviors improved since restarted. No changes will be made at his time.
-11/5/19: R15 continues on antidepressant medications. R15 failed GDR in 2018 and it will be addressed in 2020.

R15's physician notes from 1/9/19 to 12/1/19, lacked documentation regarding R15's use of antidepressant medication and lacked documentation of contraindications for gradual dose reduction of sertraline.

On 1/23/20, at 12:53 p.m. the consultant pharmacist (CP) verified R15's last GDR was attempted on 10/22/18. CP indicated R15 failed the dose reduction attempt and the medication had been restarted on 12/14/18. CP verified no GDR had been attempted in 2019 and stated the psychotropic committee had determined in November 2019, they would address it in 2020, so as not to disturb R15 over the holidays.

On 1/23/20, at 1:59 p.m. the director of nursing and administrator verified the facility had a psychotropic medication committee and indicated they were totally revamping the group the

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F 758	Continued From page 26 following Tuesday. DON indicated they had developed a new form to use to analyze and track current concerns regarding residents' use of psychotropic medications and GDR's. DON verified the facility should have attempted a GDR yearly, as required, or had documention in place regarding contraindications to a dose reduction. The Monitoring of Psychoactive Medications policy dated 11/2019, indicated the use of psychoactive medications would be monitored at least once monthly during the medication regimen review (MRR) and upon request between MRR's to ensure that residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 758		
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,	F 880		3/4/20

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F 880	Continued From page 27 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, 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.	F 880		

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	245529	A. BUILDING _____ B. WING _____	01/23/2020

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F 880	Continued From page 28 §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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement an infection surveillance program to track and trend potential infections within the facility. This practice had the potential to affect all 36 residents in the facility. Findings include: On 1/23/20, at 11:12 a.m. during review of the facilty's infection surveillance, the director of nursing (DON) stated those residents receiving antibiotics were kept on a monthly log by unit and this data would be collected by herself and entered into the tracking log. Review of the log revealed documentation included the unit name, resident name, room #, admit date, existing infection from previous month, infection type, body system of infection, surveillance definition met, symptoms, onset date, date of insertion, date of removal, device days, infection risk factors, diagnostics performed, test date, type of test, results (organism colony counts for urine), antibiotic resistant organism, antibiotic name, class, dose, route, frequency, provider, antimicrobial RX origin, start date, end date, total days of therapy, meets criteria, transmission based precautions required, and date symptoms resolved. Upon review of the previous six months	F 880	No residents were found to be affected by this practice. All BFV residents could be affected by this practice. A new tracking/trending infection surveillance system has been implemented to track daily if a resident has symptoms that could potentially put other residents at risk to contract a communicable illness. The system will also be used to track/trend verified infections, which are now being kept kept on a monthly log by unit in real time on the AbTracker System This data is initiated by nursing and overseen by DON/IP with documentation included the unit name, resident name, room #, admit date, existing infection from previous month, infection type, body system of infection, surveillance definition met, symptoms, onset date, date of insertion, date of removal, device days, infection risk factors, diagnostics performed, test date, type of test, results (organism colony counts for urine), antibiotic resistant organism, antibiotic name, class, dose, route, frequency, provider, antimicrobial RX origin, start date, end date, total days of therapy, meets criteria, transmission	

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F 880	Continued From page 29 of surveillance logs, the logs revealed only the residents requiring antibiotics were included. At that time, the DON verified she did not include any residents not requiring antibiotics and, also, did not fill out the surveillance log until she was able to do so. The DON further verified she had not begun the January 2020, infection control log even though the month was almost over. The DON continued to explain that she would check every single day for infections by speaking with the nurses and this included weekends and holidays, however, denied having any documentation regarding this. At that time, the DON indicated she had only been with the facility since June 2019, and had been unable to focus all of her attention to infection control. The DON further verified daily surveillance with documentation was expected. A policy regarding infection control surveillance was requested but not received.	F 880	based precautions required, and date symptoms resolved. An Infection Control RN has been hired to assist DON/IP in tracking, trending, staff education, surveillance related to Infection Control and Prevention. Policies regarding Infection Control and Prevention, Antibiotic Stewardship have been reviewed and revised. All licensed nurses have been educated on the new system for tracking symptoms and infections. All nursing staff have been educated on the new policy changes. Audits of charts to ensure all residents who have symptoms that could potentially cause other residents, staff from contracting a communicable disease will be reviewed daily by DON or designee for 3 weeks, then audits will be 3 times a week for 2 months. Results of the Audits will be reviewed monthly at QAPI. Ongoing monitoring will be at the recommendation of QAPI Team.	

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	245529	A. BUILDING **01 - NURSING HOME** B. WING _____	**01/23/2020**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Bigfork Valley Communities Nursing Home 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2020

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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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 description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 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	K 000		

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K 000	Continued From page 2 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 47 beds and had a census of 35 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
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	K 351		2/26/20

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K 351	Continued From page 3 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 by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect the residents. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 01/23/2020, observations revealed that there was a florescent light fixture attached to the sprinkler piping that is located in the lower level mechanical room that houses the fire sprinkler riser system. This deficient condition was verified by the Maintenance Supervisor.	K 351	On 1/24/2020 Maintenance staff rehung the florescent light fixture, so it is no longer hanging on sprinkler pipe. Recurrence will be prevented by: Maintenance will monitor light fixtures on their rounds. Education: All Maintenance staff have been educated on sprinkler pipes and their functions, also that nothing should be attached to them.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered	K 363		2/26/20

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K 363	Continued From page 4 smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had multiple corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.6.3. This deficient practice could affect 47 of 47 residents.	K 363	1 On 1/30/2020 Maintenance personnel went to room 25 in Tamarack wing and removed the prop that was holding the door open. Recurrence will be prevented by: Maintenance will be monitoring all nursing home doors on their daily rounds.	

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K 363	Continued From page 5 Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 01/23/2020, observation revealed the following deficient conditions: 1. The corridor door for resident room 25 that is located in the Tamarack wing was being propped open. 2. The door to resident room 3 in the Aspen wing had warped door that had created a 1/2" gap at the top of the doors. The door creates a condition that will not limit the transfer of smoke and do not meet the requirements for corridor doors. This deficient condition was verified by the Maintenance Supervisor.	K 363	Education: All staff are receiving education on all nursing home doors not being propped open by any device. 2 On 2/7/2020 Maintenance personnel installed a smoke seal around Aspen room 3 door which eliminated the gap from warped door. Recurrence will be prevented by: Maintenance will monitor all doors on their daily rounds for any gaps that may occur in the future. Education: All Maintenance staff received education on door gabs for smoke seals and to monitor doors.	
K 511 SS=D	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 interview with the staff	K 511	On 1/24/20202 Maintenance staff	2/26/20

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K 511	Continued From page 6 the facility had a deficient condition affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.1.2 and the NFPA 70 "National Electrical Code" 2011 edition. This deficient practice could affect the residents. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 01/23/2020, observations revealed that there are combustible being stored around and against electrical panels that are located in the lower level mechanical room that also contains the facility's fire sprinkler riser assembly. This deficient condition was verified by the Maintenance Supervisor.	K 511	cleaned out the lower level mechanical room. All combustibles and clutter were removed from around and against electrical panels. Recurrence will be prevented by: Maintenance staff will no longer clutter up lower level mechanical room. Education" Maintenance staff were educated on cluttering up mechanical rooms and the effects it has as a safety risk.	