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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: DFKS

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) **048545400**

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 November 5, 2014 (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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 11/05/2013
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 01/16/2014
(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
11/12/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN 24-5529

Post Certification Revisit completed on November 5, 2013, by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal certification regulations. Please refer to the CMS 2567B for both health and life safety code. Effective October 23, 2013, the facility is certified for 40 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5529 January 16, 2014

Mr. Michael Anderson, Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

Dear Mr. Anderson:

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 October 23, 2013, 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Mr. Michael Anderson, Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

January 16, 2014

RE: Project Number S5529024

Dear Mr. Anderson:

On September 6, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 22, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 5, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 21, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 25, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 22, 2013, effective October 23, 2013 and therefore remedies outlined in our letter to you dated September 6, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245529	A. Building B. Wing	11/5/2013

Name of Facility	Street Address, City, State, Zip Code
BIGFORK VALLEY COMMUNITIES	258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **09/25/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **09/25/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/25/2013**
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **09/25/2013**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **09/25/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/25/2013**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/25/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/25/2013**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/25/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/25/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/25/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/cbl	01/16/2014	28035	11/05/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
8/22/2013	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245529	A. Building B. Wing **01 - NURSING HOME**	10/21/2013

Name of Facility	Street Address, City, State, Zip Code
BIGFORK VALLEY COMMUNITIES	258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0038	**08/23/2013**	ID Prefix Reg. # **NFPA 101** LSC K0050	**08/25/2013**	ID Prefix Reg. # **NFPA 101** LSC K0056	**10/23/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/cbl	**Date:** 01/16/2014	**Signature of Surveyor:** 03006	**Date:** 10/21/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/22/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DFKS

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) **048545400**

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 **08/22/2013** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Vienna Andresen, HFE NE II 09/24/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 11/12/2013 (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
11/12/2013
(L33)

DETERMINATION APPROVAL

CCN #245529

At the time of the standard survey completed August 22, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 3023

September 6, 2013

Mr. Michael Anderson, Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

RE: Project Number S5529024

Dear Mr. Anderson:

On August 22, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601

Telephone: (218)308-2104 Fax: (218)308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 1, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 1, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 22, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 February 22, 2014 (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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 12, 2013

Mr. Michael Anderson, Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

RE: Project Number S5529024 - **Please note that corrections have been made to the Statement of Deficiencies and a corrected copy is enclosed.** The Plan of Correction for the deficiencies must be submitted within **ten calendar days** of your receipt of the **September 6, 2013** letter:

Dear Mr. Anderson:

On August 22, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601

Telephone: (218)308-2104 Fax: (218)308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 1, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 1, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 22, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 February 22, 2014 (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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

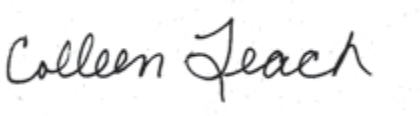
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

Corrected 2567 sent standard mail and via email to the administrator on 9/12/2013

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

PRINTED: 09/12/2013
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
SEP 20 2013
Minnesota Department of Health

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 _____	08/22/2013

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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156		

Approved w/ Addendum 9/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mike [signature] TITLE: Administrator (X6) DATE: 9-19-13

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.

Corrected 2567 sent standard mail and via email to the administrator on 9/12/2013

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

PRINTED: 09/12/2013
FORM APPROVED
OMB NO. 0938-0391

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F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	**F-156** **CORRECTIVE ACTION:** R23 was mailed the correct form of 10055 on 9/18/13. Education was provided to LSW to ensure compliance with the Medicare denial forms. A folder with the correct forms and descriptions of use has been created. **DATE OF COMPLETION:** September 18, 2013 **DATE CERTAIN:** September 25, 2013	

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

Mike

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156	**RECURRENCES WILL BE PREVENTED BY:** Audits will be completed monthly x 6 months and reported to Quality Assurance Committee by the MDS Coordinator/ ADON.	

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Medicare denial notices for 1 of 1 resident (R23) who had received Medicare benefits. Findings include: R23's medical record indicated R23 had received Medicare skilled nursing services from 6/17/13 to 6/30/13. The record also indicated the required Expedited Notice (Center for Medicare Services [CMS] form 10123) and CMS form 10124 had been given to the resident on 6/26/13. However, the traditional notice of Medicare non-coverage (CMS form 10055) had not been provided to R23 or the legal representative prior to termination of coverage. On 8/22/13, at 10:20 a.m. the licensed social worker (LSW) stated the facility was utilizing CMS	F 156		

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F 156	Continued From page 3 form 10124 in the place of the traditional demand bill notice. According to the Center for Medicaid and State Operations/Survey and Certification Group memo reference date 09-20, the CMS form 10124 is to be given to the resident or the representative upon receiving the determination of the Expedited Notice. On 8/22/13, at 10:25 a.m. the LSW stated she was unaware the facility had been using the incorrect form and verified R23 was not provided the required demand bill forms prior to the discontinuation of Medicare part A coverage.	F 156		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	**F225** **CORRECTIFVE ACTION:** Education for Bigfork Valley Vulnerable Adult Policy for Reporting will be completed for all nursing staff. Educational material contained definitions of immediately as defined by the Minnesota Department of Health. All future vulnerable adult incidents will be completed within the time frame of 30 minutes as established by the Minnesota Department of Health. **DATE OF COMPLETION:** September 25, 2013	

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F 225	Continued From page 4 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 consistently implement their policy and procedure related to immediately reporting incidents of potential mistreatment to the state agency (SA) for 6 of 20 vulnerable adult reports reviewed. This practice involved 6 resident (R35, R32, R41, R29, R40 and R9). Findings include: Review of the facility's Vulnerable adult (VA) reports from January 2013, through August 2013, related to resident to resident altercations revealed the following: 1. VA report dated 8/14/13, at 6:12 p.m. indicated R35 grabbed R32's wrists, started to yell at her and "became aggressive." The report indicated the administrator was immediately notified, however, the SA was not notified of the incident	F 225	**DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** Audits will be completed weekly by Director of Nursing and reported to the Quality Council x 6 months. Ongoing training will be provided quarterly to all staff in Bigfork Valley Communities.	

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F 225	Continued From page 5 until 8/15/13, at 3:30 p.m. (21 hours later). 2. VA report dated 7/19/13, at 2:45 a.m. indicated R41 had an unwitnessed fall and sustained a fractured hip. The report indicated the administrator was immediately notified, however, the SA was not notified of the incident until 7/19/13, at 1:30 p.m. (12 hours later). 3. VA report dated 5/29/13, at 3:40 p.m. indicated R29 had struck R32 as she passed by. The report indicated the administrator was immediately notified, however, the SA was not notified of the incident until 5/30/13, at 1:30 p.m. (22 hours later). 4. VA report dated 4/15/13, at 8:30 p.m. indicated R32 struck R40 in the arm and stated "don't do that." The report also indicated staff were unsure what had happened prior to R32 striking R40. Additionally, the report indicated the administrator was immediately notified, however, the SA was not notified of the incident until 4/18/13, at 3:30 p.m. (2 days and 18 later). 5. VA report dated 3/23/13, at 9:14 p.m. indicated R29 was holding an item that R32 wanted. The report indicated R32 pushed R29 and R29 pushed R32 back causing her to fall into a chair. The report also indicated the administrator was immediately notified, however, however, the SA was not notified of the incident until 3/24/13, at 4:00 p.m. (18 hours later). 6. VA report dated 3/16/13, at 1:36 p.m. indicated R40 was found attempting to pull R9 out of bed. The report indicated the administrator was immediately notified, however, the SA was not notified until 3/20/13, at 2:31 p.m. a total of (3	F 225		

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F 225	Continued From page 6 days and 23 hours later). On 8/20/13, at 2:20 p.m. the licensed social worker (LSW) stated staff had been educated to report any allegations of potential abuse to the SA immediately but not to exceed 24 hours. On 8/20/13, at 2:45 p.m. the assistant director of nursing (ADON) stated any allegations of abuse and neglect were to be reported to the SA within 24 hours of the incident. On 8/20/13, at 2:50 p.m. the director of nurses (DON) verified facility practice was to report an incident to the SA within and not to exceed 24 hours. Review of the Abuse Prevention Plan dated 8/11/11, directed the staff to report the incidents to the SA immediately. It further directed the staff regarding External Reporting: "All alleged incidents of maltreatment are reported to the state agency and to all other agencies as required and all necessary corrective actions, depending on the results of the investigation, are taken. "Immediately" means as soon as possible , but not more than 24 hours after the discovery of the incident." This policy incorrectly directed the facility staff to investigate the incident prior to reporting and incident. It also misguided the reader for immediately meant without delay and did not allow for a time period of up to 24 hours to report allegations of abuse or neglect.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226		

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 _____	08/22/2013

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 226	Continued From page 7 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently implement their policy and procedure related to immediately reporting incidents of potential mistreatment to the State Agency (SA) for 6 of 20 vulnerable adult reports reviewed. This practice involved 6 resident (R35, R32, R41, R29, R40 and R9) Findings include: The Abuse Prevention Plan dated 8/11/11, directed staff to report the incidents to the SA immediately. It further directed staff regarding External Reporting: "All alleged incidents of maltreatment are reported to the state agency and to all other agencies as required and all necessary corrective actions, depending on the results of the investigation, are taken. "Immediately" means as soon as possible , but not more than 24 hours after the discovery of the incident." This policy incorrectly directed facility staff to investigate the incident prior to reporting the incident. It also misguided the reader for immediately meant without delay and does not allow for a time period of up to 24 hours to report allegations of abuse or neglect. Review of the facility's Vulnerable adult (VA) reports from January 2013, through August 2013, related to resident to resident altercations revealed the following:	F 226	**F226** **CORRECTIVE ACTION:** Bigfork Valley Communities Policy has been reviewed by LSW, DON, Administrator and ADON. Education will be provided to all staff in regards to the Vulnerable Adult Policy with emphasis on definitions set forth by the Minnesota Department of Health. Education will be provided to all new employees quarterly. **DATE OF COMPLETION:** September 25, 2013 **DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** Audits will be completed by Administrative Assistant monthly x 3 months and reported to Director of Nursing. Director of Nursing will report to the Quality Council x 6 months.	

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F 226	Continued From page 8 1. VA report dated 8/14/13, at 6:12 p.m. indicated R35 grabbed R32's wrists, started to yell at her and "became aggressive." The report indicated the administrator was immediately notified, however, the SA was not notified of the incident until 8/15/13, at 3:30 p.m. (21 hours later). 2. VA report dated 7/19/13, at 2:45 a.m. indicated R41 had an unwitnessed fall and sustained a fractured hip. The report indicated the administrator was immediately notified, however, the SA was not notified of the incident until 7/19/13, at 1:30 p.m. (12 hours later). 3. VA report dated 5/29/13, at 3:40 p.m. indicated R29 had struck R32 as she passed by. The report indicated the administrator was immediately notified, however, the SA was not notified of the incident until 5/30/13, at 1:30 p.m. (22 hours later). 4. VA report dated 4/15/13, at 8:30 p.m. indicated R32 struck R40 in the arm and stated "don't do that." The report also indicated staff were unsure what had happened prior to R32 striking R40. Additionally, the report indicated the administrator was immediately notified, however, the SA was not notified of the incident until 4/18/13, at 3:30 p.m. (2 days and 18 later). 5. VA report dated 3/23/13, at 9:14 p.m. indicated R29 was holding an item that R32 wanted. The report indicated R32 pushed R29 and R29 pushed R32 back causing her to fall into a chair. The report also indicated the administrator was immediately notified, however, however, the SA was not notified of the incident until 3/24/13, at 4:00 p.m. (18 hours later).	F 226		

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F 226	Continued From page 9 6. VA report dated 3/16/13, at 1:36 p.m. indicated R40 was found attempting to pull R9 out of bed. The report indicated the administrator was immediately notified, however, the SA was not notified until 3/20/13, at 2:31 p.m. a total of (3 days and 23 hours later). On 8/20/13, at 2:20 p.m. the licensed social worker (LSW) verified staff had been educated to report any allegations of potential abuse to the SA immediately but not to exceed 24 hours. On 8/20/13, at 2:45 p.m. the assistant director of nursing (ADON) verified facility practice was to report any allegations of abuse and neglect to the SA within 24 hours of the incident. On 8/20/13, at 2:50 p.m. the director of nurses (DON) verified facility practice was to report an incident to the SA within and not to exceed 24 hours. The DON stated staff had up to 24 hours to complete the report.	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an individualized activity program for 2 of 2 residents	F 248	**F248** **CORRECTIVE ACTION:** Comprehensive Activities Assessments were completed on R23 and R26. Comprehensive Activities assessments will be completed annually and reviewed quarterly by the Life Enrichment Coordinator. The assessments will be used in care planning all elders' individual activity	

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F 248 Continued From page 10

(R26 and R23) reviewed for activities on the memory care unit.

Findings include:

R26 did not receive an individualized activity program.

R26's diagnoses included glaucoma and dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) dated 8/8/13, indicated R26 had severe cognitive impairments, trouble concentrating and had occasional verbal and physical behaviors.

The Activity Assessment dated 8/17/10, indicated R26 enjoyed activities such as playing cards, sewing, music, reading, church activities, watching television, shopping, fishing, walks outside and visiting with others.

The current plan of care (POC) directed staff to engage R26 in conversation, western movies, playing solitaire or folding laundry. The POC also directed staff to escort R26 to activities of interest on and off of the nursing unit.

On 8/19/13, from 4:00 p.m. to 8:00 p.m. R26 was observed to sit in the Balsam Neighborhood dining room. R26 was observed to eat her meal in the corner of the dining room, by herself. During this observation period R26 was not observed to be engaged in conversation or activities.

The posted activity calendar dated 8/20/13, indicated the following activities for the day included:

F 248

preferences. The Comprehensive Activities Assessment has been made available through the computer software Bigfork Valley utilizes. Activity assessments are easily accessible for review and revision.

DATE OF COMPLETION:
September 18, 2013

DATE CERTAIN:
September 25, 2013

RECURREENCES WILL BE PREVENTED BY:
The Life Enrichment Coordinator will complete monthly audits on completion of assessments, in accordance with MDS schedule, for six months and will report to the LTC Quality Council.

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F 248	Continued From page 11 10:00 a.m. Day Care visit 11:00 a.m. Gardening 1:30 p.m. Trivia/crafts 2:30 p.m. coffee 3:00 p.m. sort and fold 6:30 p.m. poker/card games. On 8/20/13, at 9:53 a.m. several children from a day care were observed to be escorted to the Cedar Neighborhood activity room. At this time R26 was observed seated in the Balsam Neighborhood dining room. At 10:10 a.m. an activity staff member was observed to escort two residents from the Balsam Neighborhood to the day care activity. R26 was observed to remain on the Balsam Neighborhood unit. On 8/20/13, at 1:30 p.m. R26 was observed sitting on the bed in her room looking out the window. R26 was not observed to be invited to the scheduled Trivia/craft activity. On 8/20/13, at 3:15 p.m. R26 was observed seated on a couch in the Balsam living room. At no time was R26 observed to be engaged in the scheduled sort/fold activity as identified on the calendar. The posted activity calendar dated 8/21/13, indicated the following activities for the day included: 10:00 Roll and Stroll 11:00 Catholic Communion 1:00 Knit / crochet 1:30 Bible Stories 1:45 Music On 8/21/13, at 8:10 a.m. dietary aide (DA)-A was	F 248		

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F 248	Continued From page 12 observed to ask R26 to fold a pile of towels (Cover ups). R26 was observed to stand and independently fold the items and then sat down. At no time did the staff interact with R26 while she completed this task. On 8/21/13, at 9:40 a.m. the director of nurses (DON) was observed to bring R26 a pile of baby clothes to fold. R26 was observed to refuse to fold the baby clothes and watched as the DON completed the task. On 8/21/13, at 9:45 a.m. the DON was observed to bring R26 a pile of napkins to fold. R26 was observed to complete the task without direction or interaction from the staff. On 8/21/13, at 10:10 p.m. activity aide (AA)-A was observed outside with approximately six residents walking along the sidewalks/paths of the facility. R26 was not observed to be included with the other residents participating in the Roll and Stroll activity. On 8/21/13, at 11:15 a.m. R26 was observed visiting with family members. The facility monitored resident activities both completed by the nursing assistants and by the activity staff members. Review of the nursing assistant documenting for the months of May, June, July and August 2013, identified sporadic documentation of visiting with staff, visiting with family, music and watching television. The last documentation was completed on 8/18/13, but no activities were identified during the survey conducted on 8/19/13 - 8/22/13.	F 248		

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F 248	Continued From page 13 Review of the activity staff documentation identified in May 2013, R26 had participated in 2 activities, in June 2013, R26 had participated in no activities, in July 2013, R26 had participated in 8 activities and in August 2013, R26 had participated in 4 activities. R23 did not receive and individualized activity program. R23's diagnoses included dementia with behavioral disturbances and depression. The quarterly MDS dated 6/24/13, indicated R23 had severe cognitive impairments and was totally dependent upon the staff for all activities of daily living. The MDS did not identify any type of behavior problems or any type of limitations related to activities. The current POC identified R23 as a northern cowboy, who liked to hold hands or items in his hands, liked to visit with small children, listen to music or play catch with a beach ball. The POC directed staff to provide R23 opportunities to have contact with family members and other residents as desired. The POC also directed staff to assist with cares as needed. The facility undated questionnaire related to R23's usual life routine. The questionnaire indicated R23 liked animals, enjoyed homemade bread and being busy on the farm working with equipment. On 8/19/13, from 4:00 p.m. to 8:00 p.m. R23 was observed to be in the dining room for the evening meal. Once R23 had completed the meal he was observed to be escorted back to his room and	F 248		

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F 248	Continued From page 14 assisted to bed. At no time were activities provided for him. The posted activity calendar dated 8/20/13, indicated the following activities for the day included: 10:00 a.m. Day Care visit 11:00 a.m. Gardening 1:30 p.m. Trivia/crafts 2:30 p.m. coffee 3:00 p.m. sort and fold 6:30 p.m. poker/card games. On 8/20/13, at 9:53 a.m. R23 was observed in bed, sleeping at the time of the day care visit. On 8/20/13, at 1:30 p.m. R23 was observed sitting in the Balsam living room where a radio was playing. R23 was not observed to respond to the radio nor was he offered to join the trivia and craft activity. On 8/20/13, at 3:10 p.m. R23 was observed in bed with the curtains closed and the lights off. R23 was not offered to join in the sort and fold activity. The posted activity calendar dated 8/21/13, indicated the following activities for the day included: 10:00 Roll and Stroll 11:00 Catholic Communion 1:00 Knit / crochet 1:30 Bible Stories 1:45 Music On 8/21/13, at 9:00 a.m. R23 was observed to be	F 248		

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F 248	Continued From page 15 assist with breakfast. Staff was observed to interact with R23 during the meal, however, R23 was not able to carry on a conversation. On 8/21/13, at 9:15 a.m. R23 was observed to be assisted into the Balsam living room. The television was on, however, R23 did not respond to television. At 9:20 a.m. the television was turned off and the radio was turned on. R23 was not observed to respond to the music. On 8/21/13, at 10:10 p.m. activity aide (AA)-A was observed outside with approximately 6 residents walking along the sidewalks/paths of the facility. R23 was not observed to be included with the other residents participating in the Roll and Stroll activity. On 8/21/13, at 11:15 a.m. R23 was observed sitting in the wheelchair in his room. R23 was not included in the church activity. On 8/21/13, at 11:30 p.m. a group of residents were observed on the Cedar living room area participating in a hymn sing. None of the residents from the Balsam Neighborhood were observed to participate in the activity. Review of the nursing assistant documentation for the months of May, June, July and August 2013, identified sporadic documentation of visiting with staff, visiting with family, music and watching television. The last documentation was completed on 8/18/13, but no activities were identified during the survey conducted on 8/19/13- 8/22/13. Review of the activity staff documentation identified in May 2013, R23 had participated in 9	F 248		

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F 248	Continued From page 16 activities, in June R23 had participated in 7 activities, in July 2013, R23 had participated in 7 activities and in August 2013, R23 had participated in 11 activities. Review of the facility activity calendars for August, July, and June of 2013 identified 1-6 organized daily activities. The activities were to include all of the residents in the facility. However, none of the activities were specialized for the needs of the residents residing on the Balsam/memory care neighborhood. On 8/21/13, at 12:15 p.m. the life enrichment coordinator (LEC)stated nursing and activity staff were to provide activities for the residents on the Balsam unit. The LEC also stated nursing staff were to document when they provided a resident with an activity. Additionally, the LEC stated she attempted to spend one hour a week specifically on the Balsam unit, but confirmed she did not have a set schedule as to when the hour was to be completed. The LEC stated during the weekly one hour visit she usually completed one to one visits with the 16 residents residing on the Balsam unit. The LEC explained the residents residing in the Balsam neighborhood may not tolerate the group activities that occurred in other area of the facility due to memory loss. The LEC verified she had not monitored the Balsam unit to ensure daily activities were occurring on the unit. In addition, the LEC confirmed during the survey conducted on 8/19/13 - 8/21/13, no organized activities were provided specifically for the residents in the Balsam Neighborhood by the activity department. The Activities and Quality of Life policy dated 8/11/11, directed staff to provide an organized	F 248		

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F 248	Continued From page 17 activity and recreational program for each resident. The policy also indicated the programs provided must be determined by the residents assessments and plans of care. Additionally, the policy indicated the activity program was to enrich the residents lives and eliminate the plagues of loneliness, helplessness and boredom. On 8/21/13, at 1:40 p.m. the director of nurses confirmed the facility was not ensuring all of the residents on the Balsam unit were receiving individualize activities.	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain an odor free environment for 2 of 2 residents personal rooms (R21 and R16.) Findings include: On 08/19/2013, at 06:32 p.m. A strong urine odor was noted in R21 and R26's shared room. At this time urine was observed on the floor around the toilet in their shared bathroom. On 8/21/13, at approximately 1:00 p.m. a strong urine odor was noted in R21 and R26's shared room. Urine was also observed on the bathroom	F 253	**F253** **CORRECTIVE ACTION:** The bathroom for R21 and R16 was cleaned. The carpet for R21 and R16 was cleaned. The bathroom will be on a daily cleaning schedule. A check off list will be placed inside the door to assure compliance with an odor free environment. Carpet cleaning has been scheduled weekly. Education will be provided to all Cedar staff regarding the cleaning schedule and check off sheet.	

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F 253	Continued From page 18 floor around the toilet. On 8/21/13, at 1:58 p.m. a strong urine odor was noted in R21 and R26's shared bathroom and also in their shared room. Urine was observed on the bathroom floor around the toilet. At this time the director of nursing (DON) and housekeeper-A (H-A) observed and verified the findings. H-A stated a personal glider rocker in the room also smelled of urine. H-A and the DON verified that the bathroom, resident room and chair had a strong urine odor. At 2:05 p.m. the DON stated nursing staff was responsible for cleaning the room and to maintain an odor free environment. Following this observation housekeeping was observed cleaning R21's and R26's room / bathroom. On 8/22/13, at 8:20 a.m. the DON verified urine was again observed on the bathroom floor of R16 and R21. The DON stated it had been a problem and R21 had just been provided with a urinal to help with the urine problem. In addition, the DON verified resident rooms should be kept odor free.	F 253	**DATE OF COMPLETION:** September 25, 2013 **DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** Audits will be conducted weekly by the Administrator and reported to Quality Council quarterly.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	**F280** **CORRECTIVE ACTION:** Care plans have been updated for R3, R23 and R26. Activity assessments will be completed on all new admissions, significant change, annually and as needed. The Life Enrichment Coordinator will review and update care plans to promote individualized, elder centered care per care plan.	

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F 280	Continued From page 19 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the plan of care related to falls/accidents for 1 of 3 residents (R3) identified at risk for falls; and for 2 of 2 residents (R23 and R26) who required individualized activity plans. Findings include: R3 had multiple falls incidents, and the care plan had not been revised to include fall interventions following fall incidents. Review of the admission record for R3 revealed that she was admitted to the facility with diagnoses that included, but were not limited to: dementia with behavioral disturbances, insomnia, memory loss, macular degeneration, Alzheimer's disease, osteoarthrosis and type II diabetes. Review of the annual Minimum Data Set (MDS) dated 8/1/13, revealed R3 had severe cognitive impairment, required extensive assistance of one person for bed mobility, transfers, and ambulation and had two or more fall incidents since the last quarterly MDS completed on 5/10/13. Review of the fall incidents from 3/16/13-8/4/13,	F 280	Care plans were updated and revised on R3 and communicated to staff. A Falls/behavior committee was started on July 18, 2013 and changed to a weekly meeting to discuss current falls and other incidents for all residents. Incident policy updated to utilize immediate interventions. **DATE OF COMPLETION:** September 25, 2013 **DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** This will be audited by Social Services weekly and reported to Quality Council x 6 months.	

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 _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 20	F 280		

revealed that R3 had four unwitnessed falls all of which occurred in her bedroom. The following are a summary of the fall incidents:

On 3/16/13 at 6:30 p.m. R3 was found on the floor of her bedroom in a kneeling, "praying" position in front of her roommate's bed. R3 stated that on the way back from the bathroom and decided to go for a run. R3 then commented that she was praying. It was unclear whether this was a fall or if she was actually found praying as she said she was doing. There was no injury noted. The intervention implemented was a personal chair alarm and bed alarm, and the recliner was also moved to the living room for increased resident supervision.

On 6/30/13, at 3:10 p.m. R3 was found on the floor of her bedroom. When the investigation was completed, it was found that she was not using her walker. It was not clear whether a fall intervention had been implemented to minimize fall reoccurrence.

On 7/13/13, at 6:30 p.m. R3 was found on the floor of her bedroom. No injury occurred. The intervention implemented to minimize fall reoccurrence included initiation of gripper socks for R3.

On 7/21/13, at 10:00 p.m. R3 was found sitting next to her bed, her back against the bed and her feet straight out. R3 stated that she just slid right down. No injuries occurred. The intervention implemented to minimize fall reoccurrence included replacement of a broken night light in R3's room so that she could see if she decided to get up at night.

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F 280	Continued From page 21 Review of the care plan dated 8/8/13, revealed the following interventions related to falls: "I am at high risk for falls. I will have less than 2 [two] falls through the review date. Be sure my call light is within reach and encourage me to use it for assistance as needed. Make sure I have a clear path in my room, and that my O2 [oxygen] lines aren't tangled up. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident /family/ caregivers/ IDT as to causes. Staff remind me that I need assistance when walking/ transferring but I sometimes still try to self-transfer and staff assist me if they see I am doing this." R3's care plan identified that she was in a restorative nursing program, with a goal to maintain her ability to ambulate 300 feet daily, with a four wheeled walker, gait belt and the assistance of one person. R3 was also provided active range of motion exercises seven days a week. A care plan was developed for the following: "I am monitored for ambulating without assistance, wandering and making decisions to ambulate without regards to safety." Interventions included: "Place call light within reach wherever I sit in my room. Re-direct me and assist when I am trying to ambulate on my own. Remind me to use the call light whenever you are in my room. Wander alert: I wear a wander guard on my walker... When I get up without any assistance, often times it is because I need to go to the bathroom, please ask me if I need to. When you walk by my room ask if I need anything. Sometimes this prevents me from walking by myself. " The care plan did not include interventions developed after fall incidents dated 7/13/13 and 7/21/13, which included making sure that a night light was turned on when her room was dark and ensuring that	F 280		

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F 280	Continued From page 22 she was using gripper socks. During interview with the assistant director of nursing (ADON) on 8/21/2013, at 1:16 p.m. she confirmed that fall interventions identified following fall incidents which included ensuring that a night light was used when the residents room was dark, and the ensuring gripper socks were used had not been added to the resident written care plan. The facility did not revise the care plans of R26 and R23 to reflect current activity interests or frequency. R26's diagnoses included glaucoma and dementia with behavioral disturbances. The activity assessment dated 8/17/10, identified R26 enjoyed activities such as playing cards, sewing, music, reading, church activities, watching television, shopping, fishing, walks outside and visiting with others. The current computerized plan of care directed the staff to engage R26 in conversation, western movies, playing solitaire or folding laundry. The plan of care directed the staff to escort R26 to activities of interest on and off of the nursing unit. The plan of care did not direct the staff as to how often R26 was to be engaged in activities. During observations on 8/19/13, from 4:00 p.m. to 8:00 p.m., on 8/20/13, from 8:00 a.m. to 4:30 p.m., and on 8/21/13, from 7:00 a.m. to 2:30 p.m. R26 was not observed to participate in any of the organized activities offered by the facility. R23's diagnoses included dementia with behavioral disturbances, and depression.	F 280		

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F 280	Continued From page 23 The current computerized plan of care identified the resident as a northern cowboy, who liked to hold hands or items in his hands, visit with small children, listen to music or play catch with a beach ball. The plan directed the staff to to provide opportunities for R23 to have contact with family members and other residents as desired. The plan of care did not direct the staff as to how often R23 was to receive activities. The facility had an undated questionnaire related to R23's usual life routine. The questionnaire indicated R23 liked animals, enjoyed homemade bread, and being busy on the farm working with equipment. During observations on 8/19/13, from 4:00 p.m. to 8:00 p.m., on 8/20/13, from 8:00 a.m. to 4:30 p.m., and on 8/21/13, from 7:00 a.m. to 2:30 p.m. R23 was not observed to participate in any of organized activities offered by the facility. On 8/21/13, at 1:40 p.m. the director of nursing (DON) reviewed the plans of care for R26 and R23. She confirmed they did not accurately reflect their current interests nor did they direct the staff on how often activities were to be offered. She confirmed the plans of care needed to be updated/revised. The Comprehensive Plan of Care policy dated 8/15/11, directed the staff to review and revise the plan of care following any changes in the residents needs.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 24 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services consistent with the written plan of care for 1 of 3 residents (R32) reviewed for accidents. Findings include: R32's diagnoses included Alzheimer's disease, adjustment disorder with mixed anxiety and depression, dementia with behavioral disturbances and unspecific sleep disturbance. R32's quarterly Minimum Data Set (MDS) dated 8/7/13, revealed R32 was severely cognitively impaired and required supervision for walking and transferring. R32's Fall Risk Assessment dated 8/20/13, indicated she was at a moderate risk for falls. R32 was able to walk independently; however, she had a lurching, swaying, or slapping gait. On 8/21/13, at 11:40 a.m. R32 was walking in the balsam unit hallway with regular white socks on her feet. She lacked tennis shoes or non-slip footwear. On 8/21/13, at 12:19 a.m. R32 was seated in the balsam unit dining room with regular white socks on her feet. R32 lacked tennis shoes or non-slip footwear. She proceeded to get up and walk around the dining room and up and down the hallway. On 8/21/13, at 12:35 p.m. licensed practical nurse (LPN)-D confirmed R32 was wearing a regular pair of socks, with no grippers to the soles of her feet. LPN-D was aware R32 should have had	F 282	**F282** **CORRECTIVE ACTION:** Care plans were updated and revised on R32 and communicated to staff. A Falls/behavior committee was started on July 18, 2013 and changed to a weekly meeting to discuss current falls and other incidents for all residents. Incident policy updated to utilize immediate interventions on September 17, 2013. **DATE OF COMPLETION:** September 25, 2013 **DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** This will be audited by Social Services weekly and reported to Quality Council x 6 months.	

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F 282	Continued From page 25 gripper socks and/or tennis shoes on when she was ambulating. Review of R32's incident reports between 7/5/13 through 8/22/13, revealed she had sustained two falls. One of the falls caused a three centimeter bruise to the right side of her face and a small laceration on the toes of her right foot. R32's current plan of care dated 8/15/13, identified her as a high risk for falls and directed staff to ensure R32 wore the appropriate footwear when ambulating such as non-slip socks, slippers or tennis shoes. On 8/22/13, at 8:51 a.m. director of nursing (DON) confirmed her expectation for staff was to follow R32's plan of care to minimize her risk for falls. The facility's Comprehensive Care Plan policy dated 8/15/11, revealed the plan of care would meet the medical, nursing, mental and psychosocial needs identified in the resident's comprehensive assessments.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure fall interventions were consistently implemented for 2	F 323	**F323** **CORRECTIVE ACTION:** Weekly interdisciplinary meetings are started on July 19th to meet bi-monthly for falls/behaviors/incidents. Meetings changed to weekly after Survey. Policy regarding falls/incidents updated and will be implemented on 9/20/13. Education provided to all staff on immediate interventions for falls.	

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F 323	Continued From page 26 of 3 (R3 and R32) residents reviewed for falls. Findings include: Review of the admission record for R3 revealed that the resident had been admitted to the facility with diagnoses that included, but were not limited to: dementia with behavioral disturbances, insomnia, memory loss, macular degeneration, Alzheimer's disease, osteoarthrosis, and type II diabetes. Review of the annual Minimum Data Set (MDS) dated 8/1/13, revealed that R3 had severe cognitive impairment; required extensive assistance of one person for bed mobility, transfers, and ambulation and had two or more fall incidents since the last quarterly MDS completed on 5/10/13. Review of the fall incidents from 3/16/13-8/4/13, revealed the following incidents: On 3/16/13 at 6:30 p.m. R3 was found on the floor of her bedroom in a kneeling, "praying" position in front of her roommate's bed. R3 was interviewed, during which she stated that on the way back from going to the bathroom she decided to go for a run. R3 then commented that she was praying. It was unclear whether this was a fall or if she was actually found praying as she said she was doing. There was no injury noted. The intervention implemented to minimize fall reoccurrence included implementation of a personal chair alarm and bed alarm. R3's recliner was also moved to the living room so that she could be supervised while sitting in the recliner.	F 323	Floor Manager will update staff weekly on fall interventions with follow up provided to Interdisciplinary Team weekly. **DATE OF COMPLETION:** September 25, 2013 **DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** Audits will be completed weekly by Social Services reporting to Quality Council monthly x 6 months.	

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F 323	Continued From page 27 On 4/10/13, at 9:58 p.m. a fall occurred while staff were ambulating R3. The report indicated her feet became tangled in the oxygen tubing. The intervention implemented to minimize fall reoccurrence included shorter oxygen tubing. Staff were also educated to keep a clear path in her room. On 6/30/13, at 3:10 p.m. R3 was found on the floor of her bedroom. When the investigation was completed, it was found that she was not using her walker. It was not clear whether a fall intervention had been implemented to minimize fall reoccurrence. On 7/9/13, at 7:25 a.m. R3 was observed to slide off her bed to the floor. She had no shoes on at the time of the fall, only anklets were worn. No injury was noted. It was not clear whether a fall intervention had been implemented to minimize fall reoccurrence. On 7/13/13, at 6:30 p.m. R3 was found on the floor of her bedroom. No injury occurred. The intervention implemented to minimize fall reoccurrence included initiation of gripper socks for R3. On 7/21/13, at 10:00 p.m. R3 was found sitting next to her bed, her back against the bed and her feet straight out. R3 stated that she just slid right down. No injuries occurred. The intervention implemented to minimize fall reoccurrence included replacement of a broken night light in R3's room so that she could see if she decided to get up at night. R3 was observed on 8/20/13, at 1:16 p.m. during which it was noted that she was sound asleep	F 323		

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and was laying on the edge of the bed with legs dangling over the edge of the mattress. Nursing assistant (NA)-C was notified of R3's position on 8/20/13, at 1:20 p.m. and NA-C assisted R3 to the middle of the bed where her legs rested on the bed. NA-C was also interviewed on 8/20/13, at 1:20 p.m. during which she stated that R3 often slept on the edge of the bed with legs dangling off the edge of the mattress.

R3 was again observed while sleeping in bed on 8/21/13, at 9:30 a.m. and it was noted that she was very close to the edge of the bed with one leg hanging off of it. R3 was not wearing gripper socks on her feet. This writer reported R3's position to NA-E and she was repositioned into the middle of the bed so that her body was in the middle of the bed and her legs rested firmly on the mattress.

R3 was observed on 8/21/13, at 1:00 p.m. sleeping in bed in her room. It was noted that her bed was all the way low to the floor, and she was again wearing regular anklet socks and not gripper socks.

NA-A was interviewed on 8/21/13, at 1:00 p.m., during which she confirmed that R3 did not have gripper socks on her feet while sleeping in bed. NA-A confirmed that R3 did not even have gripper socks available for use. NA-A confirmed that she did not know R3 should have been using gripper socks. Additionally, NA-A stated that she put R3's bed in the lowest position to minimize her risk of injury should she fall. NA-A stated that she did not know if R3's care plan included placing the bed in the lowest position to the floor and that it was just something she decided to do. NA-A confirmed that R3 often slept on the edge of the

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bed and her legs often dangled off the bed. NA-A stated that there was no care plan instruction to check on R3 with any frequency to ensure that she had not fallen out of bed or fell while attempting to ambulate independently. NA-A stated that she was supposed to check on R3 every two hours to see if she needed toileting assistance.

Review of the care plan dated 8/8/13, revealed the following interventions related to falls: "I am at high risk for falls. I will have less than 2 [two] falls through the review date. Be sure my call light is within reach and encourage me to use it for assistance as needed. Make sure I have a clear path in my room, and that my O2 [oxygen] lines aren't tangled up. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident /family/ caregivers/ IDT as to causes. Staff remind me that I need assistance when walking/ transferring but I sometimes still try to self-transfer and staff assist me if they see I am doing this." R3's care plan identified that she was in a restorative nursing program, with a goal to maintain her ability to ambulate 300 feet daily, with a four wheeled walker, gait belt and the assistance of one person. R3 was also provided active range of motion exercises seven days a week. A care plan was developed for the following: "I am monitored for ambulating without assistance, wandering and making decisions to ambulate without regards to safety." Interventions included: "Place call light within reach wherever I sit in my room. Re-direct me and assist when I am trying to ambulate on my own. Remind me to use the call light whenever you are in my room. Wander alert: I wear a wander guard on my walker...

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When I get up without any assistance, often times it is because I need to go to the bathroom, please ask me if I need to. When you walk by my room ask if I need anything. Sometimes this prevents me from walking by myself." The care plan did not include interventions developed after fall incidents dated 7/13/13 and 7/21/13, which included making sure that a night light was turned on when her room was dark and ensuring that she was using gripper socks.

During interview with the assistant director of nursing (ADON) on 8/21/2013, at 1:16 p.m. she stated that R3 should have had either gripper socks or shoes on when in bed so that if R3 got up unassisted, she had appropriate foot wear on, to minimizes fall risk. The ADON stated that the bed for this resident should not have been in the lowest position, but rather should have been positioned so that R3 could easily swing her legs over the bed edge and get to a standing position. The ADON confirmed that although R3 was having more falls and she was sleeping on the edge of the bed, she had not developed fall interventions that included increased supervision of R3 to ensure her safety while sleeping in bed.

R32's diagnoses included Alzheimer's disease, adjustment disorder with mixed anxiety and depression, dementia with behavioral disturbances and unspecific sleep disturbance. R32's quarterly MDS dated 8/7/13, revealed she was severely cognitively impaired and required supervision for walking and transferring. R32's Fall Risk Assessment dated 8/20/13, indicated she was at a moderate risk for falls. R32 was able to walk independently; however, she had a lurching, swaying, or slapping gait. On 8/21/13, at 11:40 a.m. R32 was walking in the

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F 323	Continued From page 31 balsam unit hallway with regular white socks on her feet. She lacked tennis shoes or non-slip footwear. On 8/21/13, at 12:19 a.m. R32 was seated in the balsam unit dining room with regular white socks on her feet. R32 lacked tennis shoes or non-slip footwear. She proceeded to get up and walk around the dining room and up and down the hallway. On 8/21/13, at 12:35 p.m. licensed practical nurse (LPN)-D confirmed R32 was wearing a regular pair of socks, with no grippers to the soles of her feet. LPN-D was aware R32 should have had gripper socks and/or tennis shoes on when she was ambulating. Review of R32's incident reports between 7/5/13 through 8/22/13, revealed she had sustained two falls. One of the falls caused a three centimeter bruise to the right side of her face and a small laceration on the toes of her right foot. R32's current plan of care dated 8/15/13, identified her as a high risk for falls and directed staff to ensure R32 wore the appropriate footwear when ambulating such as non-slip socks, slippers or tennis shoes. On 8/22/13, at 8:51 a.m. director of nursing (DON) confirmed her expectation for staff was to follow R32's plan of care to minimize her risk for falls.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334	**F334** **CORRECTION ACTION:** R36 was given his Pneumococcal vaccine on 8/23/13.	

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 _____	08/22/2013

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 334	Continued From page 32 immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:	F 334	Pneumococcal Vaccination has been added to the Admissions checklist to ensure that all future admissions have an up to date vaccination record. Educational Material will be provided upon admission to the elder or the family member reviewing the risks and benefits of Pneumococcal vaccinations. **DATE OF COMPLETION:** September 18, 2013 **DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** Audits will be completed monthly by floor manager and reported to Director of Nursing. Director of Nursing will report to Quality Council Quarterly x 1 year.	

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F 334	Continued From page 33 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to ensure 1 of 1 resident (R36) who had declined the pneumococcal vaccine was fully informed about the risks and benefits of treatment. Findings include: R36 was admitted to the facility on 7/3/12. The Immunization Record dated 7/10/12, indicated R36 had declined the pneumococcal vaccine. The quarterly Minimum Data Set (MDS) dated 5/21/13, indicated R36 was cognitively intact. On 8/20/13, at 2:02 p.m. the director of nursing (DON) stated there was no documentation in the medical record that indicated R36 was informed of the risks and benefits of treatment. The DON	F 334		

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F 334	Continued From page 34 also stated R36 was never again offered the pneumococcal vaccine. On 8/20/13, at 2:18 p.m. registered nurse (RN)-A verified R36 had declined the immunization on 7/10/12. RN-A stated she had documented R36's decline in the medical record. On 8/21/13, at 8:38 a.m. R36 stated he was not feeling well at the time the pneumococcal vaccination was offered therefore, he had declined it. R36 stated he was never offered the vaccination again nor given the risks of not receiving it. R36 stated he would take the pneumococcal vaccine now that he was feeling good. On 8/21/13, at 12:00 p.m. RN-A stated she had verbally informed R36 of the importance of the vaccination, however, had failed to document it. On 8/21/13, at 3:00 p.m. the DON stated the facility did not have a policy and procedure that addressed the risk/versus benefit of the pneumococcal vaccine.	F 334		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F371** **CORRECTIVE ACTION:** All dishwasher racks that have scale build up will be replaced. New dishwasher racks were ordered on 9/19/13. **DATE OF COMPLETION:** September 19, 2013	

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	245529	A. BUILDING _____ B. WING _____	08/22/2013

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F 371	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure surfaces that came into contact with food items were clean, sanitary and well maintained in the Balsam and Spruce kitchenettes. This practice had the potential to effect 24 of the 39 residents residing in the facility. Findings include: On 8/21/13, at 1:10 p.m. a sanitation tour of the Balsam kitchenette was conducted with dietary manager (DM). During the tour, the wooden counter top used for food service preparation was observed to lack a sealed finish to all surfaces, which allowed a porous, uncleanable surface to have direct contact with food items. Additionally, food debris was observed in the joints of counter top. DM confirmed the counter top was not sanitary and needed to be refinished or replaced. At 1:25 p.m., a drawer located next to the stove was observed to have a thick, gray matter on its face. Additional cupboards were also observed to have gray and black matter on their surfaces. DM verified the drawers and cupboards needed to be cleaned. At 1:27 p.m., the dishwashing racks were observed to have a thick scale build-up, which peeled off upon contact. Dietary aide (DA)-A stated the racks were "bad and should be replaced." DM indicated, "The dishwasher racks are supposed to be cleaned weekly." DM added she did not know the frequency for which the dishwasher racks were to be de-limed, for	F 371	**DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** Dishwasher racks that have scale build up will not be used. Monthly audits will be done by dietary manager or designee starting 9/13/13 for one year, reporting to Quality Council quarterly x 4. **CORRECTIVE ACTION:** Any pan or other cooking equipment that has black build up debris will not be used. **DATE OF COMPLETION:** August 22, 2013 **DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** All equipment that is used in Bigfork Valley kitchens will have prior approval from the dietary manager.	

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F 371	Continued From page 36 removal of the built-up scale. DM further stated, an employee had informed her a few weeks prior that the dishwasher racks needed to be replaced due to lime build-up. DM verified the scale build-up on the dishwasher racks provided an unsanitary surface and they needed to be replaced. At 1:32 p.m., two fry pans were observed to have thick, black debris on them. Additionally, three pans used for baking had black debris on them. DM verified the fry pans and baking pans were not be used and were to be removed from use. At 1:35 p.m., black matter and debris was observed underneath both kitchenette refrigerators. Additionally, the door seal of the second refrigerator was coming off at the bottom, prohibiting the door from sealing properly. DM verified the refrigerator gasket needed to be replaced. On 8/21/13, at 3:17 p.m. a sanitation tour of the Spruce kitchenette was conducted with the DM. During the tour, the dishwasher rack was observed to have a thick scale matter on it, similar to that which was observed in the Balsam kitchenette. Additionally, a 14 inch fry pan and a six inch fry pan were noted with thick, black debris on them. The cupboard door was also observed to have a black matter on the surface. DM verified the cookware was not clean and should not have been used. DM also verified the dishwasher rack needed to be replaced and the cupboards needed to be cleaned. Cleaning schedules and policies were requested, but were not provided.	F 371	Monthly audits will be done by the dietary manager or designee starting 9/13/13 for one year, reporting to Quality Council quarterly x 4. **CORRECTIVE ACTION:** The Balsam refrigerator has been replaced. **DATE OF COMPLETION** August 26, 2013 **DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** All refrigerators will have clean and intact seals. Monthly audits will be done by the dietary manager or designee to ensure cleanliness starting 9/13/13 for one year. All refrigerators in communities will be pulled out so the floor can be cleaned in a sanitary manner according to the posted cleaning schedule. A monthly audit will be done by dietary manager or designee starting 9/13/13 for one year, reporting to Quality Council quarterly x 4.	

F371 CONTINUED

CORRECTIVE ACTION:
All cupboards will be cleaned according to the posted cleaning schedule. Staff will maintain cleanliness of cupboards and counters on an as needed basis.

DATE OF COMPLETION:
August 22, 2013

DATE CERTAIN:
September 25, 2013

RECURRENCES WILL BE PREVENTED BY:
A monthly audit will be done by the dietary manager or designee starting 9/13/13 for one year.

CORRECTIVE ACTION:
The counter in Balsam will be refinished with a sealed surface that is cleanable. Porous cracks will be filled to assure that no foods will be able to get in cracks or seams by September 21, 2013.

DATE OF COMPLETION:
September 21, 2013

DATE CERTAIN
September 25, 2013

RECURRENCES WILL BE PREVENTED BY:
Dietary Manager along with Plant Manager will monitor counter to assure the Balsam counter remains cleanable. A quarterly audit will be done by dietary manager or designee starting 10/13/13 for one year.

NOTE: Cleaning schedules were provided to the Health Department upon request. Dietary cleaning schedules that were provided were for the three communities in LTC and the main kitchen.

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F 441 F 441 SS=E	Continued From page 37 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	**F441** **CORRECTIVE ACTION:** Infection Control Policy has been updated to reflect the use of Cavi-wipes. Staff education has been completed on use of Cavi-wipes. MSDS Sheets have been updated. **DATE OF COMPLETION:** September 20, 2013 **DATE CERTAIN:** September 25, 2013 **RECURRENCES WILL BE PREVENTED BY:** Audits will be completed by DON weekly x 8 and reported to Quality Council monthly x 3.	

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F 441	Continued From page 38	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to properly disinfect glucometers according to the manufacturer's instructions. This practice had the potential to affect 8 of 8 residents (R5, R10, R12, R17, R20, R21, R36 and R38) who required glucometer testing.

Findings include:

On 8/21/13, at 11:17 a.m. during medication storage review of the balsam/cedar medication cart, a plastic, uncovered cup was observed in the top drawer. The drawer also contained several pieces of disposable sanitizer wipes. Licensed practical nurse (LPN)-C revealed her practice was to cut up the larger OxyFect H wipes (disposable wipes utilized to disinfect reusable equipment) at the start of her shift and keep them in a plastic cup in her medication drawer until she needed them to disinfect the facility's community glucometer after each use.

On 8/21/13, at 1:06 p.m. during medication storage review of the cedar/spruce medication cart, a plastic, uncovered cup was observed atop the medication cart. The cup contained several pieces of disposable sanitizer wipes. LPN-B revealed he followed the same practice as LPN-C for storage and use of the OxyFect H sanitizer wipes.

On 8/21/13, at 2:48 p.m. the facility's infection control nurse confirmed it was her expectation for staff to follow the Material Safety Data Sheet

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F 441	Continued From page 39 (MSDS) (information sheet which directed staff on proper storage, handling and disposal of specific products) recommendations for storage and handling of the OxyFect H sanitizer wipes. On 8/22/13, at 7:00 a.m. LPN-C and LPN-B confirmed they cut the sanitizer wipes into strips due to lack of space for the OxyFect H container to be held the medication carts and to eliminate wastefulness of the product. Review of the OxyFect H MSDS dated 9/26/12, revealed the wipes were to remain in the original container and the container was to remain tightly closed and sealed until use. Review of the facility's Glucometer Cleaning policy dated 8/15/11, indicated the sanitizer wipes were to be removed from the container after donning gloves and prior to wiping the glucometer's exterior surfaces. The policy specified use of a sanitizer wipe called Lemon 64. On 8/22/13, at 9:17 a.m. DON confirmed the facility's current glucometer cleaning practice with OxyFect H sanitizer product did not reflect the facility's policy.	F 441		

Received 9/24/13 LB

Addendum to the Plan of Correction

9/23/13

F 156- Form 10055 was implemented immediately. All new Medicare admissions will have their charts audited after they have received the Medicare Denial form. Audits will be completed by the MDS Coordinator/ADON. Audits will be completed weekly x 4 weeks then randomly x 6 months. Audits will be reported to the Quality Council x 6 months

F225- All required incident reports will be reported immediately or as soon as possible. All elders will be kept safe

Audits will be completed daily and randomly. Audits will be reported to the Quality Council monthly x 3 months and then quarterly thereafter. Audits will be conducted by the Director of Nursing.

F-226- Audits will be conducted weekly by the Administrative Assistant. Audits will be reported to the Director of Nursing. The Director of Nursing will report to the Quality Council x 6 months.

F-248- All elders care plans will be reviewed to make sure the elders choices for activities are care planned.

Weekly audits will be completed by the Life Enrichment Coordinator to make sure care plans for activities are being followed. Life Enrichment Coordinator will report audits to the Director of Nursing. Director of Nursing will report to Quality Council monthly x 6 months.

Random audits will be completed by The Director of Nursing on an ongoing basis to ensure compliance. Random audits will be reported to Quality Council quarterly after the six month time frame.

F253- All rooms were examined for odor. Rooms with odor had the carpet shampooed and set up on a routine cleaning schedule.

Audits will be completed by the Administrator weekly and randomly to ensure an odor free environment.

F-280 Care plans will be reviewed for all elders in Bigfork Valley Communities. Observation audits will be completed by the Floor Manager weekly x 8 weeks and then monthly x 6 months. Audits will be

reported to the MDS Coordinator/ADON who will report to Quality Council monthly x 3 months and then quarterly.

F-282: Care plans will be reviewed and updated for all elders who trigger for risk of falls. Observation audits will be completed by the Floor Manager and reported to MDS Coordinator/ADON. MDS Coordinator will report to Quality Council monthly x 6 months. Observation audits will be completed weekly x 8 weeks and then monthly x 6 reporting to Quality council x 1 year.

F-323 Care plans interventions will be reviewed for all elders showing a risk for falls. Interventions will be updated with the Floor Manager providing education to staff. Observation audits will be completed by the Floor Manager and reported to the Director of Nursing. Director of Nursing will report to Quality Council monthly x 6 months. Observation audits will be completed weekly x 8 weeks and then monthly x 6 reporting to Quality council x 1 year.

F-334 All other elders will be checked for proper documentation for their pneumococcal vaccine. A checklist for all new admissions has been implemented to ensure compliance with this regulation

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	245529	A. BUILDING 01 - NURSING HOME B. WING _____	08/22/2013

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K 000	INITIAL COMMENTS	K 000	POC ok FS 9-20-13	

DC: 10-1-13

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 FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Bigfork Valley Communities Nursing Home 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

Exit: 8-22-13

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101

Or by e-mail to:

RECEIVED
SEP 20 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M. Re Andrew	Director of Senior Services	9-19-13

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 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 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. The building is divided into 4 smoke zones with 30 minute and 2-hour fire barriers. The original building has a common 2-hour fire barrier between the nursing home and the Bigfork Valley Hospital. The entire building has an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes corridor smoke detection, with	K 000		

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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
K 000	Continued From page 2 additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition, with automatic fire department notification. All hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. 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 40 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations it was determined that the facility exit signage is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 7.2.1.6. This deficient practice could negatively affect 10 of the 40 residents of the facility, any staff and any visitors in the Balsam dining room by causing confusion in an emergency.	K 038	**K038** **Plan of Correction:** Maintenance has labeled door (NOT AN EXIT) **Date of Completion:** 8/23/2013 **Corrective Acton Monitored by:** Plant Operations Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. BUILDING 01 - NURSING HOME B. WING _____	08/22/2013

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K 038	Continued From page 3 Findings include: Observations during the facility tour on August 22, 2013 between 10:00 am and 12:00 pm, by surveyor 03006, revealed that the Balsam dining room exterior glass door opens into an enclosed court yard and is not labeled NO EXIT. The Maintenance staff verified this finding during the facility tour and at the exit conference.	K 038		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on a review of fire drill records it was determined that the facility staff have not conducted fire exit drills in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all 40 residents, any visitors and the staff in a fire emergency. Findings include: A review of the fire exit drill records for Bigfork	K 050	**K050** **Plan of Correction:** Have changed times of fire drills to vary. **Date of Completion:** 8/25/13 **Corrective Action Monitored by:** Plant Operations Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. BUILDING 01 - NURSING HOME B WING _____	08/22/2013

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K 050	Continued From page 4 Valley Communities for 2012 and 2013, prior to the facility tour on August 22, 2013 at approximately 9:40 am, by surveyor 03006, revealed that the fire exit drills have not been conducted at unexpected times under varying conditions. 1) 2 of the day shifts drills were conducted at at 7:05 and 7:12 am, 2) 3 of the evening shifts drills were conducted at 5:28, 5:28 and 5:30 pm, and 3) 3 of the overnight shifts drills were conducted at 5:00, 5:00 and 5:40 am. The Maintenance staff verified these findings during the facility tour and at the exit conference.	K 050		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations it was determined that the automatic sprinkler system is not installed in accordance with NFPA 13 Standard for The	K 056	**K056** **Plan of Correction:** Maintenance has installed new ceiling tile Maintenance has replaced ceiling tile to repair gap **Date of Completion:** 8/23/2013 **Corrective Action Monitored by:** Plant Operations Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A BUILDING 01 - NURSING HOME B WING _____	08/22/2013

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K 056	Continued From page 5 Installation of Sprinkler Systems, 1999 edition. This deficient practice would allow a fire to extend above the suspended ceiling into a space that is not sprinkler protected, which will negatively impact all the residents, the visitors and the staff in these areas. Findings include: Observations during the facility tour on August 22, 2013, between 10:00 am and 12:00 pm, by surveyor 03006, revealed that: 1) A ceiling tile was missing in the IT basement storage room, and 2) A gap of 1 inch around sprinkler head in Cedar Lane janitor's closet was discovered The Maintenance staff verified these findings during the facility tour and at the exit conference.	K 056		