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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DIUO

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 **10/28/2014** (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:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Rebecca Haberle, HFE NEII — 12/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 12/09/2014 (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
Posted 12/12/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/03/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5529

On October 28, 2014 a Post Certification Revisit (PCR) was completed to verify correction of deficiencies from the PCR and extended survey that identified Substantard Qaulity of Care (SQC) completed September 8, 2014 pursuant to the standard survey completed on July 10, 2014. As a result of achieving substantial compliance, this Department recommended the following action to the CMS RO related to the remedies in their letter of September 19, 2014:

Civil Money Penalty for the deficiency cited at F323, remain in effect
Mandatory denail of payment for new Medicare and Medicaid admissions, effective October 10, 2014, be discontinued Octobver 15, 2014.

The faciltiy is subject to a two year loss of NATCEP beginning September 8, 2014, the date of the revisit that identified SQC. Refer to the CMS 2567b for the results of this visit.

Effective October 15, 2014, the facilit is certified for 40 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5529

December 3, 2014

Mr. James Blum, Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

Dear Mr. Blum:

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 15, 2014 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)
cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 3, 2014

Mr. James Blum, Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

RE: Project Number S5529025

Dear Mr. Blum:

On September 19, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective September 24, 2014. (42 CFR 488.422)

On September 19 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective October 10, 2014. (42 CFR 488.417 (b))

Furthermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 8, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on July 10, 2014 and not achieving substantial compliance at the Post Certification Revisit (PCR) conducted September 2, 3 and 4, 2014 which resulted in an extended survey being conducted September 5, 7 and 8, 2014. The extended survey revealed conditions in the facility constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy to residents health or safety. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On October 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR completed September 4, 2014 and an extended survey, completed on September 8, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 15, 2014.

Based on our visit, we determined that your facility has corrected the deficiencies issued pursuant to our PCR and the extended survey completed on September 8, 2014, effective October 15, 2014. As a result of the revisit findings, the Category 1 remedy of state monitoring would be discontinued, effective October 15, 2014.

In addition, we recommended to the CMS Region V Office the following actions related to the remedies recommended in our letter of September 19, 2014:

- Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 10, 2014 be discontinued, effective October 15, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies,

As we notified you in our letter of July 29, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 8, 2014.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Enclosure

cc: Licensing and Certification File 5529r2_14

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	10/28/2014

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **10/15/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **10/15/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **10/15/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **10/15/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **10/15/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **10/15/2014**
ID Prefix **F0388** Reg. # **483.40(c)(3)-(4)** LSC	Correction Completed **10/15/2014**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **10/15/2014**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **10/15/2014**
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	Date:	Signature of Surveyor:	Date:
	LB/mm	11/26/2014	18618	10/28/2014
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
7/10/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DIUO

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 **09/08/2014** (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

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 :
Rebecca Haberle, HFE NEII 10/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Heath
Enforcement Specialist 11/07/2014 (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
Posted 11/25/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/03/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5529

On September 2, 3 and 4, 2014, a Post Certification Revisit (PCR) was conducted by the Department of Health. Substandard Quality of Care (SQC) was identified which resulted in an extended survey. The extended survey was conducted on September 5, 7 and 8, 2014. Conditions in the facility constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to residents health or safety.

During this visit, two deficiencies issued pursuant to the standard survey were not corrected and are as follows:

- F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
- F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

In addition, at the time of this revisit, we identified the following deficiencies:

F0164 -- S/S: D -- 483.10(e), 483.75(l)(4) -- Personal Privacy/confidentiality Of Records
F0272 -- S/S: E -- 483.20(b)(1) -- Comprehensive Assessments
F0278 -- S/S: D -- 483.20(g) - (j) -- Assessment Accuracy/coordination/certified
F0356 -- S/S: C -- 483.30(e) -- Posted Nurse Staffing Information
F0388 -- S/S: D -- 483.40(c)(3)-(4) -- Personal Visits By Physician, Alternate Pa/np
F0497 -- S/S: E -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice
F0520 -- S/S: D -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

As a result of this revisit, this Department imposed the Category 1 remedy of State Monitoring, effective September 24, 2014.

In addition, this Department is recommending the following remedies to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444
- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 10, 2014. (42 CFR 488.417 (b))

Furthermore, Bigfork Valley Communities is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 8, 2014, due to the extended survey resulting in Subtstandard Quality of Care.

Refer to the CMS 2567 for health along with the plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6931

September 19, 2014

Mr. Joey Jacobson, Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

RE: Project Number S5529026

Dear Mr. Jacobson:

On July 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 10, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On September 2, 3 and 4, 2014, a Post Certification Revisit (PCR) was conducted by the Department of Health. Substandard Quality of Care (SQC) was identified which resulted in an extended survey. The extended survey was conducted on September 5, 7 and 8, 2014. Conditions in the facility constituted both **Substandard Quality of Care (SQC)** and **Immediate Jeopardy (IJ)** to residents health or safety. We presumed based on your plan of correction, that your facility had corrected these deficiencies as of August 4, 2014. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey completed on July 10, 2014. The deficiencies not corrected are as follows:

F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

In addition, at the time of this revisit, we identified the following deficiencies:

F0164 -- S/S: D -- 483.10(e), 483.75(l)(4) -- Personal Privacy/confidentiality Of Records
F0272 -- S/S: E -- 483.20(b)(1) -- Comprehensive Assessments
F0278 -- S/S: D -- 483.20(g) - (j) -- Assessment Accuracy/coordination/certified
F0356 -- S/S: C -- 483.30(e) -- Posted Nurse Staffing Information
F0388 -- S/S: D -- 483.40(c)(3)-(4) -- Personal Visits By Physician, Alternate Pa/np
F0497 -- S/S: E -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice
F0520 -- S/S: D -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the attached CMS-2567, whereby corrections are required.

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective September 24, 2014. (42 CFR 488.422)

In addition, this Department is recommending the following remedies to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 10, 2014. (42 CFR 488.417 (b))

Furthermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 8, 2014.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation and appeal rights.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on September 8, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **<u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bigfork Valley Communities is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 8, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

PLAN OF CORRECTION (ePoC)

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,

- Submit to acknowledge your receipt of the 2567, your review and your PoC submission.

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 remedy be imposed:

• 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. 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 ePoC.

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

If substantial compliance with the regulations is not verified by October 10, 2014 (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 January 10, 2015 (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 an ePoC 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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	9/8/2014

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 **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **09/08/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0285** Reg. # **483.20(m), 483.20(e)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/08/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/08/2014**	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**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/10/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. BUILDING _____ B. WING _____	R 09/08/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted on September 2, 3, 4, 5, 7, and 8, 2014, to determine compliance with federal deficiencies issued during a recertification survey exited on July 10, 2014. An immediate jeopardy (IJ) at F323 began on 7/10/14, when R41 returned to the facility following a hip surgery repair as a result from a fall at the facility. At the time of readmission, interventions were not implemented to minimize R41's risk for falls. As a result, R41 sustained additional falls including a fall on 8/20/14, which resulted in a scalp laceration. The IJ was identified on 9/4/14. The interim administrator, director of senior services, and the director of nurses were notified of the IJ on 9/4/14, at 1:50 p.m. The IJ was removed on 9/8/14, at 10:45 a.m. An extended survey was conducted by the Minnesota Department of Health on September 5, 7, and 8, 2014.	{F 000}		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164	Approved - final addendum received 10/20/14 SB	

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

RN, MSN LNHA 10-3-14

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 164	Continued From page 1 Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide privacy during personal cares for 1 of 1 resident (R41) in the sample who utilized an audible monitor. Findings include: R41's significant change Minimum Data Set (MDS) dated 7/17/14, indicated R41 was diagnosed with dementia, had a history of a hip fracture, severe cognitive impairment and required extensive assistance with all activities of daily living. R41's care plan dated 7/18/14, identified R41 at risk for falls but did not direct staff to utilize a "baby monitor" (audible monitor which allowed the staff to hear R41's movements while he was	F 164	F164 CORRECTIVE ACTION: Personal Privacy/Confidentiality of RecordsThe noise monitor was removed from R41's room on 9/29/2014. A policy has been created for use of the noise monitor. DATE OF COMPLETION: October 13,2014 DATE CERTAIN: October 13,2014 RECURRENCES WILL BE PREVENTED BY: In the event of future usage of the noise monitor, the Floor Manager will audit daily to ensure compliance with the policy and that the noise monitor is shut off at the end of night shift. The noise monitor will be considered a temporary treatment and documented by the floor nurse daily.	

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F 164	Continued From page 2 alone in his room or during the provision or personal cares) at R41's bedside. R41's medical record lacked an assessment for the use of the audible monitor. On 9/3/14, at 9:24 a.m. R41 was observed in bed, sleeping. A baby audible monitor was observed positioned on the floor in R41's room. At this same time, nursing assistant (NA)-Q stated the monitor's receiver was stationed on the nurses cart in the common lounge area. NA-Q stated it was the licensed practical nurses' (LPN) responsibility to listen to the monitor to hear what R41 did while in his private bedroom. At 9:25 a.m. LPN-C stated R41 had the ability to speak and visited daily with his spouse while in his own room. LPN-C confirmed everyone in the common lounge area (several residents and staff) could hear conversations held in R41's room and stated the above conversation with NA-Q was heard throughout the common area. On 9/3/14, at 11:36 a.m. LPN-C stated the facility had utilized the audible monitor for the past month in an attempt to keep R41 safe. LPN-C confirmed when the staff were assisting R41 with cares, the conversation could be heard in the dining room/common lounge on the Balsam wing. She stated the monitor was very helpful on the evening and night shifts but it could be turned off while staff assisted R41 with cares. On 9/4/14, at 9:57 a.m. the monitor receiver was observed stationed on the nurse's cart in the Balsam dining room. A voice on the monitor stated, "Okay [R41's name] let's sit up." The	F 164		

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F 164	Continued From page 3 voice continued to direct R41 to put his shirt on, apply a belt and comb his hair. The entire conversation between R41 and the nursing assistants was heard in the Balsam dining room. At the time of the conversation cook-A, R26, R23 and R40 were in the dining room within hearing distance of the monitor. At 10:10 a.m. NA-A and NA-L were observed to ambulate R41 to the dining room. NA-A confirmed they had just assisted R41 with morning cares, in his room. On 9/5/14, at 2:40 p.m. R41 was observed in bed with NA-L seated next to him. A monitor was observed stationed on R41's night stand next to R41's bed. The monitor was turned on. NA-L and the surveyor had a short conversation while R41 slept. At 2:43 p.m. the receiver for the monitor was observed stationed next to the fire extinguisher in the main dining room. Cook-A stated she had heard the entire conversation between NA-L and the surveyor while she was in the dining room. Four other residents were present in the dining room at the time of the conversation. On 9/5/14, at 3:40 p.m. the director of nurses (DON) stated she expected staff to maintain R41's personal privacy during cares and would not want the conversation between the staff and R41 to be announced throughout the dining room. The DON stated the use of an audible monitor was new for the facility and confirmed they had not developed a policy and procedure related to it's use but again stated she expected staff to maintain R41's personal privacy.	F 164		

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F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F272 R41's MDS was corrected to show a history of falls and injury related to his falls on 9/22/2014. MDS was accepted into record on 9/22/2014. MDS Coordinator received education on correct coding of MDS on 9/22/2014. DATE OF COMPLETION: October 13,2014 DATE CERTAIN: October 13,2014 RECURRENCES WILL BE PREVENTED BY: Ongoing education will be provided to MDS Coordinator to ensure coding accuracy. Director of Nursing will audit the next MDS after any fall with injury. Audits will be completed x 3 months and reported to the Quality Assurance Committee.	

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F 272	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete Care Area Assessments (CAAs) following the completion of admission or significant change (full) Minimum Data Sets (MDS) for 4 of 4 residents (R24, R51, R41, R27) who had full MDSs completed. Findings include: R24's required CAAs were not completed at the time of the admission MDS. R24's admission MDS dated 8/25/14, indicated R24 had intact cognition and required extensive assistance with all activities of daily living. The CAA Triggers Summary form dated 8/26/14, indicated R24 required comprehensive assessments in the areas of visual function, activities of daily living function, urinary incontinence, psychosocial well being, activities, falls, nutritional status, dehydration, pressure ulcers, psychotropic drug use, pain and return to community referral. R24's clinical record included a CAA worksheet for each area in which the facility had placed a check mark next to areas of concern for R24, however, the facility failed to complete a summary of the information regarding the additional assessments performed on the care areas triggered by the completion of the admission MDS.	F 272		

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F 272	Continued From page 6 R51's CAAs were not completed at the time of the admission MDS. R51's admission MDS dated 8/6/14, indicated R51 had intact cognition and required supervision with activities of daily living. The CAA Triggers Summary dated 8/7/14, indicated R51 required comprehensive assessments in the areas of cognitive loss, communication, activities of daily living, behavioral symptoms, falls, nutritional status, dehydration, dental care, pain and return to community referral. R51's clinical record contained a CAA worksheet in which the facility had placed a check mark next to areas of concerns for each identified need. However, the facility failed to complete a summary of the information regarding the additional assessments performed on the care areas triggered by the completion of the admission MDS. R41's CAAs were not completed at the time of the significant change MDS. R41's significant change MDS dated 7/17/14, indicated R41 had severely impaired cognition and required extensive to total assistance with all activities of daily living. The CAA Triggers Summary form dated 7/18/14, indicated R41 required comprehensive assessments in the areas of cognitive loss, visual function, communication, urinary incontinence, mood state, behavioral symptoms, falls, nutritional status, dehydration, pressure ulcers and pain. R41's clinical record included a CAA worksheet	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 7 for each area in which the facility had placed a check mark next to areas of concern for R41. However, the facility failed to complete a summary of the information regarding the additional assessments performed on the care areas triggered by the completion of the admission MDS. R27's CAAs were not completed at the time of the significant change MDS. R27's significant change MDS dated 8/11/14, indicated R51 had intact cognition and required supervision with activities of daily living. The CAA Triggers Summary dated 8/19/14, indicated R27 required comprehensive assessments in the areas of vision, communication, activities of daily living, urinary incontinence, falls, nutrition, dental pressure ulcers and pain. R27's clinical record contained a CAA worksheet in which the facility had placed a check mark next to areas of concerns for each identified need. However, the facility failed to complete a summary of the information regarding the additional assessments performed on the care areas triggered by the completion of the admission MDS. On 9/4/14, at 11:00 a.m. the director of nurses (DON) stated she had recently realized the CAAs had not been completed as required. She stated the MDS coordinator had attended a training in August of 2014, and had reported she had not been completing the CAAs correctly. She reviewed the above identified CAAs and verified they had not included a comprehensive	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 8 assessment of the residents' needs. On 9/4/15, at 3:10 p.m. registered nurse (RN)-B confirmed she had been completing the MDS assessments since January of 2014. She stated she had not realized the CAAs needed to include a comprehensive assessment of each of the identified triggered areas which were to assist the facility to ensure they were providing appropriate care for the resident. RN-B stated upon completion of the CAA worksheet/check mark sheet, she had updated the care plans but had not completed comprehensive assessments of the identified areas. The Care Area Assessment policy dated 8/15/11, directed staff to complete CAAs following the completion of a full MDS (annual, significant change) in order to assist staff in identifying the residents problems and needs and strengths to promote the residents highest practicable level of function. The Resident Assessment Instrument (RAI) (manual for completion of the MDS) directed the persons completing the MDS to complete the CAA process. The manual indicated the CAA process provided for further assessment of the triggered areas by guiding staff to look for causal or confounding factors, some of which may be reversible as it was important the CAA documentation included the causal or unique risk factors for decline or lack of improvement. The manual also indicated the care plan then addressed those factors, with the goal of promoting the resident's highest practicable level of functioning such as improvement where possible or maintenance and prevention of	F 272		

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F 272	Continued From page 9 avoidable declines. The manual further indicated documentation should support the writer's decision making regarding whether to proceed with a care plan for a triggered CAA and the type(s) of care plan interventions that were appropriate for a particular resident and indicated documentation could appear anywhere in the clinical record such as progress notes, consults, flowsheets, etc.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	R41's CAA's were not altered during the correction of the MDS. Ongoing education is being provided to the MDS Coordinator regarding The Care Area Assessments and accuracy of completion. Date Certain: October 13, 2014 DATE OF COMPLETION: October 13,2014 DATE CERTAIN: October 13,2014 RECURRENCES WILL BE PREVENTED BY: Audits will be completed on CAA's weekly x 4 weeks and then monthly x 6 months with the reports being given to the Quality Assurance Committee Monthly 6 months.	

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F 278	Continued From page 10 material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident's Minimum Data Set (MDS) assessment accurately identified a history of falls and fracture for 1 of 3 residents (R41) reviewed for assessment accuracy. Findings include: R41's significant change MDS dated 7/17/14, indicated R41 was diagnosed with dementia, Parkinson's disease, status post hip fracture, severe cognitive impairment and had a history of falls. Review of R41's progress notes revealed on 7/5/14, at 11:28 p.m. R41 was found on the floor at the foot of his bed after an unwitnessed fall in which he sustained a hip injury. The note indicated R41 was sent to the emergency room where X-ray confirmed a left hip fracture, was admitted to the hospital and returned to the facility on 7/10/14. Review of R41's significant change MDS lacked identification of R41's fall with subsequent hip fracture. On 9/4/14, at 11:00 a.m. the director of nurses reviewed R41's MDS and stated it had been coded incorrectly. The DON stated the MDS should have identified R41's hip fracture as being directly related to his history of falls.	F 278		

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F 278	Continued From page 11 A policy related to accuracy of MDS coding was requested an none was provided.	F 278		
{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 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 interview and document review, the facility failed to revise the written care plan to include fall interventions for 1 of 3 residents (R41) reviewed for falls. Findings include: R41 was hospitalized on 7/5/14, after a fall and	{F 280}	F280 R41's care plan has been updated to include interventions to prevent falls. Education completed with licensed staff in regards to update care plans. DATE OF COMPLETION: October 13,2014 DATE CERTAIN: October 13,2014 RECURRENCES WILL BE PREVENTED BY: Audits will be completed by Unit Coordinator weekly x 4 then monthly and reported to the Quality Assurance Committee x 6 months	

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{F 280}	Continued From page 12 sustained a hip fracture. R41 was readmitted to the facility on 7/10/14, after having an open reduction and internal fixation (commonly known as pinning) of the right femur. R41's fall interventions implemented following readmission from the hospital for the hip fracture on 7/10/14, directed staff to keep R41's call light within reach and encourage use, ensure appropriate foot wear was worn when ambulating or mobilizing in wheelchair, physical therapy evaluation and treatment as ordered and if R41 was restless it could be a sign of pain or need to use the bathroom. R41 had three fall incidents following readmission from the hospital to the facility and the following interventions were identified as being implemented: On 8/14/14, at 6:43 p.m. post fall interventions included: purchasing hip pads to cushion falls if they occurred and potentially self-release belts that alarmed when removed. These interventions had not been implemented or added to R41's care plan. On 8/20/14, at 6:55 p.m. post fall interventions included: take R41 to the bathroom before and after meals, make sure his wheelchair breaks were never locked unless a transfer in or out is involved, increase R41's ambulation and modified restorative program to include ambulation every 1-2 hours while awake. On 8/30/14, at 1:30 a.m. post fall interventions included: another noise monitor was placed in his room with the receiver placed by the nurse,	{F 280}		

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{F 280}	Continued From page 13 nursing assistants (NAs) to toilet R41 every 2 hours as care planned. R41's current care plan updated 8/20/14, indicated R41 was at risk for falls and directed staff to: ensure R41's call light was within reach and to encourage R41 to use for assistance as needed with prompt staff response for all requests for assistance, ensure R41 was wearing appropriate foot wear when ambulating or mobilizing in wheelchair, physical therapy evaluation and treatment as ordered or as needed, encourage participation in activities that promoted exercise / physical activity for strengthening and improved mobility and to anticipate and meet his needs. The interventions also indicated if R41 was restless it could be a sign of pain or need to use the bathroom. The care plan further indicated R41 needed to be evaluated for, and supplied appropriate adaptive equipment or devices as needed and to re-evaluate as needed for continued appropriateness and to ensure least restrictive device or restraint is used. On 9/3/14, at 10:34 a.m. RN-A confirmed the aforementioned interventions hade not been added to R41's care plan. -At 3:03 p.m. the DON confirmed R41's care plan was not updated to include the current fall interventions.	{F 280}		
{F 323} SS=J	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	{F 323}		

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{F 323}	Continued From page 14 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 demonstrated a systematic failure to comprehensively assess and effectively implement interventions in order to minimize the risk of serious injury or death from a fall for 1 of 3 residents (R41) reviewed with a history of falls, resulting in immediate jeopardy (IJ). In addition, the facility's failure to comprehensively assess and effectively implement interventions for falls resulted in actual harm for 1 of 3 residents (R41) reviewed with a history of falls, who sustained a hip fracture and a scalp lacerations following two separate falls. Findings include: The IJ began on 7/10/14, when R41 returned from the hospital following surgical repair of a hip fracture as a result of a fall on 7/5/14. The facility's systematic failure to comprehensively assess and effectively implement interventions for R41's falls was identified on 9/4/14. The administrator and the director of nursing (DON) were notified of the IJ on 9/4/14, at 1:50 p.m. The IJ was removed on 9/8/14, at 10:45 a.m. however, non-compliance remained at the lower scope and severity level of a G, which indicated actual harm that was not immediate jeopardy. R41's Admission Record report dated 7/10/14,	{F 323}	F323 R41 continues to utilize a chair and a bed alarm. R41 also continues to utilize the self releasing seat belt while in his wheelchair. The Bigfork Valley Falls Committee has implemented a new format with the weekly meeting concentrating on falls, interventions used, and effectiveness of the interventions and continued monitoring. All staff has been educated on the falls policy and procedure, the temporary care plans, the falls committee and its purpose. DATE OF COMPLETION: October 13,2014 DATE CERTAIN: October 13,2014 RECURRENCES WILL BE PREVENTED BY: A checklist has been implemented to ensure regulatory compliance. Audits will be completed by Director of Nursing after each fall occurrence and reported to Bigfork Valley Quality Assurance monthly x 6 months.	

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{F 323}	Continued From page 15 indicated R41's diagnoses included status post right hip fracture on 7/5/14, dementia with behaviors, atrial flutter, hypertension and Parkinson's disease. R41's significant change Minimum Data Set (MDS) dated 7/17/14, indicated R41 had severe cognitive impairment, required total assistance with bed mobility and transfers, was not able to ambulate and required extensive assistance with all activities of daily living (ADLs). The MDS indicated R41 did not have a history of falls (incorrectly coded) and was physically abusive to staff less than daily. A Care Area Assessment (CAA) was not completed for R41's falls or behaviors. R41's Bigfork Valley Hospital Discharge Summary dated 7/10/14, indicated R41 was hospitalized on 7/5/14, after a fall and subsequent surgical repair of a hip fracture. The summary indicated R41 was readmitted to the facility on 7/10/14, following an open reduction and internal fixation (commonly known as pinning) of the right femur. R41's hospital return care plan updated 7/10/14, indicated the fall interventions implemented upon return from the hospital included ensuring R41's call light was within reach and to provide encouragement to use when needing assistance, ensure R41 wore appropriate footwear when ambulating or mobilizing in wheelchair, physical therapy evaluation and treatment as ordered and as needed and if R41 was restless it may have	{F 323}		

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{F 323}	Continued From page 16 been an indication of pain or need to use the bathroom. R41's Fall Event reports along with R41's nurse progress notes from 7/31/14, forward were reviewed and the following was noted after readmission to the facility: - On 8/14/14, at 6:43 p.m. R41's event report indicated R41 was supervised in the common lounge area seated at a table when he attempted to get up from the table and walk. The report indicated R41 became off balance and fell hitting the back of the head which resulted in a 2.0 centimeter (cm) X 2.0 cm hematoma to the back of the head. Although there was an injury to R41's head, the report indicated R41 did not require hospitalization. The section of the report that identified Predisposing Environmental Factors indicated "Other." Predisposing Physiological Factors section of the form indicated R41 had a gait imbalance. The fall investigation and analysis section was not completed until 8/19/14, (five days following the incident). R41's progress note read: follow up for fall on 8/14/14, whereas R41 was seated at a dining room table and at about 4:00 p.m. R41 attempted to stand and ambulated a few steps by himself, lost his balance, tripped and fell striking his head and falling on his bottom. Licensed practical nurse (LPN) noted a 2.0 x 2.0 cm hematoma, but R41 was as alert as his usual. A skin tear on his left elbow from a previous fall had also reopened. The report indicated R41 was lifted off of the floor via Hoyer lift and inspected for further injury. The report further indicated staff	{F 323}		

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{F 323}	Continued From page 17 attempted to keep a visual on R41 at all times and he also had a noise monitor in his room when he was in bed and interventions at this time not completely effective. The Action section of the report indicated the facility would look into purchasing hip pads to cushion falls if they occurred and potentially a self-release seat belt that alarmed when removed. - R41's Event Report dated 8/20/14, indicated R41 fell 6:55 p.m. when R41 tipped over his wheelchair sideways when being supervised in the dining room and suffered a large laceration to the back of the head which required seven staples to close the wound. The report indicated predisposing environmental factors was not completed. The section for Predisposing Physiological Factors indicated R41 had a gait imbalance. The Fall Investigation and Analysis section was not completed until 8/28/14, (eight days following the fall). The note indicated, R41 was seated in the wheelchair at a dining room table, reading a magazine. The note also indicated staff were in the room assisting other residents and noted R41 appeared content. The note further indicated several minutes later, a crash was heard and R41's wheelchair was tipped over and R41's head had struck the wall causing a laceration which required a hospital emergency room visit for the placement of seven staples to the top of his head. The note indicated it was somewhat unclear how the fall occurred, but is seemed likely that R41 had tried to get up and got off kilter. The Action portion of the report indicated numerous interventions had been attempted to help decrease R41's falls, with somewhat limited success, however, previous	{F 323}		

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{F 323}	Continued From page 18 interventions had not focused on why R41 desired to get up unassisted. Additionally, the report indicated hip protectors had been ordered to help cushion a fall should another occur and further interventions would be: taking R41 to the bathroom before and after meals, making sure his brakes were never locked unless a transfer in or out was involved, increase ambulation and R41's restorative program was modified to include to walk R41 every 1-2 hours while awake. R41's Rehabilitation Screen form dated 8/26/14, indicated R41 was referred to occupational therapy (OT) after tipping the wheelchair over on 8/20/14, and was assessed for wheelchair safety on 8/26/14. The assessment included the following, "Resident in reclining back wheelchair with anti-tip bars. Resident tipped w/c sideways per fall report. OT unaware of any device to prevent this. Resident does have neutral body position in w/c. Leg rests removed to prevent tripping. Anti-roll back bars requested to be installed on w/c. Width of w/c is within normal limits and arm rest height is appropriate. Resident does not spend much time in w/c as he often sits in recliner." R41's Fall Event form dated 8/30/14, indicated R41 was found with his knees on the floor leaning over the bed in his bedroom. The report indicated R41 suffered a minor injury identified as an open area on left knee which measured 2.5 cm x 2.0 cm. The report indicated the injury looked like a rug burn. The incident report identified, "Staff was checking on the resident every 15 minutes prior to the fall." The section of	{F 323}		

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{F 323}	Continued From page 19 the incident report that identified Predisposing Environmental and Physiological Factors included: clutter furniture, poor lighting, confused, incontinent, gait imbalance and impaired memory. The fall investigation and analysis was not completed until 9/3/14, (four days following the incident) by RN-A. The Action part of this fall was, "Wound will be monitored for signs of infection, but for now will be left open to air. Another noise monitor was brought and put in his room, the other end will be by the nurse. CNA's [certified nursing assistants, NAs] to make sure [R41] is toileted very 2 hours as care planned." R41's care plan dated as last updated on 8/20/14, included the following falls interventions, "Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance. Ensure that I am wearing appropriate foot wear when ambulating or mobilizing in w/c. PT [physical therapy] eval and treat as ordered or PRN. If I am restless this may be a sign of pain or need to use the bathroom. 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/caregiver/ IDT [interdisciplinary team] as to causes. Encourage me to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Anticipate and meet my needs. I need to be evaluated for, and supplied appropriate adaptive equipment or devices as needed. Re-evaluate as needed for continued appropriateness and to ensure least restrictive device or restraint."	{F 323}		

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{F 323}	Continued From page 20 R41 was observed on 9/2/14, at 6:00 p.m. ambulating with two staff assist, gait belt and a front wheeled walker from the bathroom to the common lounge recliner. R41 had appropriate tennis shoes on, wore glasses and followed direction easily. R41 was ambulated to a recliner where he sat reclined and slept until the end of the observation at 7:23 p.m. R41 had constant supervision while in the common lounge during the observation. -At 6:37 p.m. a personal alarm nor a bed alarm were observed in R41's room. R41's room was observed clutter free with clear paths to the bathroom and out of the room. The bed was in the low position. R41 was again observed on 9/3/14, at 9:24 a.m. while he slept in bed. The bed was very low to the ground, the room was not cluttered, there were clear pathways to the bathroom, R41's call light was within reach and there was a baby monitor stationed on the floor of his room in the on position. During interview with nursing assistant (NA)-Q on 9/3/14, at 9:24 a.m. (at the time of the observation) NA-Q explained residents were allowed to sleep as long as they wished and were allowed to wake naturally. When NA-Q was asked regarding the use of a baby monitor, NA-Q stated the receiver to the monitor was kept on the nurses' cart in the common lounge area. NA-Q stated it was the responsibility of the LPN to listen to the monitor to hear what R41 did while in his private bedroom.	{F 323}		

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{F 323}	Continued From page 21 LPN-C was then interviewed on 9/3/14, at 9:25 p.m. and confirmed the monitor was turned on at the time NA-Q was interviewed and verified the receiver was in the common lounge area. RN-A was interviewed on 9/3/14, at 9:26 a.m. and stated R41 was supposed to have the monitor on while in bed and the receiver was supposed to be monitored at all times by the licensed nursing staff assigned to the dementia unit. RN-A stated the monitor had "gone missing" at some unknown point and a new monitor was placed in R41's room on the morning of 9/3/14, (during the course of re-visit to the facility). RN-A confirmed he had not reviewed the impulsive, restless behavior R41 displayed prior to falls to determine if it correlated to possible pain, bowel/bladder patterns, hunger, boredom, and/or medication usage as part of a comprehensive assessment of R41's falls. - At 10:34 a.m. RN-A verified facility staff were taking R41 to the bathroom before and after meals, R41's walking program was modified and confirmed the aforementioned fall interventions were not added to R41's care plan. RN-A stated the hip protectors and Velcro seat belt alarm were not implemented and the facility could not provide evidence they were ordered. RN-A confirmed toileting R41 every two hours was not a new intervention and the addition of the "noise monitor" was not an added intervention. RN-A stated the noise monitor was implemented after R41 came back from the hospital after breaking his hip on 7/10/14. RN-A further stated increased supervision was not implemented for R41	{F 323}		

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{F 323}	Continued From page 22 following any of the falls. RN-A stated a comprehensive assessment and root cause analysis to identify the antecedents to R41's falls was not completed following the falls on 8/14/14, 8/20/14 and 8/30/14. RN-A confirmed no further interventions had been developed nor implemented. RN-A verified the facility lacked a system to ensure all residents (including R41) had the support devices they needed to potentially prevent falls. On 9/3/14, at 11:29 a.m. NA-J stated he had not had any specific direction to check on R41 at any specific interval. NA-J stated he usually checked on R41 "every ten minutes or so," but it was not a specific time frame. NA-J stated he checked on R41 "as often as I can." On 9/3/14, at 11:32 a.m. NA-M (Balsam unit Cook/NA) stated she watched R41 while he was in the main area. NA-M stated she was not aware of the NAs doing any special training or monitoring of R41. NA-M stated R41 was "very quick" and stated she had not received any special training related to R41's falls. On 9/3/14, at 11:36 a.m. LPN-C stated she had told the staff to monitor R41 every 15 minutes. LPN-C stated she wrote the interventions following each fall on the fall investigation incident report and on a temporary fall care plan. LPN-C stated staff were instructed to write the types of interventions to try. LPN-C stated she was not allowed to update the care plans and stated the RNs updated the care plans. LPN-C	{F 323}		

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	245529	A. BUILDING _____ B. WING _____	R 09/08/2014

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{F 323}	Continued From page 23 stated the facility did falls safety training, and they had been "working really hard" to keep R41 from falling. On 9/3/14, at 11:45 a.m. NA-K stated he tried to keep R41 in a line of sight at all times, but there were no special interventions to prevent falls. NA-K stated R41 was very quick. On 9/4/14, at 9:48 a.m. NA-L stated the staff tried to keep R41 in the main area and were to check on him at least "once an hour" when he was in his room and make sure the monitor was on "so we know when he gets up." NA-L stated, "We try to make sure he is never out of site when he is out of his room. We try to keep him safe." On 9/4/14, at 9:56 a.m. NA-A stated the facility had attempted several different interventions with R41. NA-A explained R41 had a low bed and mats on the floor in the past, but they were not successful for him. NA-A stated R41's bed was to be kept at a "regular height," so when R41 stood up, he could easily stand on his own. NA-A confirmed R41 was not able to safely ambulate independently. Review of the facility policy for Monitoring Falls and Their Causes, the following was noted: "2. Identifying Causes of a Fall or Fall Risk: a. Within 24 hours of a fall, the nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence including medical history, known functional impairments, etc. b. Staff will evaluate chains of events or circumstances preceding a	{F 323}		

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{F 323}	Continued From page 24 recent fall, including: i. Time of day of the fall; ii. Time of the last meal; iii. What elder was doing; iv. Whether elder was standing, walking, reaching, or transferring from one position to another; v. Whether the elder was among other persons or alone; vi. Whether the elder was trying to get to the toilet; vii. Environmental issues involved; viii. Whether there is a pattern of falls for this elder. c. The staff will continue to collect and evaluate information until they either identify the cause of falling or determine that the cause cannot be found. d. When possible, the Attending Physician or nursing staff will document basis for identifying specific factors as the cause. e. All the gathered information will be turned into the fall committee for review. f. If the cause of a fall is unclear, if the fall may have a significant medical cause such as transient ischemic attack or an adverse drug reaction, or if the elder continues to fall despite attempted interventions, the nursing staff will discuss the situation with the Attending Physician or Medical Director. g. If causes of a fall cannot be readily identified and if the fall is accompanied by other signs and symptoms (e.g., confusion or lethargy), the staff and physician will consider a possible underlying acute medical condition...Documentation- When a resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found (e.g., "resident found lying on the floor between bed and chair"). 2. Data collected, including vital signs and any obvious injuries. 3. Interventions, first aid, or treatment administered. 4. Notification of the physician or family, as indicated. 5. Identify who was involved. 6. Completion of a falls risk assessment within 24 hours of fall. 7. Appropriate interventions taken to prevent future falls..."	{F 323}		

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{F 323}	Continued From page 25 On 9/3/14, at 2:19 p.m. the director of nursing (DON) confirmed the fall assessments completed following R41's falls on 8/14/13, 8/20/14, and 8/30/14, were not completed timely and were not comprehensive. The DON confirmed interventions were not appropriately developed, care planned and implemented. The DON stated the fall on 8/20/14, was investigated as a vulnerable adult (VA) incident and reported to the State agency via the Minnesota Department of Health (MDH) website. The Investigative Report submitted to MDH on 8/26/14, indicated the following, "Resident has resided [at Big Fork Valley Community] from 9/26/13 to current. Resident resides in the Balsam (memory care unit). POC [plan of care] assist of three to ambulate 2 to walk and 1 with w/c when resident restless and trying to get up." R41 was identified to be brought to a table in view of staff and offered a magazine, to provide a 1:1 [one to one] during restless times, redirection as needed, remove obstacles from path, ensure good lighting, and to provide appropriate foot wear. The report indicated staff were aware of POC through the fall committee and the report. The report further indicated, "Current interventions include ordering a new cushion, using EZ stand [a mechanical lifting device] for ambulation (in-service provided for staff on usage). Staffing changes to enable better coverage in memory care unit. Information reported by LPN and staff all valid witnesses. [R41] Sustained abrasion to posterior head. Injury has not affected resident's abilities. No perpetrator involved in incident. Current action	{F 323}		

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{F 323}	Continued From page 26 noted above." Although the form identified further interventions, such as the use of magazines while at the table, R41's care plan did not address these identified interventions. On 9/3/14, at 3:03 p.m. the DON confirmed the fall interventions identified in the VA report and the new cushion had not been ordered or implemented and the EZ stand for ambulation was not being used. The DON verified R41's care plan had not been updated to include the use of a magazine for diversional activities when R41 was restless and increased supervision of R41 had not been implemented. The DON stated staffing in the dementia unit had been increased on 8/21/14. The DON stated the change was the licensed nurse would no longer leave the unit for portions of the shift, but the facility had not made a plan to increase supervision of R41. The DON also confirmed a comprehensive assessment and root cause analysis, that identified antecedent(s) to the falls had not been completed following the fall on 8/20/14. The immediate jeopardy began on 7/10/14, and identified on 9/4/14, was removed on 9/8/14, at 10:45 a.m. when the facility completed a comprehensive assessment of R41's fall risk which considered the causal factors of previous falls and effectively implemented interventions that were pertinent to those causal factors. Implemented interventions included the following: pain assessment, bowel and bladder assessment, medication review by the nurse practitioner, bed alarm, lowering the bed height, falls mats added to the floor next to the bed, increased ambulation, chair alarms and an audible monitor when R41 was in his room alone.	{F 323}		

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{F 323}	Continued From page 27 R41's care plan was updated to reflect the new interventions and staff members on the memory care unit verified through interview they had received education on R41's compressive, interdisciplinary care plan/ fall interventions. Non-compliance remained at the lower scope and severity level of a G, which indicated actual harm that was not immediate jeopardy.	{F 323}		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356	F356 The daily nursing staffing form was updated to reflect the changes required. The nursing staff responsible for filling out the daily nursing staffing form was educated on the changes required and educated on the proper way to fill in the form. The daily nursing staffing form will be generated from our scheduling software. This will continue to be printed out by the Night Shift Nurse daily and will be updated daily by the facility scheduler and by the RN supervisor to reflect any changes in the schedule. DATE OF COMPLETION: October 13,2014 DATE CERTAIN: October 13,2014 RECURRENCES WILL BE PREVENTED BY: Audits will be completed by the Director of Nursing weekly to ensure compliance and reported to our Quality Assurance Committee monthly x 6 months and then quarterly.	

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F 356	Continued From page 28 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the nurse posting was accurate regarding the actual amount of registered nurse (RN) staff on duty for 2 of 2 days reviewed. This had the potential to affect all 37 residents residing in the facility. Findings include: On 9/5/14, at approximately 2:00 p.m. during the extended survey, the Daily Nurse Staffing Form posted next to the Balsam unit door dated 9/5/14, was not accurate. The posting indicated the facility had two RNs working the day shift. The form indicated two different day shift times as 6:00 a.m. to 2:30 p.m. and 6:30 a.m. to 3:00 p.m. The posting was not accurate as the RN did not arrive at the facility until 8:00 a.m. and worked until 4:30 p.m. Review of the 9/4/14, Daily Nursing Staffing Form indicated on 9/4/14, the day shift had 2 RNs. The form indicated two different day shift times as 6:00 a.m. to 2:30 p.m. and 6:30 a.m. to 3:00 p.m. The posting was not accurate as the RN did not arrive at the facility until 8:00 a.m. and worked until 4:30 p.m. On 9/5/14, at 2:54 p.m. the director of nursing confirmed the RN worked from 8:00 a.m. to 4:30	F 356		

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F 356	Continued From page 29 p.m. and the Daily Nurse Staffing Form did not reflect the actual hours worked. She stated the 6:00 a.m. to 2:30 p.m. and 6:30 a.m. to 3:00 p.m. shifts were completed by the nursing assistants and licensed nurses. She stated if a staff member called in, the Daily Nurse Staffing Form was not updated to reflect the changes in the nurse staffing pattern. The DON stated the facility did not have a policy related to the actual staffing pattern posting.	F 356		
F 388 SS=D	483.40(c)(3)-(4) PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a physician evaluated newly admitted residents thirty days after admission as required for 3 of 5 newly admitted residents (R42, R48, R51) who were reviewed for timely physician required visits. Findings include:	F 388	F388 R51 was seen by a MD on 9/23/14. R42 was seen by a MD on 9/17/14. R48 was seen by an MD on 8/6/14 and 9/29/14. Regulations were reviewed with the Medical Director and with Clinical Coordinator from Scenic Rivers Health Care Center. Licensed staff and Social Services informed of regulations regarding admission to Skilled Nursing Facility.	

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F 388	Continued From page 30 R42 was admitted to the facility on 4/1/14, with diagnoses including Alzheimer's dementia, history of myocardial infarction and essential hypertension. R42's clinical record indicated R42 was seen by the nurse practitioner (NP) on 4/30/14, for a 30 day visit. On 6/23/14, R42 was reviewed by the primary physician for a 60 day visit and on 6/25/14, he was seen by the NP for a 90 day visit. R48 was admitted to the facility on 4/22/14, with diagnoses including dementia, hyperlipidemia and osteoporosis. R48's clinical record indicated R48 was seen by the NP on 5/21/14, for a 30 day evaluation and was seen by the primary physician on 6/17/14, for a 60 day review, and on 7/29/14, by the NP for a 90 day review. R51 was admitted to the facility on 7/28/14, with diagnoses including hypertension and Parkinson's disease. R51's clinical record indicated R51 was seen by the NP on 8/25/14. At the time of the revisit survey R51 had not seen his primary physician. On 9/5/14, at 11:42 a.m. the interim administrator stated she was not aware the initial 30 day visit was to be completed by a physician and not a nurse practitioner. The interim administrator stated she would look into the concern. On 9/5/14, at 11:53 a.m. the director of nurses stated she was not aware the NP was not able to compete the first 30 day evaluation / visit. She stated the facility did not have a policy related to initial physician visits. She confirmed the identified residents did not see their primary physicians until greater than 60 days after	F 388	DATE OF COMPLETION: October 13,2014 DATE CERTAIN: October 13,2014 RECURRENCES WILL BE PREVENTED BY: Audits will be completed by Long Term Care Educator after each admission and presented to the Quality Assurance Committee as admissions occur x 3 months. Random audits of admissions will be completed after scheduled audits to ensure continued compliance x 6 months.	

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F 388	Continued From page 31 admission.	F 388		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance evaluations were performed for 5 of 5 nursing assistants (NA) reviewed (NA-D, NA-I, NA-N, NA-O, NA-P). Findings include: NA-D was hired on 4/6/10. Her personnel file indicated the date of her last performance evaluation was 5/1/12. NA-I was hired on 3/13/00. His personnel file	F 497	F497 Performance evaluations will be completed on all active NA's in Long Term Care by October 13, 2014.Continueing education for all employees hired for over 1 year will be completed by October 13, 2014. DATE OF COMPLETION: October 13,2014 DATE CERTAIN: October 13,2014 RECURRENCES WILL BE PREVENTED BY: A Education program will be implemented in 2015 to ensure all Long Term Care staff has met the requirement for continuing education.	

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F 497	Continued From page 32 indicated the date of his last performance evaluation was 4/27/12. NA-N was hired on 6/18/13. Her personnel file indicated she had not had a performance evaluation since her date of hire. NA-O was hired on 2/17/09. Her personnel file indicated the date of her last performance evaluation was 4/5/12. NA-P was hired on 3/6/13. His personnel file indicated he had not had a performance evaluation since his date of hire. On 9/5/14, at 11:25 a.m. human resources assistant (HRA) confirmed NA-D, NA-I, NA-N, NA-O, and NA-P all lacked the completion of current performance evaluations. The PERFORMANCE EVALUATION policy dated 07/01, indicated employees would typically have a performance evaluation at the end of the orientation period and evaluations were typically held annually thereafter on the employee's anniversary date.	F 497		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		

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F 520	Continued From page 33 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assurance and assessment (QAA) committee identified quality concerns and developed / implemented policies and systems to ensure quality of life related to falls for 1 of 3 residents (R41) who had been identified for falls during the recertification survey which resulted in an immediate jeopardy during the revisit survey. Findings include: During the initial survey completed on 7/10/14, R41 was identified to have sustained harm	F 520	F520 The Bigfork Valley Communities Quality Assurance Committee was updated regarding falls on 10/2/2014. DATE OF COMPLETION: October 13,2014 DATE CERTAIN: October 13,2014 RECURRENCES WILL BE PREVENTED BY: Bigfork Valley Communities Quality Assurance Committee has adopted a different Quality Improvement Worksheet that will assist the committee in identify quality issues and assist the committee in achieving quality compliance. The committee has also adapted a new format regarding quality improvement reporting that will assist the committee in monitoring the effectiveness of the interventions.	

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F 520	Continued From page 34 related to falls. Refer to F323. During the revisit survey conducted on 9/2/14, 9/3/14, 9/4/14, 9/5/14, 9/6/14, and 9/8/14, R41 was identified in immediate jeopardy (IJ) related to continued falls. The Immediate Jeopardy at F323 was identified on 9/4/14. On 9/7/14, at 12:00 p.m. the director of nurses (DON) confirmed the QAA met monthly and stated during the QAA meeting completed in August and September, 2014, the committee discussed the falls which had occurred, but they had not developed an action plan to minimize falls within the facility. She stated the committee did not feel they had enough information to make changes at this time. She confirmed the facility had reviewed F323 from the recertification survey conducted in 7/2014, but an action plan had not been developed to decrease/minimize falls.	F 520		

Bigfork Valley
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October 20, 2014

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

Dear Ms. Burkman,

Please find enclosed our addendum to the plan of correction for the survey conducted at Bigfork Valley Communities, ending September 8, 2014. The addendum and plan is considered our allegation of substantial compliance. Please consider October 15, 2014 the date certain for all deficiencies.

Sincerely,

Mr. James G. Blum, LNHA
Bigfork Valley Communities
218-743-4330

Addendum
Approved
10/20/14

Addendum to the Plan of Correction

October 15, 2014

F164

The audio monitor has been removed from the list of interventions in the prevention of falls. The audio monitor will not be used anywhere in the facility. Staff will continue to utilize bed and chair audible alarms as interventions for falls.

F272

Documentation of the CAA's will include but not be limited to:

A) Relevant documentation for each triggered CAA describing causes and contributing factors
B) The nature of the issue or condition-what is the problem, why is it a problem
C) Complications affecting or caused by the care area for the elder
D) Risk factors related to the presence of the condition that affects the staff's decision to proceed with care planning
E) Factors that must be considered in developing individualized care plan interventions including the decision to care plan or not to care plan various findings for the individual elder
F) The need for additional evaluations by the attending physician and other health professionals as needed
G) The resources or assessment tools used for decision making and conclusions that arose from performing the CAA

F278

The MDS will be audited by the Director of Nursing x three months and reported to the Quality Council. After the three month period, random audits will be completed on all MDS's to ensure coding accuracy x 6 months and reported to Quality Council.

On the original plan of correction, the plan of correction for F272 and for F278 was incorrectly documented. The plan for F272 was for F278 and the plan for F278 was for F272.

F323

All staff has been educated on the falls policy. Staff has been educated on immediate interventions and implementation of interventions, the temporary care plans, the falls committee and its purpose. The Bigfork Valley falls committee has implemented a new format with our weekly meetings to concentrating on falls, interventions and effectiveness of the interventions. A checklist has been implemented by the Director of Nursing to include:

1) Check elder for injuries
2) Review of the incident report

h. An incident report must be completed for resident falls. The incident report form should be completed by the charge nurse on duty at the time and be completed in Point Click Care.
i. The nursing staff will initiate a temporary care plan for all falls. The temporary care plan will be used to implement immediate interventions to assist in prevention of falls. Nursing staff will initiate a Neurological Assessment for any un-witnessed falls

2. Interventions and Identifying Causes of a Fall or Fall Risk:

a. Immediately after assessing the elder for injuries, the nursing staff will begin to try to identify possible or likely causes of the incident.
b. Staff will evaluate chains of events or circumstances preceding a recent fall, including:
    i. Time of day of the fall;
    ii. Time of the last meal
    iii. What the elder was doing;
    iv. Whether the elder was standing, walking, reaching, or transferring from on position to another;
    v. Whether the elder was among other persons or alone;
    vi. Whether the elder was trying to get to the toilet;
    vii. Environmental issues involved
    viii. Whether there is a pattern of falls for this elder
c. Based on the fall risk assessment that was just completed, immediately implement appropriate interventions to prevent further falls.
d. The staff will continue to collect and evaluate information until they either identify the cause of fall or determine that the cause cannot be found.

3. Ongoing assessment and follow up

a. All the gathered information will be reviewed by the Interdisciplinary team to be reviewed each day of stand up rounds. Information will also be turned into the fall committee for review
b. If the cause of a fall is unclear, if the fall may have a significant medical cause such as transient ischemic attack or an adverse drug reaction (ADR), or if the elder continues to fall despite attempted interventions, the nursing staff will discuss the situation with the Attending Physician or Medical Director.
c. If causes of a fall cannot be readily identified and if the fall is accompanied by other signs and symptoms (e.g., confusion or lethargy), the staff and physician will consider a possible underlying acute medical cause.

4. Documentation

When a resident falls, the following information should be recorded in the resident's medical record:

1. The condition in which the resident was found (e.g., "resident found lying on the floor between bed and chair").

2. Data collected, including vital signs and any obvious injuries.
3. Interventions, first aid, or treatment administered.
4. Notification of the physician and family, as indicated.
5. Identify who was involved
6. Completion of a falls risk assessment within 24 hours of fall
7. Appropriate interventions taken to prevent future falls.
8. The signature and title of the person recording the data.
9. If the incident is a suspected VA, notify the Common entry point immediately along with the DON and the Administrator

5. **Reporting**

Notify the following individuals when an elder falls:

I. The elder's family;
II. The Attending Physician (timing of notification may vary, depending on whether injury was involved);
III. The Director of Nursing Services; and
IV. The Charge Nurse for the shift
V. The Administrator

Report other information in accordance with facility policy and professional standards of practice.

Date Certain (updated): October 15, 2014

F356

Daily Staffing forms will be audited daily x 1 month and reported to Quality Council. Random weekly audits will be completed x 6 months and reported to Quality Council.

F497

A spreadsheet has been created with the hire dates of all LTC staff. Spreadsheet information will be updated in 2015 to include

1) Name of employee
2) Hire date of the employee
3) Mandatory In-service Training date
4) Infection Control training date
5) Dementia Training date
6) Restorative Nursing Training date
7) Performance Evaluation Completion date

3) If family/MD was notified
4) Review for Notifications for State Agencies
5) Interview Staff and document
6) Review for documentation in elder record
7) Review environment for hazards and risks
8) Review for analysis of causal factors
9) Discuss, review and implement current and future interventions
10) Train staff, elders, family on interventions
11) Monitor that interventions are implemented
12) Evaluate effectiveness
13) Revise and modify care plan as needed
14) Nurse's aide care sheet revised with interventions
15) Documentation that states interventions were implemented
16) Documentation to evaluate effectiveness
17) Documentation in care plan
18) Documentation that states Nursing Assistance Care sheets were updated
19) Documentation that states Nursing Assistance have been educated

All staff will follow the following procedure on Falls:

1. **After a Fall:**

a. If a resident has just fallen or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities. Note any abrasions, bruises, skin tears, lacerations, fractures and incidents of unknown origin.
b. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid and transport to the emergency room if necessary.
c. Once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details.
d. Evaluate the situation and attempt to determine the root cause of the fall. Implement appropriate interventions to prevent further falls. See #2 below for detailed instructions.
e. Nursing staff will notify the elder's Attending Physician and family in an appropriate time frame. When a fall results in a significant injury, is unwitnessed with significant injury or results in a significant change in condition, nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, nursing staff will notify the practitioner routinely (e.g., by fax or phone the next office day).
f. Nursing staff will observe for delayed complications of a fall for forty-eight (48) hours after an observed fall, and will document findings in the medical record.
g. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/ consciousness and overall function. It will note the presence or absence of significant findings.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DIUO

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 **07/10/2014** (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

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): **YES** (L15)

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

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NEII 08/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/02/2014 (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
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 29, 2014

Mr. Joey Jacobson, Administrator
Bigfork Valley Communities
258 Pine Tree Drive, P.O. Box 258
Bigfork, Minnesota 56628

RE: Project Number S5529025

Dear Mr. Jacobson:

On July 10, 2014, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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>Electronic 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;

<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 August 19, 2014, 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 August 19, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

Failure to submit an acceptable ePoC 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 October 10, 2014 (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 January 10, 2015 (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 an ePoC 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

PRINTED: 07/29/2014
FORM APPROVED
OMB NO. 0938-0391

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

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 _____ RECEIVED AUG 04 2014	07/10/2014

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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a significant change in status assessment for 1 of 1 resident (R40) reviewed with an identified decline in bed mobility, transferring and eating and an	F 274	F274 CORRECTIVE ACTION: Physical therapy referral sent for R40 DATE OF COMPLETION: August 4, 2014 DATE CERTAIN: August 4, 2014 RECURRENCES WILL BE PREVENTED BY: Section G of the Quarterly MDS will be audited by Director of Nursing x 12 months for changes in ADL status. Report will be reviewed by the LTC Quality Assurance Committee x 12 months	08/04/14

Approved 8/8/14 c Addendum

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jenna Jacobson | TITLE: CFC Adm | (X6) DATE: 8/4/2014

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.

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

PRINTED: 07/29/2014
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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 _____	07/10/2014

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 274	Continued From page 1 assessment was not completed. Findings include: R40's quarterly Minimum Data Set (MDS) dated 1/29/14, indicated R40 required extensive assist with dressing, toileting, personal hygiene, limited staff assistance with bed mobility and transferring; R40 required supervision when eating and walking. R40's quarterly MDS dated 5/14/14, indicated R40's diagnoses included heart failure (decrease in heart function to pump blood), a stroke, dementia and anxiety. The MDS also indicated R40 had severe cognitive impairment, required extensive assist with bed mobility, transferring, dressing, eating, toileting, personal hygiene and limited staff assistance with walking with the use of a walker. R40's care plan dated 5/2/14, indicated R40 had limited physical mobility related to cognitive changes and required staff supervision, encouragement and staff assistance with mobility. The care plan also indicated R40 utilized a walker for ambulation and occasionally needed reminders to use it; the care plan indicated R40 was at high risk for falls due to an unsteady gait. On 7/8/14, at 2:34 p.m. R40 was observed seated in the dining room. A staff member was observed to assist R40 into a standing position. Once standing, R40 was observed to be able to maneuver herself around the dining room area with the use of a walker. On 7/9/14, at 11:23 a.m. registered nurse (RN)-B confirmed R40's quarterly MDS dated 5/14/14,	F 274		

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

PRINTED: 07/29/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/10/2014

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 274	Continued From page 2 identified a decline with R40's gait, transferring, bed mobility, toileting and balance. RN-B stated once the decline was identified, R40 would have benefited from a restorative nursing program to help her with her gait instability. In addition, RN-B stated R40 did have a standing order for a physical therapy (PT) and/or occupational therapy (OT) evaluation as needed, however verified this order was not initiated. On 7/9/14, at 12:57 p.m. RN-C verified nursing had a standing order for PT/OT screenings which could be initiated as needed. On 7/10/14, at 8:16 a.m. R40 was observed to be seated at the dining room table. A nursing assistant (NA)-A was observed to assist R40 up from the dining room chair using a gait belt. NA-A stated to R40, "You seem to be having trouble standing today." The facility's Minimum Data Set (MDS) policy and procedure dated 8/15/11, indicated the MDS coordinator tracked residents to monitor for a decline or improvement in status that would not not normally resolve itself without further intervention by staff or by implementing clinical interventions that would have an impact on more than one area of the residents health status. The policy also indicated within 72 hours of the resident tracking, the interdisciplinary team would meet and determine if a signification change was present and if so, a significant change MDS would be completed within 14 days.	F 274		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245529	A. BUILDING _____ B. WING _____	07/10/2014

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 279	Continued From page 3 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan for the use of a probiotic medication, being given for history of intestinal infections due to Clostridium difficile, for 1 of 5 residents (R29) reviewed for unnecessary medications. Findings include: R29's Consolodated Orders (Chart) Report (COR, physician orders) dated 6/30/14, identified diagnosis of Alzheimer's disease and indicated an order for Florastor (saccharomyces boulardii, a probiotic medication) 250 mg (milligrams) capsule once daily for history of intestinal infections due to Clostridium difficile.	F 279	F279 CORRECTIVE ACTION: The care plan for R29 has been updated to include the history and usage of the probiotic. DATE OF COMPLETION: July 31, 2014 DATE CERTAIN: July 31, 2014 RECURRENCES WILL BE PREVENTED BY: Medications will be reviewed by the Director of Nursing monthly for usage of unnecessary medications and care plans will be audited weekly x 4 and then monthly x 11 for unnecessary medications.	07/31/14

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F 279	Continued From page 4 R29's Medication Administration Sheets dated 7/1/14, through 7/31/14, revealed R29 had received Florastor 250 mg capsule once daily. R29's care plan dated 6/17/14, identified functional bowel incontinence related to physical and cognitive impairment and directed staff to check R29 every two hours and as required for incontinence. However, R29's care plan lacked documentation regarding the use of the Florastor medication and history of intestinal infections due to Clostridium difficile. On 7/9/14, at 12:01 p.m. registered nurse (RN)-C verified R29's care plan had no documentation regarding use of the probiotic medication (Florastor) and history of intestinal infections due to Clostridium difficile. On 7/10/14, at 2:14 p.m. the director of nursing confirmed R29's care plan dated 6/17/14, lacked identification of the use of the probiotic medication (Florastor) and history of intestinal infections due to Clostridium difficile and stated it should have been identified on the care plan. The facility policy Comprehensive Plan of Care effective date 8/15/11, read, "Purpose: To ensure that each elder of Bigfork Valley Communities has a plan of care that includes measurable objectives and timetables to meet their medical, nursing, mental and psychosocial needs identified in their comprehensive assessments. Procedure 6) The comprehensive care plan will include elder choice, rights, likes, dislikes, goals, medical and non medical interventions."	F 279		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=D	Continued From page 5 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 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 interview and document review, the facility failed to revise the care plan to include interventions for side effect monitoring for a potential drug to drug interaction as identified by the pharmacist for 1 of 5 residents (R20) reviewed for unnecessary medications. In addition, the facility failed to revise the care plan to include fall prevention interventions for 1 of 5 residents (R41) reviewed for accidents. Findings include: R20's physician orders dated 7/11/14, indicated	F 280	F280 CORRECTIVE ACTION: Side effect monitoring has been initiated on R20. DATE OF COMPLETION: July 18, 2014 DATE CERTAIN: July 31, 2014 RECURRENCES WILL BE PREVENTED BY: Administrator will audit care plans weekly x 4 and monthly x 6 for side effect monitoring and for fall interventions. Audits will be reported to Long Term Care QI monthly x 6	07/18/14

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F 280	Continued From page 6 R20 received citalopram hydrobromide (antidepressant) 40 milligrams (mg) at 1600 (4:00 p.m.) for depression which was started on 10/1/12. The orders also indicated R20 received Baclofen (for treatment of spasticity) 10 mg three times a day for muscle spasms which was started on 4/22/14. R20's care plan dated 5/6/14, directed staff to administer the antidepressant medication to R20 as ordered by the physician and to also monitor, document and report ongoing signs and symptoms of depression unaltered by the medication to the physician, as needed. The care plan also directed staff to monitor for the effectiveness of and side effects of the medication. The care plan did not address Baclofen use. R20's pharmacist consult report dated 11/21/13, indicated an identified potential for drug to drug interaction between the combined use of citalopram and Baclofen which could cause serotonin syndrome. The report directed staff to review the combined medication use with R20's provider and to monitor for signs/symptoms of this interaction which included increased sweating, agitation, tremor, increased blood pressure, muscle spasms. The report also directed staff to review this potential adverse interaction with R20's provider during next visit but no later than two months. The director of nursing (DON) acknowledged this review and recommendation on 1/30/14. However, R20's physician/provider did not sign the recommendation. R20's Side Effects Monthly Flow Sheets from April 2014, through July 2014, revealed no	F 280		

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F 280	Continued From page 7 documentation for the monitoring of the identified risk of serotonin syndrome and symptoms to monitor for. On 7/10/14, at 9:43 a.m. registered nurse (RN)-C confirmed R20's care plan lacked interventions for spasms and the use of Baclofen as well as the direction to monitor for signs and symptoms of serotonin syndrome. On 7/10/14, at 12:03 p.m. the DON confirmed R20 continued to receive both medications that placed him at risk for serotonin syndrome and stated the specific monitoring for the drug to drug interaction was not done. The DON confirmed R20's care plan should have been updated to include direction to monitor for signs and symptoms of serotonin syndrome. R41's care plan dated 7/7/14, identified R41 was at risk for falls and indicated R41 had a history of falls. The care plan directed staff to ensure R41's call light was within reach, encourage use, respond promptly to all requests, ensure R41 wore appropriate footwear when ambulating or mobilizing in wheelchair, if R41 was restless it could be a sign of pain or need to use the bathroom, assist to walk as far as R41 desired as it would keep R41 from getting up on his own and to request a physical therapy (PT) evaluation and treatment as needed. Review of R41's medical record revealed the following incident reports: - a fall on 9/29/13, with new interventions to include: a different wheelchair was to be used on	F 280		

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F 280	Continued From page 8 a trial basis to prevent forward leaning and bilateral floor mats next to bed. However, no changes were made to the care plan. -a fall on 9/30/13, new interventions included: Fall floor mats added to both sides of bed. A different wheelchair was to be used on a trail basis as it appeared to fit him better and he did not lean quite as far forward. No changes made to the care plan. -a fall on 10/5/13, new interventions included a bed alarm was placed and on 10/7/13, every 30 minute checks were initiated while R41 was in bed. However, no changes were made to the care plan. -a fall on 10/25/13, new intervention was to use a chair alarm whenever R41 sat in the wheelchair. However, no changes were made to the care plan. -a fall on 10/27/13, and on 11/1/13, new intervention included direction to provide R41 as much 1 on 1 attention as possible in the evenings. The intervention also indicated R41 could be in the Balsam unit during the day when he wanted or when staffing was stretched too thin. The interventions also indicated staff were to try to pick up a routine for R41. However, no changes were made to the care plan. -a fall on 12/1/13, new interventions included staff to encourage R41 to get him up to walk often with two staff whenever possible and to attempt to keep his walker as close to his body as possible when walking. However, no changes were made to the care plan.	F 280		

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F 280	Continued From page 9 -a fall on 12/14/13, new interventions included use of a standing walker and staff to continue to allow R41 to walk as often as possible and take him off the unit to walk on occasion if restless and indicated staff were attempting to utilize the new EZ-Way battery powered walking aid. However, no changes were made to the care plan. -a fall on 1/27/14, interventions indicated a restorative aide was going to walk with R41 once during the day shift and the nursing assistants (NAs) would attempt to walk him more often during each shift. However, no changes were made to the care plan. On 7/10/14, at 6:07 p.m. R41's falls were reviewed with the DON and RN-C. Both RN-C and the DON confirmed none of the above identified fall interventions were added onto R41's care plan. The DON stated R41's care plan should have been revised after each fall to include any new interventions implemented for the preventions of falls. The facility's Quarterly Review of Care Plans policy dated 8/15/11, indicated the interdisciplinary team was responsible for the periodic review and updating of the care plan when there had been a significant change in the elder's condition, when the desired outcome was not met, and at least quarterly.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an admission (initial) care plan to include fall interventions in order to prevent further falls for 1 of 5 residents (R45) reviewed for accidents. Findings include: R45's Physician Visit note dated 3/11/14, indicated R45 had progressive dementia with sundowning. The note also indicated, prior to admission, R45's spouse was required to sleep by R45's bed and also needed someone with him full time due to R45's difficulty with concentration, poor balance and falling down. R45's Progress Notes from 3/11/14, to 3/13/14, revealed R45 had two falls within the facility. R45's Admission Summary dated 3/17/14, indicated R45 was admitted to the facility 3/11/14, and his current diagnoses included dementia with behaviors disturbances, acute pain and anemia. On 7/10/14, at 12:43 p.m. registered nurse (RN)-C stated, R45 did not have an initial or temporary care plan developed nor implemented when he was admitted. On 7/10/14, at 7:35 p.m. the director of nursing (DON) verified R45 did not have an initial or temporary care plan initiated at admission. The DON verified she would have expected staff to	F 281	F281 CORRECTIVE ACTION: Temporary plan of care has been initiated on the admission checklist that will be used on all admissions DATE OF COMPLETION: July 31, 2014 DATE CERTAIN: July 31, 2014 RECURRENCES WILL BE PREVENTED BY: Director of Nursing will audit all new admission 7-14 days after admission for compliance x 12 months and will report to LTC QI when applicable.	07/31/14

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F 281	Continued From page 11 complete an initial care plan at admission in order to address R45's health care needs. The facility policy titled Preliminary Care Plan, dated 8/15/11, indicated, a preliminary plan of care would be developed for each elder within 24 hours after admission, and that a registered nurse along with the interdisciplinary team would review the attending physicians orders, medication needs and routine treatments in order to implement a nursing care plan to meet the elder's immediate needs."	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 implement fall interventions according to the plan of care for 1 of 5 residents (R27) who were reviewed for accidents. In addition, the facility failed to ensure the plan of care was followed for one of one resident (R17) who required interventions to minimize the risk for the development of pressure ulcers and worsening of contractures. Findings include: R27 was identified at risk for falls and the facility failed to lift up the wheelchair leg rest pedals when seated stationary in the wheelchair in order	F 282		

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F 282	Continued From page 12 to prevent R27 from tripping and falling over them during self transfer attempts as directed by his individualized care plan. R27's care plan dated 6/18/14, indicated R27 had trouble getting started when he ambulated because his leg shook and was hard to lift. The care plan directed staff that R27's wheelchair pedals were to be removed for safety as they were a tripping hazard. The care plan indicated R27 was to utilize the leg rests when outside of the facility. On 7/10/14, at 8:25 a.m. R27's wheelchair as observed in his room with the pedals attached to the wheelchair. On 7/10/14, at 10:08 a.m. R27 was observed in the chapel, seated in his wheelchair. The wheelchair leg rests were observed attached with R27's feet resting on the pedals. On 7/10/14, at 10:04 a.m. nursing assistant (NA)-B confirmed R27 had the foot pedals in place and stated she did not recall a time that she was ever told he was not to have them on his wheelchair. On 7/10/14, at 10:12 a.m. licensed practical nurse (LPN)-A stated staff needed to be sure R27's foot pedals were lifted when R27 was stationary in his wheelchair to prevent tripping over them and falling. On 7/10/14, at 12:20 p.m. the director of nursing (DON) stated she would expect staff to follow R27's care plan as directed. R17 was identified at risk for the development of	F 282	F282 CORRECTIVE ACTION: Care plan for R27 and R17 has been updated to reflect interventions used to prevent falls and in the prevention of contractures. An updated fall policy and procedure has been implemented. Licenses nursing staff has been educated on fall policy and procedure. A restorative Nursing program is being established to address interventions for risk of development of pressure ulcers and worsening of contractures. DATE OF COMPLETION: July 31, 2014 DATE CERTAIN: July 31, 2014	07/31/14

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F 282	Continued From page 13 pressure related ulcers and worsening contractures and the facility failed to implement interventions as directed by R17's individualized care plan. R17's care plan dated 6/20/14, indicated R17 had sever cognitive impairment, was legally blind and at risk for pressure ulcers and worsening contractures. R17's care plan directed staff to place a left arm wedge to rest at the end of wrist crease so that fingers drape over the edge of the wedge to help reduce the likelihood of R17's fingertips resting on his palm and to place a rolled up wash cloths in R17's hands when sleeping to protect from contractures worsening. In addition, the care plan directed staff to ensure R17 wore Prevalon heel protectors at all times. On 7/9/14, at 8:13 a.m. NA-A was observed to enter R17's room and initiate morning cares. R17 was observed lying in bed, asleep. R17 did not have a brace / wedge nor rolled wash cloths in place on either arm, hand or wrist. R17's feet were observed bare and without any heel protectors. Upon completion of the cares, NA-A was observed to apply R17's heel protectors, soft brace on right arm / wrist and also placed an arm wedge under R17's left arm / wrist. NA-A stated R17 should have had them in place. On 7/9/14, at 8:19 a.m. NA-A confirmed R17 should have had his heel protector boots on his feet to protect him from developing pressure ulcers and wash cloths rolled up in his hands to help prevent his hand contractures from worsening. On 7/9/14, at 1:58 p.m. NA-J confirmed R17 should have had a soft brace on his right	F 282	RECURRENCES WILL BE PREVENTED BY: Audits will be completed weekly x 12 months on the MDS to identify changes in Activities of Daily Living Function by the Director of Nursing. Reports will reviewed by the LTC Quality Assurance monthly	

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F 282	Continued From page 14 arm/wrist, a wash cloth rolled up in his left hand and when the right brace was off, wash cloths rolled up in both of his hands. On 7/10/14, at 1:11 p.m. the DON stated it was her expectation that staff implement the care plans as directed. The Comprehensive Plan of Care policy dated 8/15/11, indicated the comprehensive plan of care will be used by all staff involved in the care of the elder.	F 282	F285 CORRECTIVE ACTION: Level 2 screening for R18 was completed. DATE OF COMPLETION: July 31, 2014 DATE CERTAIN: July 31, 2014 RECURRENCES WILL BE PREVENTED BY: Preadmission screening has been added to the admission checklist. Admission checklist will be audited by Director of Nursing when applicable and reported to the LTC Quality assurance committee x 6 months	
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental	F 285		

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	245529	A. BUILDING _____ B. WING _____	07/10/2014

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 285	Continued From page 15 retardation or developmental disability authority has determined prior to admission– (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR) screening was completed to determine the need for specialized services for 1 of 1 resident (R18) reviewed for PASRR pre-admission screening who had diagnoses of a developmental disability. Findings include: R18's quarterly Minimum Data Set (MDS) dated 4/14/14, indicated R18 was diagnosed with paranoid schizophrenia. The Diagnosis Report dated 2/4/11, indicated unspecified intellectual disabilities. Review of R18's clinical record revealed a form	F 285		

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F 285	Continued From page 16 titled Adult Intake, Level I: Screening Mental Illness or Mental Retardation (MR) completed on 2/24/2011. The level I PASRR form indicated R18 had mental illness and borderline intellectual functioning, diagnoses of borderline MR and cognitive childlike behaviors. The form also indicated R18 required a referral to the county office for persons with developmental disabilities for the completion of a level II PASRR for the evaluation and determination of need for special services. However, R18's clinical record lacked documentation of the completion of a level II assessment. On 7/10/14, at 12:48 p.m. the director of nursing (DON) verified a Level II PASRR was not completed by the facility for R18. At 4:35 p.m. DON stated she had checked with the county, who had no record of the Level II screening being completed for R18. DON stated, "It was not done." A policy regarding PASRR was requested, DON stated, "We do not have a policy regarding that."	F 285		
F 323 SS=G	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 interview and document review, the	F 323		

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F 323	Continued From page 17 facility failed to analyze falls to identify and implement adequate interventions to minimize the risk of further falls for 2 of 5 residents (R41, R38) reviewed for accidents. R41 sustained actual harm related to a fall which resulted in a hip fracture. Findings include: R41's Admission Record report dated 7/10/14, indicated R41 diagnoses included history of right hip fracture, dementia and Parkinson's disease. R41's quarterly Minimum Data Set (MDS) dated 4/3/14, indicated R41 had severe cognitive impairment and required extensive assistance of two plus staff for transfers, walking and toilet use. The MDS also identified R41's balance during transfers and walking was not steady, he was only able to stabilize with human assistance and had functional limitations in range of motion of his upper and lower extremities with impairment on both sides. The MDS further indicated R41 utilized a walker and wheelchair for mobility and received an active range of motion restorative program 4 days during the assessment period. R41's undated Care Area Assessment (CAA) for falls indicated R41 fell at home multiple times before admission. R41's wife was unable to care for R41 at home due to the falls, incontinence and ADL (activity of daily living) needs. The CAA identified R41 had a history of falls and had three falls from bed after admission to the facility. The CAA indicated a bed alarm was added to the bed and identified R41 had physical and cognitive impairments that placed him at increased risk for falls.	F 323	F323 CORRECTIVE ACTION: Care plans reviewed and interventions implemented for r 38 and R41. Staff educated on interventions. DATE OF COMPLETION: July 31, 2014 DATE CERTAIN: July 31, 2014 RECURRENCES WILL BE PREVENTED BY: A falls program has been implemented on 7/22/14 in which a temporary care plan is put into place immediately after a fall. Falls are reviewed on a daily basis if needed and reviewed by the Falls Committee. Audits will be completed by Director of Nursing., on Incident Reports, care plans and documentation weekly x 4 weeks and monthly x 12. Reports will be reported to the LTC QA committee monthly x 12.	07/31/14

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F 323	Continued From page 18 R41's care plan dated 7/7/14, identified R41 was at risk for falls, had a history of falls and directed staff to: -Ensure R41's call light was within reach, encourge him to use it for assistance, and respond promptly to all requests. -Ensure R41 was wearing appropriate footwear when ambulating or mobillzing in wheelchair -If R41 was restless this may be a sign of pain or need to use the bathroom. -If R41 wanted to get up and walk, assist him to walk as far as he would like as this may keep him from getting up as much on his own. -PT [physical therapy] evaluate and treat as ordered or PRN [as needed]. Review of R41's medical record revealed the following: The Initial Fall Risk Assessment dated 9/28/13, indicated R41 was at high risk for falls. Interventions: Fall risk care planned. Pressure alarm in wheelchair and bed when sleeping. Fall floor mats placed on both sides of bed and bed placed in lowest position when alone. R41's progress notes indicated R41 had sustained the following falls: -On 9/29/13, at 1:30 a.m. R41 was found on the floor after an unwitnessed fall out of bed. R41 sustained a small abrasion on the lateral side of his right knee. R41 was incontinent. Bed was in low position, call light within reach. Immediate action: vital sign and neurological checks initiated, 15 minute safety checks. 10/3/13, (4 days later) Interventions: Fall floor mats added to both sides of bed. A different wheelchair was to be used on a trail basis as it appeared to fit him	F 323		

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F 323	Continued From page 19 better and he did not lean quite as far forward. No changes made to the care plan. -On 9/30/13, at approximately 12:00 a.m. R41 was found on the floor after an unwitnessed fall out of bed. No injuries. Immediate action: vital sign and neurological checks initiated. 10/3/13, (three days later) Interventions: Fall floor mats added to both sides of bed. A different wheelchair was to be used on a trial basis as it appeared to fit him better and he did not lean quite as far forward. No changes made to the care plan. -On 10/5/13, at approximately 7:15 p.m. R41 was found on his hands and knees on the mat on the right side of the bed near the door after an unwitnessed fall from bed. No injury. Immediate action: neurological checks initiated. Bed alarm placed. 10/7/13, (two days later) every 30 minute checks while R41 was in bed. No changes made to the care plan. R41's Fall Risk Assessment dated 10/16/13, indicated R41 was a high risk for falls. Interventions: bed alarm on bed and chair, bed in lowest position and gray mats on floor beside bed. -On 10/20/13, at approximately 7:22 p.m. R41 was found on the floor on his left side after an unwitnessed fall in an unidentified location. No injuries. Immediate action: vital signs and neurological checks initiated. No incident report completed. No interventions identified. -On 10/21/13, at 11:00 p.m. R41 had a witnessed fall from bed. No injuries. Immediate action: supervison. No incident report completed. No	F 323		

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F 323	Continued From page 20 interventions identified. -On 10/23/13, at 9:05 p.m. R41 had a witnessed fall to the floor while standing in the common area by the birdcage. No injuries. Immediate action: none identified. No incident report completed. No interventions identified. -On 10/25/13, at 8:46 p.m. R41 was found lying on the floor on his left side after an unwitnessed fall in the dining room. No injuries. Immediate action: vital signs and neurological checks initiated, use chair alarm wherever R41 sits. No changes made to the care plan -On 10/27/13, at 10:38 p.m. R41 found on the floor next to the bed after an unwitnessed fall out of bed. No injuries. Immediate action: none identified. No incident report completed. 11/1/13, (5 days later) Health Status Note: " follow up for falls on 10/25, and 10/27. [R41] was to get as much 1 on 1 attention as possible in the evenings. He could be in Balsam at times during the day when he wanted to or when staffing was stretched too thin. Staff to try to pick up a routine for him." No changes made to the care plan. -On 11/4/13, at 10:39 p.m. R41 was found on hands and knees in front of chair, in front of the tv after an unwitnessed fall. No injuries. Immediate action: none identified. No incident report completed. 11/12/13, (8 days later) R41 moved to the Balsam unit. -On 11/12/13, at 11:45 p.m. R41 was found on the mat next to his bed after an unwitnessed fall from bed. No injuries. Immediate action: vital signs and neurological checks initiated. No incident report completed. No interventions	F 323		

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F 323	Continued From page 21 identified. -On 11/16/13, 11:57 p.m. R41 was found crawling on knees and hands at the end of his bed, after an unwitnessed fall from bed. He sustained an abrasion to his right knee measuring approximately 1 centimeter (cm) in circumference. Immediate action: brought to a chair in the common area and given food and drink. No incident report completed. The 11/19/13, Fall Risk Assessment indicated R41 was a high risk for falls, was diagnosed with dementia and Parkinson's and had severe cognitive impairment. The assessment also indicated R41 had multiple recurrent falls, was sometimes understood and able to understand others, verbalized very little, staff anticipated needs daily, had poor safety awareness and recognition of his physical limitations. Additionally, the assessment indicated R41 was impulsive with self transfers and used a bed and chair alarm at all times. One of the most recent falls was the result of R41 trying to turn off the air conditioner in his room r/t [related to] being cold. The asssesment indicated R41 would be moved to the bed near the door so he could be easily visualized by staff and away from the air conditioner unit. -On 11/21/13, at 11:30 a.m. R41 had a witnessed fall when he stood to walk and fell landing on his right knee sustaining a right knee abrasion measuring 1 cm x 0.5 cm. Immediate action: none identified. No incident report completed. 11/29/13 (8 days later) "Follow up for incidents on 11/18, and 11/21, indicated [R41's] previous evening routine was to watch the news every evening before bed. Staff were to put R41 in his recliner at 9:00 p.m. to watch one news station	F 323		

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F 323	Continued From page 22 and then switch the channel to the next news broadcast at 10:00 p.m. Staff were also to take him for a walk outside of Balsam occasionally." Care plan updated. -On 12/1/13, at 7:30 p.m. R41 had a witnessed fall from the bed to the mat on the floor. No injuries. Immediate action: assisted to the common area and given 1:1 time with staff. No incident report completed. The 12/2/13, Fall Risk Assessment indicated R41 was a high risk for falls. Interventions: Mobility assessment completed. Action: Staff are encouraged to get him up to walk often, use assistance of 2 whenever possible, and attempt to keep his walker as close to his body as possible when walking. No changes made to the care plan. -On 12/14/13, at 3:37 p.m. R41 had an unwitnessed fall when attempting to transfer from the sofa in the common area. No injuries. Immediate actions: vital signs and neurological checks initiated. No incident report completed. The 12/15/13, Fall Risk Assessment indicated R41 was a high risk for falls. "Interventions: standing walker. 12/17/13, Mobility Assessment completed. Action: Staff will continue to allow [R41] to walk as often as they can, and take him off unit to walk on occasion if he gets restless as well. Also staff are to try the new EZ-Way battery powered walking aid." No changes made to the care plan. -On 1/5/14, at 9:36 p.m. R41 had a witnessed fall from the bed to the mat on the floor and sustained a left elbow laceration that measured approximately 2 cm x 0.2 cm. Immediate action: vital signs and neurological checks initiated and R41 brought to sit in recliner in the common area.	F 323		

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F 323	Continued From page 23 The 1/6/14, Fall Risk Assessment indicated R41 was a high risk for falls. No interventions identified. -On 1/27/14, at 11:07 p.m. R41 had an unwitnessed fall from the bed to the floor and sustained a skin tear to the right elbow approximately 1.5 cm in a triangular shape. The 1/29/14, Fall Risk Assessment indicated R41 was high risk for falls. Interventions: "restorative aide to try and start walking with [R41] once per shift during the daytime, and CNAs will attempt to get help him walk more often during each shift." No changes made to the care plan. -On 2/28/14, at 10:27 p.m. R41 was found on the floor after an unwitnessed fall from the bed. No injury. Immediate action: "[R41] brought to the common living area and given food and drink. Vital signs and neurological checks initiated. 3/6/14 [R41] was started on antibiotics for a URI [upper respiratory infection] and started on Tamiflu [treats and helps prevent influenza] for prophylactic purposes. Interventions: 1) R41 likes to watch TV prior to bed. Will continue to go to bed in between 10-11 p.m. Toileting will continue to be prior to bed. 2) Likes to have cocktail prior to bed. Will continue prior to bed." -On 3/7/14, at 4:00 p.m. R41 attempted to self transfer from his recliner and was assisted to the floor. No injuries. Immediate action: None identified. No incident report completed. No interventions identified. A 3/27/14, Fall Risk Assessment indicated R41 was a high risk for falls. Interventions: "Staff to attempt to walk R41 at least 2-3 times per shift.	F 323		

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F 323	Continued From page 24 [R41] is a very significant fall risk due to what has appeared to be worsening Parkinson's, he is very unsteady on his feet. He has not had any falls in the last 30 days, [R41] tries to get up many times during each shift without help. When CNAs [nursing assistants] get him up to walk though sometimes he will refuse. This is occasionally because he wants to use his walker, instead of the electric walker." -On 4/7/14, on the night shift, R41 was witnessed to put his hands on the floor and crawl onto his mat next to the bed. Immediate action: R41 brought to recliner in the common area to watch television. No incident report completed. No interventions identified. -On 4/12/14, at 3:53 p.m. R41 had an unwitnessed fall from the recliner in the Balsam living room. No injuries. Immediate actions: vital signs and neurological checks initiated. No interventions identified. -On 4/16/14, at 9:44 p.m. R41 had a witnessed fall from the sofa to the floor and sustained an abrasion to the left side of his forehead measuring 2 cm x 1 cm. Immediate actions: vital signs and neurological checks initiated. No interventions identified. -On 5/30/14, at 2:15 a.m. R41 was found sitting on the mat on the foor in his room after an unwitnessed fall from bed. No injuries. Immediate actions: vital signs and neurological checks initiated. No interventions identified. -On 5/31/14, at 10:30 p.m. R41 had an unwitnessed fall while self ambulating in the hallway. No injury. Immediate actions: taken to	F 323		

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F 323	Continued From page 25 common area. No interventions identified. -On 6/19/14, at approximately 4:30 a.m. "[R41] was found sitting on the floor next to his bathroom with his knees bent and his back against the wall after unwitnessed fall in his room . He sustained a skin tear to his left elbow approximately 5 cm x 3 cm." Immediate actions: vital signs and neurological checks initiated. The 6/20/14, Fall Risk Assessment indicated R41 was a high risk for falls. Resident does walk with eyes closed at times and seldom opens them to prompting. Staff ambulates with resident at all times. No interventions identified. -On 7/5/14, at 11:28 p.m. R41 was found on the floor at the foot of his bed after an unwitnessed fall in which he sustained a hip injury. R41 was sent to the emergency room where xray confirmed a left hip fracture and R41 was admitted to the hospital. Review of R41's fall history revealed a system that lacked proper documentation of falls on an incident report. The system also lacked identification of causal factors of the falls as well as identification of interventions to prevent further falls. On 7/10/14, at 6:04 p.m. nursing assistant (NA)-G stated he did not notice any trends in R41's falls and R41 never fell with him. NA-G stated R41 got up by himself in his room and "actually tried to run." NA-G stated R41 needed constant reminders to use his walker as he would get up and begin ambulating without using his walker. NA-G further stated they took R41 for walks and had a program to walk him.	F 323		

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On 7/10/14, at 6:09 p.m. NA-H stated R41 fell when he tried to get up by himself and got aggressive at times when he tried to walk with R41. NA-H stated "I tried to let him do the walking and walk with him to keep him balanced and make sure he didn't fall." NA-H stated he had been pulled to work with R41 as he sometimes "needed a one on one to watch him."

On 7/10/14, at 6:10 p.m. NA-F and NA-E were interviewed and both were familiar with R41. NA-F stated R41 had a tendency to self transfer and get up by himself. NA-F also stated that a bed alarm was used for R41 when he was in bed but did not remember the alarm being used when R41 was in a chair. NA-F further stated, "We would take him for long walks; he also liked to follow the staff and would propel himself with his wheelchair around and follow us. One on one time consisted of walking with him, I would also sit down and reminisce with him about where he lived or read him a magazine." NA-E stated, "We always used a gait belt to transfer him and he always used his walker; we did lots of one on one time; when he was tired I would take him for rides in his wheelchair."

On 7/10/14, at 6:14 p.m. NA-D stated, "I can't remember everything we did for [R41's] falls, but I know that walking with him helped, because we would be with him and try to do one on one with him. We would put him in the recliner. It is so open on Cedar that it is hard to watch everything, so him moving to Balsam, which is a smaller area, made it easier to watch him."

On 7/10/14, at 6:18 p.m. NA-I stated R41 was very independent and "when he wants to go, he goes." NA-I also stated R41 used a front

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F 323	Continued From page 27 wheeled walker but he did not always use it appropriately and would sometimes carry it when he walked with it or use it to open doors. NA-I indicated they took R41 for many walks and tried to keep him as safe as possible. On 7/10/14, at 6:23 p.m. licensed practical nurse (LPN)-C stated she was familiar with R41. She also stated she really did not notice a trend in R41's falls. She futher stated R41 liked to walk and he was very quick on getting up on his own. LPN-C stated, "We tried to keep him in our sight. We walked with him often and tried to keep him away from the windows as he would try to hit the window with his walker. We did a lot of one on one time; he liked to walk, so we walked a lot. We always used a transfer belt to assist him and he always used a walker. We always made sure he wore shoes when up and at night we put gripper socks on him; we tried to go with his lead and let him walk as much as he wanted." One 7/10/14, at 6:07 p.m. R41's falls were reviewed with director of nursing (DON) and registered nurse (RN)-C. RN-C confirmed the bed and wheelchair pressure alarms, fall mats and bed in lowest position fall interventions were not on R41's care plan. After the fall on 10/5/13, a new intervention of 30 minute checks while R41 was in bed was identified on the incident report. DON confirmed they did not have any documentation of the thirty minute checks. RN-C confirmed the 30 minute check interventions were not on the care plan. RN-C confirmed the chair alarm intervention identified after the 10/25/13 fall was not on the care plan. RN-C confirmed the intervention to use a battery powered walking aid identified after the fall on 12/14/13 was not on the care plan.	F 323		

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RN-C stated there was a pattern to R41's falls in that the majority were from out of bed onto the fall mat and took place between 4:00 p.m. and 4:00 a.m. DON and RN-C both confirmed they did not have an opportunity to do an analysis of causal factors after each fall. DON stated they attempted to provide one on one attention for R41 which meant that one staff member would watch him as much as possible on the evening shift. DON indicated they had one staff member always located in the Balsam lounge area and they would try to bring R41 there for supervision. However, DON also stated they did not always bring him to that area and it was R41's choice to go there. DON confirmed R41 required additional supervision and stated they had considered moving R41 to a room closer to the nurses' station, adding an audible monitor to his room to better hear the bed alarm or R41 moving in the room, and adjusting the nursing schedule based on acuity to provide better supervision for R41 but had not had the opportunity to do so.

R38 was at risk for falls and the facility failed to identify and implement adequate interventions to minimize the risk of further falls.

R38's admission record dated 7/10/14, identified diagnoses of dementia with behavioral disturbances, anxiety, edema, congestive heart failure and osteoarthrosis. R38's quarterly MDS dated 5/16/14, indicated R38 had severe cognitive impairment, required supervision and one assist with ambulation, limited assist of one for transfers, had falls and one fall with injury.

R38's care plan dated 6/11/13, identified focus of

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F 323	Continued From page 29 moderate risk for falls with interventions of but not limited to if in an unsafe situation please re-direct or provide assistance, ensure wearing appropriate footwear when ambulating, review information on past falls and attempt to determine cause of falls, record possible root causes, alter/remove any potential causes if possible and educate resident/family/caregivers/IDT (interdisciplinary team) as to causes. R38's current Fall Risk Assessment dated 5/9/14, indicated R38 was at risk for falls, had a history of falls in last 6 months one to two times, medication use: diuretics, cathartics, vision pattern: inadequate, continence in last 14 days: frequently incontinent, agitated behavior in last seven days occurred less than daily, gait analysis: uses short discontinuous steps and/or shuffling steps, exhibits jerking or instability when making turns and wears poorly fitting shoes. Nurse Progress note dated 5/9/14, indicated R38 was at risk for falls. Interventions: staff try and keep an eye on R38 as much as possible. Comments: R38 walks with a pigeon toed stance, toes pointing outwards, and often walks somewhat hunched over. R38 wears ACE wraps for severe peripheral edema most prevalent in ankles and feet, because of this often just wears non-slip socks as shoes only fit depending on his edema level, R38 was frequently incontinent to some extent, but this may be mostly dribbling, ambulates independently, but sometimes does needed guidance and had not demonstrated any orthostatic hypotension. Document review of R38's incident reports revealed the following:	F 323		

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F 323	Continued From page 30 -Incident report dated 5/31/14, at 10:10 p.m., "staff person doing a unit check and resident grabbed staff person's wrist and would not let go, [R38] was pulling staff person toward the lounge chair saying, 'down, sit down now and do not get up.' When staff person asked [R38] to let go of wrist [R38] replied, 'You asking for this.' And hit staff person on the chin with a closed fist hard enough to cause pain, [R38] than stepped back like [R38] was going to hit staff person again and [R38] lost his balance and fell backwards onto [R38's] bottom. Immediate action taken description: nursing assistant alerted to situation and assist [R38] to feet and to the bathroom to change soiled brief [had been incontinent of stool], refusing vital sign checks." R38's clinical record post fall lacked evaluation of causative factors related to the fall in order to initiate adequate interventions to minimize the risk for further falls. Incident report dated 6/1/14, at 1:45 a.m., R38 remained agitated after fall on 5/31/14, at 10:10 p.m. R38 was unable to sit still or lay down in bed and started pacing the unit. Nursing assistant found R38 sitting on the floor in the hall near his prior room facing the main entrance holding onto the railing with left hand. R38 had stated, " I do not know, I had to sit down than I could not get back up. " Immediate action taken: R38 was checked for mobility of extremities and assisted to standing position, escorted and assisted into bed and post fall protocol implemented. Level of pain: hurts a little bit. R38's clinical record post fall lacked evaluation of causative factors related to the fall in order to initiate adequate interventions to minimize the risk for further falls. Incident report dated 6/10/14, at 11:57 p.m. R38	F 323		

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F 323	Continued From page 31 had been laid down in bed at 11:15 p.m. and 15 minutes later staff checked on R38 and found R38 laying on the floor on his back with head at the foot end of the bed, in room between R38's bed and roommates bed. Immediate action taken: R38 had been checked for pain and injuries, had no new complaints of pain or injury, neuro's were initiated, staff assisted off the floor using a Hoyer mechanical lift and laid R38 back down in bed. R38 got out of bed and walked a few steps, complained of normal knee pain, was given Tylenol pain medication. R38's clinical record post fall lacked evaluation of causative factors related to the fall in order to initiate adequate interventions to minimize the risk for further falls. Incident report dated 6/29/14, at 1:45 a.m., nursing assistant informed R38 was on floor, upon entering R38's room R38 was observed on the floor, on back with feet toward the vanity and head toward the wall, between the beds, holding own head and shoulders off the floor. R38 had stated, "I fell, help me up. No I did not hit my head." Immediate action taken: R38 was examined for injuries, no external wounds found. R38 was assisted to a sitting position and then to a standing position, continued to deny hitting head and denied any discomfort, post fall protocol implemented for unwitnessed fall. R38's clinical record post fall lacked evaluation of causative factors related to the fall in order to initiate adequate interventions to minimize the risk for further falls. Incident report dated 7/5/14, at 12:50 p.m. staff alerted nurse R38 was on floor on knees in living room. Staff stated R38 had bent down onto the floor to pick up some small pieces of paper, R38	F 323		

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F 323	Continued From page 32 got on his knees and then could not get back up, R38's wheelchair was stationed directly behind R38. R38 had stated "get me up, get me up." When staff asked R38 what happened R38 continued to tell staff to get him up. Immediate action taken: observed for injury, R38 denied pain, assisted R38 from floor to wheelchair with assist of two staff, redness noted on bilateral knees, blanches with touch. R38's clinical record post fall lacked evaluation of causative factors related to the fall in order to initiate adequate interventions to minimize the risk for further falls. On 7/9/14, at 7:58 a.m., The DON stated they reviewed falls daily at stand up meetings and registered nurse (RN)-C should be documenting what is implemented, IDT signs off on falls weekly on Thursdays. On 7/9/14, at 8:30 a.m., RN-C stated regarding R38's falls: -fall incident on 5/31/14, isolated incident, R38 was agitated, no changes made, verified no documentation had been made in R38 clinical record post fall regarding IDT review and no investigation had been completed to identify root cause of fall. -fall incident dated 6/1/14, RN-C stated occurred a couple hours after fall on 5/31/14, made no changes, R38 was agitated, staff was trying to get him to lay down in bed or sit down and R38 refused, verified no documentation had been made in R38's clinical record post fall regarding IDT review and no investigation had been completed to identify root cause of fall. -fall incident dated 6/10/14, RN-C verified no documentation had been made in R38's clinical record post fall regarding IDT review and no investigation had been completed to identify root	F 323		

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F 323	Continued From page 33 cause of fall. -fall incident on 6/29/14, RN-C stated IDT discussed giving more natural diuretics to decrease peripheral edema without giving more medication. R38 had peripheral edema in feet and feet almost rounded at bottom, provide ace wraps and try to keep on as much as R38 allowed, edema likely cause of fall. RN-C verified no documentation had been made regarding this in R38's clinical record. RN-C stated (in regards to what interventions attempted that were non-medication) R38 was given watermelon, hot green tea, tried cold green tea and had stated not sure if documented anywhere. -fall incident dated 7/5/14, RN-C had stated we have not reviewed or discussed this fall yet. On 7/10/14, at 8:44 a.m. RN-C verified no documentation was done in R38's clinical record regarding the non-medication interventions attempted nor the effectiveness of the non-medication interventions.. On 7/10/14, at 2:12 p.m. The DON stated after a fall she would expect staff to immediately discuss how to keep the resident safe until other managers got there and would also expect staff to document what they were doing. The DON stated she would expect the managers to discuss the falls at stand up rounds and then document what interventions were going to be implemented and to do an investigation to figure out root cause of fall. The Monitoring Falls and Their Causes policy dated 9/17/13, indicated an incident report must be completed for all elder falls. Incident reports must be completed no later than 30 minutes after the fall. The policy also directed within 24 hour of	F 323		

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F 323	Continued From page 34 a fall, the nursing staff will begin to try to identify possible or likely causes of the incident. The staff will continue to collect and evaluate information until they either identify the cause of falling or determine that the cause cannot be found. The policy further directed staff to document completion of a falls risk assessment within 24 hours of fall and appropriate interventions taken to prevent future falls.	F 323	F329 CORRECTIVE ACTION: Gradual dose reduction for R20 and R29 initiated. DATE OF COMPLETION: July 31, 2014 DATE CERTAIN: July 31, 2014	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	RECURRENCES WILL BE PREVENTED BY: Gradual dose reductions will be completed every six months unless failure of Gradual dose reduction can be shown by documentation in the elder's medical records. At that time, justification for continued use will be documented in the elder's medical record. Audits will be completed weekly by MDS Coordinator x 4 and then Monthly x 6. All audits will be reported to the Long Term Care Quality Council	07/31/14

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F 329	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure dosage reductions were attempted, unless clinically contraindicated, for the continued use of antidepressants and antianxiety medications for 1 of 5 residents (R20) reviewed for unnecessary medication. In addition, the facility failed to ensure adequate side effect monitoring for drug to drug interactions from citalopram hydrobromide and Baclofen (a medication that relaxes skeletal muscles) for 1 of 5 residents (R20) reviewed for unnecessary medications. Findings include: R20's Diagnosis Report dated 7/10/14, indicated R20 had diagnoses to include depressive disorder, generalized anxiety disorder and muscle spasms. R20's annual Minimum Data Set (MDS) dated 1/30/14, indicated R20 had severe cognitive impairment. The MDS identified mood concerns of: having little interest in doing things 2 to 6 days during the assessment period, being short tempered or easily annoyed 12 to 14 days, rejected care 1 to 3 days during the assessment period. The MDS indicated R20 had no hallucinations, delusion or behavioral symptoms during the assessment period. R20's Consolidated Orders (Chart) Report (COR, physician's orders) dated 7/11/14, directed to offer R20 citalopram hydrobromide (Celexa) starting on 10/1/12, 40 milligrams (mg) once daily at 4:00 p.m. for depressive disorder. COR also identified to offer diazepam (Valium) starting on 9/5/12, 5 mg once daily and 10 mg once daily at HS (bedtime) for generalized anxiety disorder.	F 329		

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F 329	Continued From page 36 COR directed to offer Baclofen starting 4/22/14, 10 mg three times daily for muscle spasms. The Consultant Pharmacist's Medication Review documents were reviewed from October 2013, to June 2014, and indicated the following: -On 10/24/13, the consultant pharmacist (CP) recommended, "Due for consideration of diazepam GDR [gradual dose reduction] as well as citalopram GDR." An "X" mark was placed next to the statement, "Review with the resident's physician/provider during his/her next visit, but no later than (2) months." The form identified the director of nursing (DON) acknowledged the recommendation, however, the form lacked the date of her acknowledgement. The CP recommendation form lacked a physician/provider signature. -On 11/21/13, CP recommended, "1. Due for consideration of diazepam GDR. 2. There is a drug-drug interaction between citalopram and Baclofen that could cause serotonin syndrome [a potentially life threatening drug reaction that causes the body to have too much serotonin, a chemical produced by nerve cells]. Please review with provider and monitor for signs/symptoms of this interaction - increased sweating, agitation, tremor, increased blood pressure, muscle spasms." An "X" mark was placed next to the statement, "Review with the resident's physician/provider during his/her next visit, but no later than (2) months." The form identified DON acknowledged the recommendation on 1/30/14. The CP recommendation form lacked a physician/provider signature. -On 12/24/13, the CP recommended, "Please	F 329		

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F 329	Continued From page 37 review last month's comments." An "X" mark was placed next to the statement, "Review with the resident's physician/provider during his/her next visit, but no later than (2) months." The form identified DON acknowledged the recommendation on 1/30/14. The CP recommendation form lacked a physician/provider signature. -On 1/22/14, the CP recommended, "Please review November's consult." An "X" mark was placed next to the statement, "Review with the resident's physician/provider during his/her next visit, but no later than (2) months." The form identified DON acknowledged the recommendation on 1/30/14. The CP recommendation form lacked a physician/provider signature. -On 2/19/14, the CP recommended, "Please review November's consult." An "X" mark was placed next to the statement, "Review with the resident's physician/provider during his/her next visit, but no later than (2) months." The form identified DON acknowledged the recommendation on 4/7/14. The CP recommendation form lacked a physician/provider signature. -On 3/18/14, the CP recommended, "Still waiting for a response from November's consult." On 3/31/14, the nurse practitioner signed the document and included a handwritten note under the signature stating "see above." Three "X" marks were placed next to the statement, "Review with the resident's physician/provider during his/her next visit, but no later than (2) months." The CP recommendation form lacked a physician/provider signature.	F 329		

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

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	245529	A. BUILDING _____ B. WING _____	07/10/2014

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BIGFORK VALLEY COMMUNITIES	258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628

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F 329	Continued From page 38 -On 4/24/14, CP made no further reference to the November consult, nor identified issues with diazepam or citalopram. The form identified DON acknowledged the recommendation on 5/5/14. The physician signed the document, but did not date his signature. -On 5/14/14, CP made no further reference to the November consult, nor identified issues with diazepam or citalopram. The form identified DON acknowledged the recommendation on 7/8/14. The CP recommendation form lacked a physician/provider signature. -On 6/17/14, CP made no further reference to the November consult, nor identified issues with diazepam or citalopram. The form identified DON acknowledged the recommendation on 7/8//14. The physician signed the document, but did not date his signature. The Physician's Progress Notes from 7/3/13, through 7/2/14, lacked documented clinical rational why a dosage reduction for citalopram or diazepam was clinically contraindicated. The Side Effects Monthly Flow Sheets from April 2014 through July 2014, revealed no monitoring for the identified risk of serotonin syndrome as identified by CP on 11/21/13. On 7/10/14, at 9:43 a.m. registered nurse (RN)-C confirmed there was no documentation in R20's medical record why a dosage reduction for citalopram and diazepam was clinically contraindicated. RN-C verified R20 had no reduction attempts of citalopram and diazepam since CP's recommendation in 10/24/13. RN-C	F 329		

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F 329	Continued From page 39 confirmed the care plan did not address the use of Baclofen, lacked nonpharmacological interventions to address R20's muscle spasms and lacked side effect monitoring to include symptoms of serotonin syndrome as identified by CP on 11/21/13. On 7/10/14, at 10:23 a.m. CP confirmed she had requested consideration for a GDR of R20's antidepressant and antianxiety medication in October 2013 and did not receive a response. CP indicated she would have expected an attempted GDR of the medication, or physician documentation of clinical rational why a GDR was clinically contraindicated. CP further stated she would have expected the nursing staff to monitor for serotonin syndrome symptoms as requested on 11/21/13. On 7/10/14, at 12:03 p.m. DON stated she expected R20's medical record to have documentation regarding the indication for further use of the antidepressant and antianxiety medication; DON verified there was no documentation in place. DON confirmed R20 continued to receive both medications which placed him at risk for serotonin syndrome; DON verified specific side effect monitoring for the drug to drug interaction was not done and they should have monitored R20 for side effects as directed by CP. A policy for psychotropic medication use was requested from DON on 7/10/14, but none was provided.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	Continued From page 40 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's consultant pharmacist (CP) failed to identify the need for a potential gradual dose reduction (GDR) for the use of Lexapro (an antidepressant medication) for 1 of 5 residents (R29), failed to act upon CP recommendations for a potential GDR attempt with the use of citalopram (Celexa, an antidepressant medication), diazepam (Valium, an anti-anxiety medication) and failed to act upon CP recommendations to monitor for serritonin syndrome (a potentially life threatening drug reaction that causes the body to have too much serotonin, a chemical produced by nerve cells) side effects from drug to drug interactions of citalopram and baclofen (a medication that relaxes skeletal muscles) for 1 of 5 residents (R20) reviewed for unnecessary medications. Findings include: The Consolidated Orders (Chart) Report (COR, physician orders) dated 6/30/14, identified R29's	F 428	F 428 CORRECTIVE ACTION: Gradual dose reduction for R20 and R29 initiated. Side effect monitoring has been initiated for R20 and R29. DATE OF COMPLETION: July 31, 2014 DATE CERTAIN: July 31, 2014 RECURRENCES WILL BE PREVENTED BY: Gradual dose reductions will be completed every 6 months. Audits will be completed weekly by MDS Coordinator x 4 and then Monthly x 6. All audits will be reported to the Long Term Care Quality Council	07/31/14

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F 428	Continued From page 41	F 428		

diagnoses to include Alzheimer's disease, dementia with behavioral disturbances, adjustment (ADJ) disorder with mixed anxiety and depressed mood. The physician's orders directed starting 2/12/13, to offer Lexapro 10 mg (milligrams) tablet once daily at HS (bedtime) for the above identified diagnoses. The clinical record lacked evidence a GDR had been attempted since admission to the facility.

The Medication Administration Records (MARs) dated 7/1/14, through 7/31/14, indicated R29 received Lexapro 10 mg daily as ordered.

Review of R29's Progress Note Nursing Home forms (PNNH) indicated the following:
- PNNH dated 7/1/14, identified under assessment and plan, "4. Antidepressant and anxiety. Continue the Lexapro at 10 mg. Will continue to evaluate GDR."
- PNNH dated 5/7/14, had no documentation regarding use of Lexapro.
- PNNH dated 3/10/14, identified using Lexapro.
- PNNH dated 1/15/14, identified plan to observe for any mood that may indicate depression, "I think the crying is dementia caused."
- PNNH dated 11/18/13, identified using Lexapro and staff had difficulty with "striking out" at personnel, previously family had refused GDR with extreme history of behavioral disturbances. However R29's PNNH had no documentation regarding clinical rational for the continued use of Lexapro at the current dose.

The Consultant Pharmacist Medication Reviews dated monthly from 9/27/13, through 6/17/14, did not identify the potential need for a GDR of Lexapro.

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F 428	Continued From page 42 On 7/9/14, at 12:01 p.m. registered nurse (RN)-C verified R29 had been receiving Lexapro 10 mg daily since admission on 2/12/13, and R29 had no GDR attempted since. On 7/10/14, at 10:14 a.m. CP had stated she would expect a dose reduction to be done for Lexapro and recommended one. At 11:12 a.m. CP stated the last date a GDR had been recommended was on 6/24/13, none since because family refuses. On 7/10/14, at 2:14 p.m. director of nursing (DON) stated she would expect a gradual dose reduction to be done twice yearly unless contraindicated and if did not work would expect documentation to justify why medication was not decreased. DON stated she would expect the consultant pharmacist to request a gradual dose reduction for the Lexapro. On 7/10/14, at 5:25 p.m., director of nursing had stated the facility had no policies in regards to consultant pharmacist responsibilities for medication regimen review. R20's was a risk for serritonin syndrome and the facility failed to act upon CP recommendations to monitor for this drug reaction. R20's Diagnosis Report dated 7/10/14, indicated R20 had diagnoses that included depressive disorder generalized anxiety disorder and muscle spasms. R20's annual Minimum Data Set (MDS) dated 1/30/14, identified R20 with severe cognitive impairment and having little interest in doing things 2 to 6 days, being short tempered or easily annoyed 12 to 14 days and rejected care 1	F 428		

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F 428	Continued From page 43 to 3 days during the assessment period and reported no hallucinations, delusion or behavioral symptoms during the assessment period. R20's physician orders dated 7/11/14, identified citalopram hydrobromide (antidepressant) 40 milligrams (mg) be given once daily at 1600 (4:00 p.m.) for depressive disorder and was started on 10/1/12. The physician's orders also identified diazepam (antianxiety medication) 5 mg be given once daily and 10 mg be given once daily at HS (bedtime) for generalized anxiety disorder and were started on 9/5/12. The orders further identified baclofen (for treatment of spasticity) 10 mg be given 3 times daily for muscle spasms and was started on 4/22/14. The Consultant Pharmacist's Medication Review documents were reviewed from October 2013 to June 2014. -On 10/24/13, the consultant pharmacist (CP) recommended: "Due for consideration of diazepam GDR [gradual dose reduction] as well as citalopram GDR." An "X" mark was placed next to the statement "Review with the resident's physician/provider during his/her next visit, but no later than (2) months. The director of nursing acknowledged the recommendation, however, did not date her acknowledgement. The physician/provider did not sign the recommendation. -On 11/21/13, the CP recommended: "1. Due for consideration of diazepam GDR. 2. There is a drug-drug interaction between citalopram and baclofen that could cause serotonin syndrome. Please review with provider and monitor for signs/symptoms of this interaction - increased sweating, agitation, tremor, increased blood	F 428		

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F 428	Continued From page 44	F 428		

pressure, muscle spasms." An "X" mark was placed next to the statement "Review with the resident's physician/provider during his/her next visit, but no later than (2) months. The DON acknowledged the recommendation on 1/30/14. The physician/provider did not sign the recommendation.

-On 12/24/13, the CP recommended: "Please review last month's comments." An "X" mark was placed next to the statement "Review with the resident's physician/provider during his/her next visit, but no later than (2) months. The DON acknowledged the recommendation on 1/30/14. The physician/provider did not sign the recommendation.

-On 1/22/14, the CP recommended: "Please review November's consult." An "X" mark was placed next to the statement "Review with the resident's physician/provider during his/her next visit, but no later than (2) months. The DON acknowledged the recommendation on 1/30/14. The physician/provider did not sign the recommendation.

-On 2/19/14, the CP recommended: "Please review November's consult." An "X" mark was placed next to the statement "Review with the resident's physician/provider during his/her next visit, but no later than (2) months. The DON acknowledged the recommendation on 4/7/14. The physician/provider did not sign the recommendation.

-On 3/18/14, the CP recommended: "Still waiting for a response from November's consult." On 3/31/14, the nurse practitioner signed the document and included a handwritten note under

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F 428	Continued From page 45 the signature stating "see above." Three "X" marks were placed next to the statement "Review with the resident's physician/provider during his/her next visit, but no later than (2) months." The physician did not sign the recommendation. -On 4/24/14, the CP made no further reference to the November consult nor identified issues with diazepam or citalopram. The DON acknowledged the recommendation on 5/5/14. The physician signed the document but did not date his signature. -On 5/14/14, the CP made no further reference to the November consult nor identified issues with diazepam or citalopram. The DON acknowledged the recommendation on 7/8/14. The physician did not sign the recommendation -On 6/17/14, the CP made no further reference to the November consult nor identified issues with diazepam or citalopram. The DON acknowledged the recommendation on 7/8//14. The physician signed the document but did not date his signature. Review of the Physician's Progress Notes from 7/3/13 through 7/2/14 revealed no documentation of justification for continued use of the antidepressant medication, citalopram, nor documentation of justification for continue use of the antianxiety medication, diazepam. Review of the Side Effects Monthly Flow Sheets from April 2014 through July 2014 revealed no monitoring for the identified risk of serotonin syndrome as identified by CP. On 7/10/14, at 9:43 a.m. registered nurse (RN)-C	F 428		

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F 428	Continued From page 46 confirmed there was no documentation in R20's chart identifying the justification for the continued use of antidepressant and antianxiety medication and R20 had not under gone any tapering of these medications since CP's recommendation in October. RN-C confirmed the care plan lacked interventions for spasms and the use of baclofen to direct monitoring of side effects related to serotonin syndrome as identified by CP in November 2013. On 7/10/14, at 10:23 a.m. CP confirmed she had requested a gradual dose reduction of R20's antidepressant and antianxiety medication in October 2013 and did not receive a response. CP confirmed that she had stopped asking for a response April 2014. CP indicated R20 was having issues with spasms during that time so she did not pursue the dose reduction for diazepam. Additionally, CP indicated she did not have documentation for the dose reduction of citalopram but indicated she would have expected a gradual dose reduction of the medication or physician documentation identifying justification of continued use of the medication to occur. CP further stated she was unaware monitoring for serotonin syndrome had not occurred. On 7/11/14, at 10:44 a.m. CP confirmed she should have documented her decision to hold on pursuing the diazepam dose reduction related to increased spasm issues and she should have pursued the dose reduction for citalopram.	F 428		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 47 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 medication refrigerator utilized for medication storage was free from ice buildup and failed to monitor refrigerator	F 431	F 431 CORRECTIVE ACTION: Refrigerator temperature log has been posted on the outside of the refrigerator. A cleaning schedule-including defrosting has been implemented. DATE OF COMPLETION: July 31, 2014 DATE CERTAIN: July 31, 2014 RECURRENCES WILL BE PREVENTED BY: Audits will be completed by the Floor Manager weekly x 8 weeks and then monthly x 4 months. Audits will be reported to the Quality Council.	07/31/14

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F 431	Continued From page 48 temperatures for proper medication storage. Findings include: On 7/10/14, at 8:22 a.m. a refrigerator used for storage of medications located in the nurses' station was observed to have a temperature of 40 degrees Fahrenheit (°F) and a thick ice buildup on the freezer shelf. Registered nurse (RN)-C and the director of nursing (DON), both present during the observation, verified the finding and stated there was no cleaning schedule for the refrigerator. Both verified refrigerator temperatures were not recorded. Medications observed to be stored in the refrigerator were as follows: Bisacodyl suppositories, Compazine suppositories, Humalog insulin, Lantus insulin and Novolog insulin (all medications which require refrigeration). At 2:19 p.m. DON stated the medication refrigerator temperature should have been checked twice a day and recorded. DON stated she would expect a monthly cleaning schedule for the medication refrigerator and verified the facility lacked both a policy for cleaning the medication refrigerator and a policy for checking and recording medication refrigerator temperatures.	F 431		

ADDENDUM TO THE DEPARTMENT OF HEALTH PLAN OF CORRECTION

Date Survey Completed 07/10/2014

F274: indicated auditing by DON x 12 months. Is that monthly or weekly x 12 months?
Auditing will be conducted monthly.

F279: does not identify QA / QI involvement
DON will report monthly to QA/QI x 11 months .

F280: does not identify corrective action for R41.
Care plan updated for R41, following readmission to LTC. Staff educated on interventions.

F281: does the initial care plan identify fall risk and fall interventions?
R45 Expired in March of 2014.

F282: is related to not following the care plan. Observational audits to ensure care plans are implemented? Education on implementation of care plans?
Observation audit on care plan intervention will be completed weekly x 4 weeks, then monthly x 6 weeks, to ensure compliance by acting administrator. Reports will be given monthly x 6 months to QA/QI.

F323: does not address the development and implementation of interventions / new interventions after falls. Education on the need for intervention development?

A temporary falls care plan with immediate interventions has been implemented after each fall. Education on falls and implementation of interventions have been completed.

F32: does not address audit for the documentation of side effect monitoring etc.

Side Effect monitoring documentation will be audited weekly x 4 weeks and monthly x 6 and reported to LTC QA/QI monthly x 6

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	245529	A. BUILDING **01 - NURSING HOME** B. WING _____	**07/09/2014**

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BIGFORK VALLEY COMMUNITIES	**258 PINE TREE DRIVE. PO BOX 258 BIGFORK, MN 56628**

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K 000	INITIAL COMMENTS FIRE SAFETY. 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. 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 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	K 000		

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

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.

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

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 _____	**07/09/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 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 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		