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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UGO4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00834

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245529**
2.STATE VENDOR OR MEDICAID NO.
(L2) **048545405**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/15/2016** (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 **47** (L18)
13.Total Certified Beds **47** (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
	47			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 01/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 01/27/2017 (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
12/13/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245529

January 27, 2017

Mr. Aaron Saude, Asst Administra Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

Dear Mr. Saude:

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 December 7, 2016 the above facility is certified for:

47 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 47 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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 27, 2017

Mr. Aaron Saude, Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

RE: Project Number S5529029

Dear Mr. Saude:

On November 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 28, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On December 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 15, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 7, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 28, 2016, effective December 7, 2016 and therefore remedies outlined in our letter to you dated November 15, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245529 Y1	A. Building B. Wing Y2	12/15/2016 Y3

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0153	Correction	ID Prefix	F0156	Correction	ID Prefix	F0279	Correction
Reg. #	483.10(b)(2)	Completed	Reg. #	483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. #	483.20(d), 483.20(k)(1)	Completed
LSC		11/04/2016	LSC		12/01/2016	LSC		12/07/2016
ID Prefix	F0280	Correction	ID Prefix	F0282	Correction	ID Prefix	F0309	Correction
Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25	Completed
LSC		12/07/2016	LSC		12/07/2016	LSC		12/07/2016
ID Prefix	F0312	Correction	ID Prefix	F0314	Correction	ID Prefix	F0323	Correction
Reg. #	483.25(a)(3)	Completed	Reg. #	483.25(c)	Completed	Reg. #	483.25(h)	Completed
LSC		12/07/2016	LSC		12/07/2016	LSC		12/07/2016
ID Prefix	F0365	Correction	ID Prefix	F0373	Correction	ID Prefix		Correction
Reg. #	483.35(d)(3)	Completed	Reg. #	483.35(h)	Completed	Reg. #		Completed
LSC		12/07/2016	LSC		11/14/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/28/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245529 Y1	A. Building 01 - NURSING HOME B. Wing Y2	12/15/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0048	11/22/2016	LSC K0050	10/26/2016	LSC K0052	10/28/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0069	10/26/2016	LSC K0154	11/17/2016	LSC K0155	11/17/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
X ☐	TL/mm	01/27/2017	27200	12/15/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/26/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245529 Y1	A. Building 03 - ASPEN CIRCLE B. Wing Y2	12/15/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	10/27/2016	LSC K0048	11/22/2016	LSC K0050	10/26/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	10/28/2016	LSC K0069	10/26/2016	LSC K0154	11/17/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0155	11/17/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	01/27/2017	27200	12/15/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/26/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UGO4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00834

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245529**
2.STATE VENDOR OR MEDICAID NO.
(L2) **048545405**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/28/2016** (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 **47** (L18)
13.Total Certified Beds **47** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Vienna Andresen, HFE NEII 11/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/12/2016 (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

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

CCN: 24 5529

At the time of the October 28, 2016 recertfication survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. In addition, at the time of the survey an investigation of cmplaint number H5529005 was completed and founf to be unsubstantiated. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 15, 2016

Mr. Aaron Saude, Assistant Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

RE: Project Number S5529029 and H5529005

Dear Mr. Saude:

On October 28, 2016, 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. In addition, at the time of the October 28, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5529005.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the October 28, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5529005 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the**

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji District Office Surveyor Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: lyla.burkman@state.mn.us
Telephone: (218) 308-2114
Fax: (218) 766-0923

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 December 7, 2016, 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 December 7, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 January 28, 2017 (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 April 28, 2017 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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.

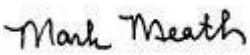
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	10/28/2016

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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Complaint investigation H5529005 was completed along with the recertification survey. The complaint was unsubstantiated.	F 000		
F 153 SS=D	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medical records were	F 153	CORRECTIVE ACTION: R10's Power of Attorney was immediately	11/4/16

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

Electronically Signed | 11/23/2016

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F 153	Continued From page 1 provided for review within twenty-four hours of request for 1 of 1 resident (R5) family member who requested review of clinical records. Findings include: On 10/25/16, at 1:36 p.m. R10's power of attorney (POA) stated on 10/28/16, she had requested the last two months of R10's medical records after the facility had reported an altercation with another resident and had not yet seen the records. POA stated the facility had reported one of the progress notes contained the other resident's name that needed to be removed. Review of R10's progress notes for the last two months did not reflect mention of another resident's name. R10's progress note dated 10/18/16, at 2:18 p.m. authored by licensed social worker (LSW) indicated R10's POA had requested to have a print out of all his progress notes for September and October 2016. R10's progress note dated 10/21/16, at 10:44 a.m. authored by LSW reported R10's POA was informed staff had been working on getting the progress notes, however needed to make sure there had not been names identified in the notes to protect confidentiality. Progress note indicated POA reported understanding and would continue to wait. On 10/26/16, at 5:06 p.m. LSW stated the facility had been in contact with the software company of their electronic health records system to request	F 153	provided (ON 10/27/16) with requested medical records upon completing the Authorization to Release Medical Records form. *See attachment(A) policy titled, "Authorization to Release Medical Records Senior Communities" which was updated on 11/22/16 to include "the resident or his/her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays". DATE COMPLETED: 10/27/16 RECURRENCES WILL BE PREVENTED BY: All residents will be updated on this policy at the next resident council meeting on _____. Policy posted on the "Resident Notice Board" in entryway to Tamarack with the Authorization to Release Medical Records form available at this location in a pocket folder. DATE COMPLETED 10/31/16. QAPI has been initiated on 11/4/16 to ensure all records are released as per Policy and Resident Rights. Ongoing monitoring of proper records release will be completed through audits and reported at the QAPI meeting monthly by the DON and Licensed Social Worker.	

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F 153	Continued From page 2 the name be removed from the document and that was what was taking so long to provide the documents to R10's POA. LSW reported she had been in contact with R10's POA to update her on the progress. The resident Combined Bill of Rights dated 12/4/15 included; 1. The resident or his or her legal representative has the right, upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and 2. After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. Facility policy Release of Protected Health Information last revised 5/2016, did not reflect current standards outlined in the resident Bill of Rights. Policy indicated routine requests for health information would be processed on a regular basis and completed within 10 working days and had to be in writing.	F 153		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be	F 156		12/1/16

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F 156	Continued From page 3	F 156		

made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which

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F 156	Continued From page 4 cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most current nursing home Bill of Rights, revised in March 2016, was posted and used by the facility. This had the potential to affect all 44 residents	F 156	CORRECTIVE ACTION: The Resident Rights large framed poster dated 1995 was removed from the location IMMEDIATELY (CORRECTED	

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F 156	Continued From page 5 residing in the facility. Findings include: During the initial tour on 10/24/16, at 2:00 p.m. the Resident Bill of Rights was observed posted on the Tamarak unit and dated 1995. On 10/26/16, at 12:45 p.m. Social worker (SW)-A provided a copy of the Resident Bill of Rights that was provided to the residents upon admission, this was dated July 1, 2007. SW-A was unaware of any updated Resident Bill of Rights. An undated facility policy entitled Bill of Rights for Residents, indicated The Bill of Rights would be posted in the facility and a copy would be provided on admission.	F 156	ON 10/25/16)- (during the survey visit). The current Combined Federal and State Bill of Rights dated 12/04/15 was verified to be posted in the entryway to the Nursing home by the DON office (CORRECTED ON 10/25/16), and currently remains in this location. The Licensed Social Worker immediately replaced (CORRECTED ON 10/26/16)the Combined Federal and State Bill of Rights in the Admission packet with the most current dated 12/04/15. RECURRENCES WILL BE PREVENTED BY: The Licensed Social Worker will provide education and have available copies of the most current Combined Federal and State Bill of Rights (dated 12/04/16) in the next Resident Council meeting on 12/13th,2016. Those residents not in attendence will have a copy of the most current Combined Federal and State Bill of Rights (12/04/15)provided to them and explained to them by the Licensed Social Worker by 12/1/16. Licensed Social Worker has signed up for updates via email from the MDH Resident Rights for LTC website link to ensure that she will have the most current version available for the admission packets and to update all current residents with future releases of the Combined Federal and	

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F 156	Continued From page 6	F 156	State Bill of Rights. (CORRECTED ON 10/28/16) CORRECTIVE ACTION MONITORED BY: A QAPI is developed (COMPLETED 11/23/16) to ensure the most current copy of the Combined Federal and State Bill of Rights is posted in a visible location (on the Resident Notices Board), and is kept current in the Admission packet. ONGOING MONITORING OF continued placement of policy on board and in packet will be completed by the DON and/or Director of Senior Services on a daily and monthly basis.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment 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	F 279		12/7/16

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F 279	Continued From page 7 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan interventions related to the use and monitoring of side effects of Plavix (a platelet inhibitor used to prevent blood clots) for 1 of 2 residents (R17) reviewed for non-pressure related skin concerns. Findings include: R17's Face Sheet indicated R17 was diagnosed with heart disease and history of a stroke. R17's quarterly Minimum Data Set (MDS) dated 10/11/16 indicated R17 had no cognitive impairment, required supervision from staff for transfers, walking and dressing, and was independent with toileting, hygiene and repositioning in bed. R17's physician orders indicated R17 received Plavix (medications that inhibits blood clots) 75 milligrams (mg) one time of day related to transient cerebral ischemic attack (stroke). R17's current care plan failed to address R17's use of Plavix and to monitor for possible adverse reactions such as bleeding, bruising and thrombotic thrombocytopenic purpura (rare blood disorder characterized by clotting in small blood vessels).	F 279	CORRECTIVE ACTION: R17's care plan was immediately updated on (CORRECTED ON 10/28/16); TO INCLUDE geri- sleeves, senile purpura, frail skin and signs and symptoms to monitor for as a side effect of the ongoing use of Plavix. (See attachment C- R17's corrected care plan). New policy was written (CORRECTED ON 11/01/16) to reflect that interventions, side effects and proper diagnoses are included on the care plan. (Policy Title: Long Term Care Resident Plan of Care (see attachment D). Staff education was immediately completed as to the new policy noted above (attachment D) with MDS Coordinator as she manages care plans (CORRECTED ON 10/28/16). R17's care plan was updated to address bruises (CORRECTED 10/28/16) R17's bruises are monitored weekly by the IDT and the Infection Prevention/Skin Nurse. (CORRECTED 10/28/16) Documentation is located in the newly created Infection Preventionist/Skin Nurse note in PCC (See Attachment F for new form created). (CORRECTED 10/28/16)	

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F 279	Continued From page 8 R17's progress note dated 10/13/16, at 9:43 a.m. authored by the MDS nurse reported R17's skin was dry and thin and R17 was encouraged to use lotion. The note identified bruising on arms which R17 had contributed to bumping into things. R17 was encouraged to wear long sleeves for protection. The note indicated the care plan would be updated. The progress note did not include extent or stages of healing of the bruising and it was not evident the care plan was revised to include the interventions for the dry skin or the use of long sleeves to aide in protection against bruising. R17's quarterly review progress note authored by the MDS nurse dated 10/25/16, at 9:41 a.m. informed R17's skin was dry but intact with bruising. The progress note did not include location, extent, or stages of healing of bruising and did not indicate a plan of care for the dry skin or the bruising. On 10/25/16, at 11:18 a.m. R17 was observed to wear a three-quarter length sleeve shirt with arms visible to elbows. R17 was noted to have bilateral upper extremity profuse bruising at different stages of healing. The bruises were also noted to range in sizes from dime size to lemon size. R17's skin was also thin and frail in appearance. R17 stated her skin was thin and bruised easily and R17 did not know if on medications that increased risk for bruising, and did not know why she bruised easily. On 10/26/16, at 9:26 a.m. registered nurse (RN)-A stated she missed the increased risk for bruising and skin injury related to the Plavix medication and should have added it to the care plan. RN-A indicated the interventions that should	F 279	New policy was written (CORRECTED 11/01/16) to include proper monitoring and documentation of bruising. Policy Title: Long Term Care Skin Breakdown Prevention Program (See attachment E). Mandatory Staff education (Licensed and Unlicensed personnel) will be completed on 12/07/16) and will include education of new policies (Attachment D, E) All residents Care Plans were reviewed and found to be compliant by the MDS Coordinator and Infection Preventionist/Skin Nurse to ensure compliance with new policy and procedure regarding skin documentation and Care plan requirements (as noted in policies attached (Attachments D, E). (CORRECTED 11/21/16). RECURRENCES WILL BE PREVENTED BY: Ongoing monthly audits for compliance of care plans and skin documentation will be completed by the DON and/or designee on an ongoing basis. QAPI is created by the DON (CORRECTED 11/23/16)to monitor for ongoing compliance on the care plan to include side effects, interventions for skin bruising/frailty/anti-coagulant documentation (including side effects) as per policy noted above and attached. DON or designee will perform the ongoing monthly audits for compliance.	

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F 279	Continued From page 9 have been added to the care plan included wearing long sleeved shirts or sleeve protectors and encourage her to lotion every night. On 10/27/16, at 9:51 a.m. RN-E stated if a resident was on a blood thinning medication it should be in the care plan. On 10/27/16, at 1:31 p.m. the director of nursing (DON) stated blood thinning medication use should be in the care plan and progress notes should include wound demographics which would include location, size, and color. The DON reviewed R17's documentation of the bruises and indicated the identification and the documentation of the bruising was insufficient. The DON stated if there was a problem with extensive bruising the physician should be notified. No policy regarding the development of the care plan was provided	F 279	QAPI noted above will include ongoing compliance monitoring for proper skin documentation per policy noted and attached. DON or designee will perform monthly audits.	
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	F 280		12/7/16

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F 280	Continued From page 10 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 a care plan to include speech therapy recommendations related to safe eating practices for 1 of 3 residents (R38) who had difficulty swallowing and had speech therapy recommendations not identified on the care plan. Findings included: R38's undated Face Sheet indicated R38 had diagnoses which included Parkinson's and chronic obstructive pulmonary disease. R38's significant change Minimum Data Set (MDS) dated 8/3/16, indicated R38 had difficulty swallowing, and had loss of liquids/solids from mouth with eating and drinking and also coughed or choked during meals or when swallowing medications. This was a change since the last MDS dated 6/21/16, which reflected no swallowing difficulty. R38's nutrition Care Area Assessment (CAA) dated 8/4/16 indicated R38 had a swallowing problem and required a mechanically altered diet. The CAA further indicated R38 required supervision with an overall goal objective to avoid complications.	F 280	CORRECTIVE ACTION: DON immediately (corrected 10/26/16) the diet order in the EHR, updated the diet order in the care plan (Attachment G) and pocket care plan (Attachment H), notified dietary and the physician. DON immediately (corrected 10/26/16) educated all licensed and unlicensed staff of the correct diet order: mechanical soft with thin liquids. R38's care plan was updated immediately (corrected on 10/26/16) within the dietary section to reflect the mechanical soft with thin liquids diet order, supervision while eating requirement, and risk for choking. R38's care plan was updated once again (corrected on 11/23/16) to include a new category/problem in a separate section titled, "Risk for choking". This will ensure that nursing will be flagged in the EHR regarding the risk for choking. (Attachment G). ALL resident records have been reviewed for proper diet order by the DON	

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F 280	Continued From page 11 R38's swallowing assessment dated 8/2/16, indicated R38 had been showing an increased risk of choking while eating and should be supervised when eating. R38 chewed food well but did not take small bites. R38's speech therapy note dated 10/13/15, revealed recommendations for R38's safe swallowing which consisted of R38 to sit up straight at 90 degrees when eating, to sit up for 30 minutes following meal, group supervision during meal, monitor lung sounds after meal, and consider providing Sinemet (Parkinson's medication which assists with motor control) one hour before meals. On 10/13/16, the speech therapist had also recommended a mechanical soft diet with nectar thickened liquids, however, on 11/2/15, the recommendation for thickened liquids had changed to thin liquid per patient request. R38's physician orders revealed a diet order dated 10/15/15, which read R38 was to have a low fat, mechanical soft textured diet with nectar consistency liquids. Physician's orders were inconsistent with speech therapy recommendations. R38's care plan lacked revision of all speech therapist interventions except for the therapeutic diet type and consistency. The nursing assistant care guide provided by the facility on 10/25/16, indicated R38 required nectar thickened liquids but did not reflect the speech therapist recommendations. The care plan further lacked revision to include increased risk for choking based off the 8/2/16, assessment.	F 280	(corrected by 12/01/16). DON met with Speech therapy on (11/01/16)to develop new process and policies for referrals, orders and recommendations. See policy titled, "Speech Therapy Evaluation for LTC" (Attachment I).(CORRECTED 11/01/16). DON created new a new policy titled, "LTC Physician Order Communication"(Attachment J)to ensure compliance with order processing is completed by the licensed nursing staff. (CORRECTED ON 11/20/16) Mandatory education will be provided by the DON on 12/07/16 and will include all Licensed nursing staff and will cover new policies noted above (Attachments G, I, J) RECURRENCES WILL BE PREVENTED BY: QAPI was created by DON (CORRECTED on 11/01/16) to monitor speech therapy orders. Monitoring by DON will be monthly. QAPI will be created by DON (CORRECTED on 11/23/16) to monitor compliance with order processing per policy. Monitoring will be performed by DON on a monthly basis.	

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F 280	Continued From page 12 On 10/27/16, at 10:30 a.m. speech language pathologist (SLP) indicated recommended interventions were expected to be added to the nursing care plan. SLP indicated there was a communication flaw between departments. On 10/27/16, at 12:15 p.m. certified dietary manager (CDM) indicated the speech therapy recommendations should have been added to the care plan by either nursing or dietary. CDM confirmed a communication flaw between speech therapy, nursing, and dietary departments existed. On 10/27/16, at 1:23 p.m. the director of nursing (DON) explained the care plan should be updated with assessed interventions and recommendations and explained the identified communication flaws would be resolved. Facility policy Resident Plan of Care last revised 10/5/16 indicated the care plan would be developed and maintained by the MDS coordinator and the nursing team, the care plan would aid in preventing or reducing declines in the resident's functional status and/or functional levels. The policy informed and directed staff assessment of residents were ongoing and care plans and pocket care plans were revised as information about the resident and the resident's condition arose.	F 280		
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.	F 282		12/7/16

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure timely repositioning and bowel incontinence care were provided as directed by the care plan for 1 of 3 residents (R26) reviewed who were dependent on staff for repositioning and incontinence care.

Findings include:

R26's Care Plan dated 10/13/16, indicated R26 had functional incontinence related to progressive dementia and directed staff to check and change R26 every two hours. The care plan also indicated R26 was at moderate risk for pressure ulcers and skin issues due to immobility and incontinence. The Care Plan directed staff to provide skin care with light layer of barrier cream after each incontinent episode and to check R26's skin during weekly bath.

The nursing assistant (NA) pocket care plan dated 10/25/16, directed staff R26 required a scheduled repositioning plan every two hours.

On 10/26/16, from 7:02 a.m. until 10:16 a.m. R26 was continuously observed.

-7:02 a.m. nursing assistant (NA)-A and NA-B transferred R26 into a wheelchair and wheeled R26 to the common area in front of the television.
-At 7:40 a.m. R26 was wheeled into the dining room.
-At 8:36 a.m. NA-A wheeled R26 to the common

CORRECTIVE ACTION:

R26'S Care plan and pocket care plan were reviewed by the DON and found to be accurate for toileting and repositioning every 2 hours(CORRECTED 10/27/16).

DON provided immediate re-education of individualized care plan for R26 to all caregivers in Aspen (CORRECTED 10/27/16). Staff will provide toileting and repositioning every 2 hours.

DON created a new policy titled, "LTC Bowel and Bladder Program" (Attachment K) to ensure compliance with individualized resident needs for toileting and repositioning. (CORRECTED 11/01/16).

DON educated Licensed nursing immediately (CORRECTED 10/27/16) to monitor toileting and repositioning throughout their shift by documenting toileting in their electronic health record for individual residents.

All other residents within Aspen are being audited for compliance with their individual toileting and repositioning plans by the DON or designee on an ongoing basis.

Mandatory staff meeting for education on new policy (attachment K) and expectations including auditing process

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F 282	Continued From page 14 area and placed her back in front of the television where she remained until 10:16 a.m. -At 10:11 a.m. NA-B stated R26 should be repositioned and checked and changed every two hours. NA-B indicated R26 was last repositioned/checked and changed when she was assisted up at 7:00 a.m. -At 10:16 a.m. NA-B wheeled R26 to her room. NA-A entered the room with a mechanical lift. Registered nurse (RN)-B entered R26's room and donned gloves. After donning gloves, both NA-A and NA-B proceeded to transfer R26 into bed. NA-B removed and discarded gloves and left the room. RN-B and NA-A opened R26's incontinent brief. NA-A stated R26 was dry, but incontinent of stool. NA-A proceeded to cleanse R26. Upon completion of the cares, both NA-A and RN-B removed their gloves and washed their hands appropriately. NA-A stated R26 should be repositioned, checked and changed every two hours and confirmed this was not provided as directed, and confirmed R26 went a total of three hours and 15 minutes without being repositioning or incontinent product checked or changed. On 10/27/2016, at 11:11 a.m. the director of nursing (DON) confirmed R26 should be repositioned, checked and changed for incontinence every two hours. The DON verified she expected staff to follow the resident care plan and R26 should have been repositioned, checked and changed every two hours as directed by care plan. No policy related to implementation of the care plan was provided.	F 282	(observational and record/documentation review) will be held on (CORRECTED on 12/07/16). RECURRENCES WILL BE PREVENTED BY: QAPI is created by DON on (CORRECTED 11/23/16)which will measure compliance with individualized toileting and repositioning plans for all residents within LTC through observational and record review audits as noted below on 5 residents per week x 4 weeks, per unit, and per shift. At the end of the 4 week period of time DON will review the audits noted above for overall compliance and will determine further frequency needs for audits. Ongoing monitoring through observational and record review audits will be performed by DON or designee as per QAPI on five residents per shift, per unit on a weekly basis to measure compliance with toileting and repositioning. At the end of the 4 week period of time DON will review the audits for overall compliance and will determine further frequency needs for audits and or additional interventions.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		12/7/16

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F 309	Continued From page 15 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive skin assessment was completed related to identified upper extremity bruising for 1 of 2 residents (R17) reviewed for non pressure related skin concerns and observed to have profuse upper extremity bruising. findings include: R17's Face Sheet indicated R17 was diagnosed with heart disease and history of a stroke . R17's quarterly Minimum Data Set (MDS) dated 10/11/16 indicated R17 had no cognitive impairment, required supervision from staff for transfers, walking and dressing, and was independent with toileting, hygiene and repositioning in bed. R17's physician orders indicated R17 received Plavix (medications that inhibits blood clots) 75 milligrams (mg) one time of day related to cerebral ischemic attack (stroke).	F 309	CORRECTIVE ACTION: R17's care plan was immediately updated on (CORRECTED ON 10/28/16); TO INCLUDE geri- sleeves, senile purpura, frail skin and signs and symptoms to monitor for as a side effect of the ongoing use of Plavix. (See attachment C- R17's corrected care plan). New policy was written (CORRECTED ON 11/01/16) to reflect that interventions, side effects and proper diagnoses are included on the care plan. (Policy Title: Long Term Care Resident Plan of Care (see attachment D). Staff education was immediately completed as to the new policy noted above (attachment D) with MDS Coordinator as she manages care plans (CORRECTED ON 10/28/16). R17's care plan was updated to address bruises (CORRECTED 10/28/16) R17's bruises are monitored weekly by the IDT and the Infection Prevention/Skin	

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F 309	Continued From page 16 R17's current care plan informed staff of R17's goal revised on 10/12/16, which indicated R17 was to have intact skin, free of redness, blisters or discoloration. Interventions included complete a skin check weekly before or after bath/shower and change positions frequently with a start date of 7/13/16. The care plan failed to address R17's risk for bruising related to Plavix use and frail skin. R17's skin check evaluations dated 10/10/16, 10/20/16, and on 10/26/16 did not identify any skin conditions or concerns. R17's progress note dated 10/13/16, at 9:43 a.m. authored by the MDS nurse reported R17's skin was dry and thin and R17 was encouraged to use lotion. The note identified bruising on arms which R17 had contributed to bumping into things. R17 was encouraged to wear long sleeves for protection. The note indicated the care plan would be updated. The progress note did not include extent or stages of healing of the bruising and it was not evident the care plan was revised to include the interventions for the dry skin or the use of long sleeves to aide in protection against bruising. R17's quarterly review progress note authored by the MDS nurse dated 10/25/16, at 9:41 a.m. informed R17's skin was dry but intact with bruising. The progress note did not include location, extent, or stages of healing of bruising and did not indicate a plan of care for the dry skin or the bruising. R17's record lacked documentation of ongoing monitoring, identification, and assessment/evaluation of existing or new	F 309	Nurse. (CORRECTED 10/28/16) Documentation is located in the newly created Infection Preventionist/Skin Nurse note in PCC (See Attachment F for new form created). (CORRECTED 10/28/16) New policy was written (CORRECTED 11/01/16) to include proper monitoring and documentation of bruising. Policy Title: Long Term Care Skin Breakdown Prevention Program (See attachment E). Mandatory Staff education (Licensed and Unlicensed personnel) will be completed on 12/07/16) and will include education of new policies (Attachment D, E) All residents Care Plans were reviewed and found to be compliant by the MDS Coordinator and Infection Preventionist/Skin Nurse to ensure compliance with new policy and procedure regarding skin documentation and Care plan requirements (as noted in policies attached (Attachments D, E). (CORRECTED 11/21/16). DON created a new policy in regards to pressure ulcers titled, "Long Term Care Skin Breakdown Prevention Program" (See attachment E). This policy covers how licensed personnel will assess, document and solve pressure ulcers or skin impairments. RECURRENCES WILL BE PREVENTED BY:	

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F 309	Continued From page 17 bruising. Progress notes were requested and not received by the facility. On 10/25/16, at 11:18 a.m. R17 was observed to wear a three-quarter length sleeve shirt with arms visible to elbows. R17 was noted to have bilateral upper extremity profuse bruising at different stages of healing. The bruises were also noted to range in sizes from dime size to lemon size. R17's skin was also thin and frail in appearance. R17 stated her skin was thin and bruised easily and R17 did not know if on medications that increased risk for bruising, and did not know why she bruised easily. On 10/26/16, at 9:26 a.m. registered nurse (RN)-A reported the information used to complete the MDS was gathered from progress notes and did not physically assess R17's skin. RN-A stated she missed the increased risk for bruising and skin injury related to the Plavix medication and should have added it to the care plan. RN-A indicated the interventions that should have been added to the care plan included wearing long sleeved shirts or sleeve protectors and encourage her to lotion every night. On 10/27/16, at 9:51 a.m. RN-E stated skin was evaluated at a very minimum on bath days and nursing assistants (NAs) also looked at skin daily with cares. RN-E explained if there were any issues, the NAs were directed to report to a nurse. RN-E stated documentation should be descriptive and every shift the bruises should be monitored until they are gone. RN-E stated if a resident was on a blood thinning medication it should be in the care plan. RN-E then looked at	F 309	Ongoing weekly audits for compliance of care plans and skin documentation will be completed by the DON and/or designee on an ongoing basis. QAPI is created by the DON (CORRECTED 11/23/16)to monitor weekly for ongoing compliance on the care plan to include side effects, interventions for skin bruising/frailty/anti-coagulant documentation (including side effects) as per policy noted above and attached. DON or designee will perform the ongoing weekly audits for compliance. QAPI noted above will include ongoing weekly compliance monitoring for proper skin documentation per policy noted and attached. DON or designee will perform weekly skin viewing audits and documentation in record and on care plan.	

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F 309	Continued From page 18 the bruises on R17's arms and asked if the documentation from the progress notes was sufficient, RN-E reported the documentation was not sufficient and should include size and locations of the bruises so they could have been monitored. On 10/27/16, at 1:31 p.m. the director of nursing (DON) indicated acknowledgement of a system issue with skin monitoring and indicated the process was going to be a part of risk management. The DON stated skin condition should have been monitored and documented at minimum once daily but ideally every shift and assessed weekly. The DON stated blood thinning medication use should be in the care plan and progress notes should include wound demographics which would include location, size, and color. The DON reviewed R17's documentation of the bruises and indicated the identification and the documentation of the bruising was insufficient. The DON stated if there was a problem with extensive bruising the physician should be notified. Facility policy on non-pressure related skin injuries was requested and not received.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		12/7/16

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F 312	Continued From page 19	F 312		

by:
Based on observation, interview and document review, the facility failed to provide timely incontinence care for 1 of 1 resident (R26) who was incontinent and dependent upon staff for bowel incontinence care.

Findings include:

R26's annual Minimum Data Set (MDS) dated 10/9/16, indicated R26 had severe cognitive impairment and diagnoses which included Alzheimer's disease, hypertension and atria fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow). The MDS also indicated R26 required extensive assist of two people for bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS further indicated R26 was always incontinent of bowel and bladder.

R26's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/7/16, indicated R26 had functional incontinence (could not get to toilet in tame due to physical disability, external obstacles, or problems thinking or communicating). The CAA indicated incontinence would be addressed in the care plan to avoid skin issues and to minimize the risk of dignity issues.

R26's Bowel and Bladder assessment dated 10/5/16, indicated R26 had advanced dementia with the inability to tell staff when needed to defecate. The assessment indicated bowel/bladder functioning interventions would

CORRECTIVE ACTION:

R26'S Care plan and pocket care plan were reviewed by the DON and found to be accurate for toileting and repositioning every 2 hours(CORRECTED 10/27/16).

DON provided immediate re-education of individualized care plan for R26 to all caregivers in Aspen (CORRECTED 10/27/16). Staff will provide toileting and repositioning every 2 hours.

DON created a new policy titled, "LTC Bowel and Bladder Program" (Attachment K) to ensure compliance with individualized resident needs for toileting and repositioning. (CORRECTED 11/01/16).

DON educated Licensed nursing immediately (CORRECTED 10/27/16) to monitor toileting and repositioning throughout their shift through observational audits and by reviewing the documentation completed on toileting in their electronic health record for individual residents.

All other residents within Aspen are being audited (through observation and record review) for compliance with their individual toileting and repositioning plans by the DON or designee on an ongoing basis.

Mandatory staff meeting for education on new policy (attachment K) and expectations including auditing process

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F 312	Continued From page 20 include a dignity program (incontinent product used and checked/changed on appropriate schedule). R26's Care Plan dated 10/13/16, indicated R26 had functional incontinence related to progressive dementia and directed staff to check and change R26 every two hours. On 10/26/16, from 7:02 a.m. until 10:16 a.m. R26 was continuously observed. -7:02 a.m. nursing assistant (NA)-A and NA-B transferred R26 into a wheelchair and wheeled R26 to the common area in front of the television. -At 7:40 a.m. R26 was wheeled into the dining room. -At 8:36 a.m. NA-A wheeled R26 to the common area and placed her back in front of the television where she remained until 10:16 a.m. -At 10:11 a.m. NA-B stated R26 should have incontinent product checked and changed every two hours. NA-B indicated R26 was last checked and changed when she was assisted up at 7:00 a.m. -At 10:16 a.m. NA-B wheeled R26 to her room. NA-A entered the room with a mechanical lift. Registered nurse (RN)-B entered R26's room and donned gloves. After donning gloves, both NA-A and NA-B proceeded to transfer R26 into bed. NA-B removed and discarded gloves and left the room. RN-B and NA-A opened R26's incontinent brief. NA-A stated R26 was dry, but incontinent of stool. NA-A proceeded to cleanse R26. Upon completion of the cares, both NA-A and RN-B removed their gloves and washed their hands	F 312	(observational and record review) will be held on (CORRECTED on 12/07/16). RECURRENCES WILL BE PREVENTED BY: QAPI is created by DON on (CORRECTED 11/23/16)which will measure compliance with individualized toileting and repositioning plans for all residents within LTC. Ongoing monitoring will be performed by DON or designee as per QAPI (through observational and record review audits) on 5 residents in Tamarack and Aspen on a weekly basis to measure compliance with toileting and repositioning x 4 weeks. A Re-evaluation on the compliance will be completed by the DON at the end of the initial 4 week period of time. AT this time the DON will determine the frequency of ongoing audits and determine any additional interventions or education as per the results of the audits. Designee who is put in place by DON will perform the pm and noc shift audits (observational and record review) on 5 residents in Tamarack and Aspen on a weekly basis x 4 weeks. Then the DON will re-evaluate the compliance and develop a new QAPI plan based on the results.	

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F 312	Continued From page 21 appropriately. NA-A stated R26 should be checked and changed every two hours and confirmed this was not provided as directed, as R26 went a total of three hours and 15 minutes without having incontinent product checked or changed. On 10/27/16, at 11:11 a.m. the director of nursing (DON) confirmed R26 should have incontinent product checked for incontinence and changed every two hours. The DON verified she expected staff to follow the resident care plan as directed. No policy related to bowel incontinence was provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was provided for 1 of 2 residents (R26) who was as risk for developing a pressure ulcer and required every two hour repositioning	F 314	CORRECTIVE ACTION: R26'S Care plan and pocket care plan were reviewed by the DON and found to be accurate for repositioning every 2	12/7/16

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F 314	Continued From page 22 assistance. Findings include: R26's annual Minimum Data Set (MDS) dated 10/9/16, indicated R26 had severe cognitive impairment and diagnoses which included Alzheimer's disease, hypertension and atrial fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow). The MDS also indicated R26 required extensive assist of two people for bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS further indicated R26 was at risk for the development of pressure ulcers. R26's Pressure Ulcer Care Area Assessment (CAA) dated 10/10/16, indicated R26 was at risk for pressure ulcers due to incontinence and immobility. The CAA also indicated R26 was immobile and was able to make simple positions changes but was not able to stand and relieve pressure adequately. R26's Braden Scale for predicting pressure sore risk dated 10/5/16, indicated R26 at risk for pressure related sores. R26's Care Plan dated 10/13/16, indicated R26 was at moderate risk for pressure ulcers and skin issues due to immobility and incontinence. The plan directed staff to provide skin care with light layer of barrier cream after each incontinent episode and to check R26's skin during weekly bath.	F 314	hours(CORRECTED 10/27/16). DON provided immediate re-education of individualized care plan for R26 to all caregivers in Aspen (CORRECTED 10/27/16). Staff will provide toileting and repositioning every 2 hours. DON created a new policy titled, "LTC Bowel and Bladder Program" (Attachment K) to ensure compliance with individualized resident needs for repositioning. (CORRECTED 11/01/16). DON created a new policy titled, "LTC Skin Breakdown Prevention" (Attachment E)to address individualized repositioning schedules in regards to skin protection and pressure prevention. DON educated Licensed nursing immediately (CORRECTED 10/27/16) to monitor repositioning throughout their shift through observational audits and by reviewing documentation on repositioning in their electronic health record for individual residents. All other residents within Aspen are being audited through observation and documentation in records as follows: 5 audits per unit, per shift x 4 weeks for compliance with their individual repositioning plans by the DON or designee. Mandatory staff meeting for education on new policy (attachment K, E) and expectations including auditing process	

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F 314	Continued From page 23 The nursing assistant (NA) pocket care plan dated 10/25/16, directed staff R26 required repositioning every two hours. On 10/26/16, from 7:02 a.m. until 10:16 a.m. R26 was continuously observed. -7:02 a.m. NA-A and NA-B transferred R26 into a wheelchair and wheeled R26 to the common area in front of the television. -At 7:40 a.m. R26 was wheeled into the dining room. -At 8:36 a.m. NA-A wheeled R26 to the common area and placed her back in front of the television where she remained until 10:16 a.m. -At 10:11 a.m. NA-B stated R26 should be repositioned every two hours. NA-B indicated R26 was last repositioned when she was assisted up at 7:00 a.m. -At 10:16 a.m. NA-B wheeled R26 to her room. NA-A entered the room with a mechanical lift. Registered nurse (RN)-B entered R26's room and donned gloves. After donning gloves, both NA-A and NA-B proceeded to transfer R26 into bed. NA-B removed and discarded gloves and left the room. RN-B and NA-A opened R26's incontinent brief. NA-A stated R26 was dry, but incontinent of stool. NA-A proceeded to cleanse R26. Upon completion of the cares, both NA-A and RN-B removed their gloves and washed their hands appropriately. NA-A stated R26 should be repositioned every two hours and confirmed this was not provided as directed by the care plan. NA-A confirmed R26 went a total of three hours and 15 minutes without being repositioned.	F 314	(observation and record review) will be held on (CORRECTED on 12/07/16). RECURRENCES WILL BE PREVENTED BY: QAPI is created by DON on (CORRECTED 11/23/16)which will measure compliance with individualized and repositioning plans for all residents within LTC. Ongoing monitoring will be performed by DON or designee as per QAPI on a weekly basis with 5 resident audits (observational and record review) being completed on each shift to measure overall compliance with toileting and repositioning. At the end of 4 weeks of measuring the DON will determine through QAPI the overall compliance with the audits (observational and record review) and will determine a further plan based on the compliance achieved.	

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F 314	Continued From page 24 On 10/27/2016, at 11:11 a.m. the director of nursing (DON) confirmed R26 should have been repositioned every two hours. The DON verified she expected staff to follow the resident care plan and R26 should have been repositioned as directed on care plan. The undated Pressure Ulcer Prevention policy indicated frequent turning, increased mobility if able, restorative program, protection for heels and elbows and pressure support surfaces for bed or chair bound residents would be implemented for Braden scores determined At Risk (score of 15-18). For residents identified at Moderate Risk (score of 13-14) the interventions were identified as same as above and use of body pillows, wedges with orders to provide 30 degree positioning. The policy indicated RN/LPN [registered nurse/licensed practical nurse] would implement pressure ulcer prevention protocols.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 323	CORRECTIVE ACTION:	12/7/16

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F 323	Continued From page 25 facility failed to ensure a formal written safety assessment was completed for 1 of 1 resident (R22) who accessed the community independently with a electric scooter. Findings include: R22's quarterly Minimum Data Set (MDS) dated 7/29/16, indicated R22 had diagnoses which included hemiplegia and aphasia. The MDS indicated R22's short and long term memory were intact but cognitive skills for daily decision making were moderately impaired and R22 required cues/supervision. The MDS also indicated R22 required extensive assist with dressing and toileting, and limited assistance with transfers and personal hygiene. The MDS further indicated R22 was non-ambulatory and used a wheelchair (w/c). R22's undated Care Plan indicated a stroke had taken away some of R22's abilities but he tried to maintain his independence with goals identified as not sustaining injury while outside of the building and not being hampered from leaving the building on his scooter when desired. The Care Plan directed staff to remind R22 to sign out when leaving the building. The Care Plan indicated R22 took a scooter [electric w/c] out in the parking lot or the pavement around the school to make a loop back to the nursing home. (distance approximately ¼ to ½ miles). The Care Plan also directed staff to look for R22 if he was gone more than one hour while on his scooter and to notify his wife when he left the facility.	F 323	R22's care plan was reviewed by the DON immediately on 10/27/16 for prior safety assessment regarding electric scooter. It was found that prior assessment was completed by OT Melissa N. on 8/18/10. It did not include outside of the facility. This has been addressed by DON and OT by creating a new policy titled, "LTC Power Mobility Driving Assessments" (Attachment M)(CORRECTED 11//22/16). The new policy assesses the ability of the resident to safely operate their electric scooter in and outside of the facility. The assessment will be completed by OT upon admission, new use of an electric scooter, annually or has a change warranting a reassessment. IDT will provide input through the wipe board process daily which will provide ongoing monitoring of the use of the electric scooter per individual resident. The DON created an electronic form in the EHR (PCC) that will automatically populate annually to complete a reassessment of the continued use of the electric scooter. (Attachment L). Policy titled, "LTC Rehabilitation Screening" and sample electronic form are provided in attachment L. (CORRECTED on 11/22/16). R22's LTC Power Mobility Driving Assessment will be completed inside the facility by a (CORRECTION date of 12/13/16). Note resident does NOT operate the electric scooter outdoors during the winter months. The assessment for the outdoor use of the	

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F 323	Continued From page 26 On 10/24/16, at 6:45 p.m. during family interview, R22's wife confirmed R22 left the facility grounds at times. R22's occupational therapy (OT) assessment dated 8/10/10, indicated R22 was provided instruction on safe technique and operating instructions for a power wheelchair and indicated R22 was able to navigate the electric w/c in the facility. However, the record lacked documentation of an assessment of R22's safety while independent in the outside environment. On 10/26/16, at 11:55 a.m. nursing assistant (NA)-C stated he worked with R22 and would assist with transferring R22 from his regular wheelchair into his electric w/c. NA-C stated R22 used a walkie talkie when going out of the facility with his electric w/c. NA-C stated R22 usually went on the trail or sometimes went up town. NA-C was not sure if R22 signed out before he would leave the building. On 10/27/16, at 11:30 a.m. the director of nursing (DON) verified R22 was lacking a safety evaluation on his ability to navigate the outdoors safely while using the scooter. The DON stated the facility was going to have R22's safety evaluated, going to call R22's wife and review and revise his care plan. No policy regarding safety assessment for residents who accessed the community independently was provided.	F 323	electric scooter will be completed in the spring prior to resident going outdoors. All other residents whom operate an electric scooter (4 total) will be reassessed by OT Melissa N. utilizing the new assessment form (Attachment M) by 12/07/16.(CORRECTED 12/07/16) REOCCURENCES WILL BE PREVENTED BY: QAPI IS CREATED ON 11/23/16 by the DON in conjunction with the Occupational Therapist to address the current and ongoing compliance with the LTC Power Mobility Driving Assessment(Attachment M) and policy titled, "LTC Rehabilitation Screening" (Attachment L). Audits will be performed by OT on a monthly basis and PRN (as noted below) to determine if further screening or updated screenings are necessary. Daily -OT will determine if further assessment is to be completed based on the information received in the daily stand up meetings. OT will update DON on compliance findings immediately to ensure safety of the residents whom utilize the electric scooters. DON will be updating during daily Stand up meeting with IDT if there are any changes in condition which warrant an immediate reassessment by OT following the policies above.	
F 365	483.35(d)(3) FOOD IN FORM TO MEET	F 365		12/7/16

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F 365 SS=D	Continued From page 27 INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facilty failed to serve the correct therapeutic diet and provide supervision with eating for 1 of 1 resident (R38) who required mechanically altered food and had swallowing difficulties with a risk for choking which required supervision when eating. Findings include: R38's undated Face Sheet indicate R38 was diagnosed with Parkinson ' s and chronic obstructive pulmonary disease. R38's significant change Minimum Data Set (MDS) dated 8/3/16, indicated R38 had severe cognitive impairment and required limited physical assist from staff for eating. The MDS also indicated R38 had difficulty swallowing, had loss of liquids/solids from mouth when eating and drinking and also coughed or choked during meals or when swallowing medications. The was a change from the last MDS dated 6/21/16, which indicated R38 had no swallowing difficulty. R38's Nutritional Care Area Assessment (CAA) dated 8/4/16, indicated R38 had a swallowing problem and required a mechanically altered diet and supervision when eating in order to avoid	F 365	CORRECTIVE ACTION: DON immediately (corrected 10/26/16) the diet order in the EHR, updated the diet order in the care plan (Attachment G) and pocket care plan (Attachment H), notified dietary and the physician. DON immediately (corrected 10/26/16) educated all licensed and unlicensed staff of the correct diet order: mechanical soft with thin liquids. R38's care plan was updated immediately (corrected on 10/26/16) within the dietary section to reflect the mechanical soft with thin liquids diet order, supervision while eating requirement, and risk for choking. R38's care plan was updated once again (corrected on 11/23/16) to include a new category/problem in a separate section titled, "Risk for choking". This will ensure that nursing will be flagged in the EHR regarding the risk for choking. (Attachment G). ALL resident records have been reviewed for proper diet order by the DON (corrected by 12/01/16).	

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F 365	Continued From page 28 complications. R38's Swallowing assessment dated 8/2/16, indicated R38 had been showing an increased risk of choking while eating and should be supervised when eating. The assessment also indicated R38 chewed food well but did not take small bites. R38's speech therapy note dated 10/13/15, revealed recommendations for R38's safe swallowing which indicated R38 should sit up at 90 degrees when eating and remain sitting up for 30 minutes following, group supervision during meal, monitor lungs after eating and consider providing Sinemet (Parkinson's medication which assist with motor control) one hour before the meal. On 10/13/16, the speech therapist had also recommended a mechanical soft diet with nectar thick liquids however, on 11/2/15, the recommendation for thickened liquids was changed to thin liquid per resident request, therefore R38 was to receive regular consistency liquids. R38's physician orders revealed a diet order dated 10/15/15, which read R38 was to have a low fat, mechanical soft textured diet with nectar consistency liquids. Physician's orders were inconsistent with speech therapy recommendations. R38's October 2016, Medication Administration record (MAR) indicated R38 received Sinemet at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m. and 10:p.m. daily. R38's care plan dated 8/5/16, indicated R38 required meal set up and supervision and some	F 365	DON met with Speech therapy on (11/01/16)to develop new process and policies for referrals, orders and recommendations. See policy titled, "Speech Therapy Evaluation for LTC" (Attachment I).(CORRECTED 11/01/16). This policy addresses dysphagia. DON created new a new policy titled, "LTC Physician Order Communication"(Attachment J)to ensure compliance with order processing is completed by the licensed nursing staff. (CORRECTED ON 11/20/16) Mandatory education will be provided by the DON on 12/07/16 and will include all Licensed nursing staff and will cover new policies noted above (Attachments G, I, J) RECURRENCES WILL BE PREVENTED BY: QAPI was created by DON (CORRECTED on 11/01/16) to monitor speech therapy orders. Monitoring by DON will be monthly and as per new orders received to ensure compliance with order processing and notification. QAPI created by DON (CORRECTED on 11/23/16) to monitor compliance with order processing per policy. Monitoring will be performed by DON on a weekly basis. Noc shift nurse is now reviewing all orders received on a daily basis to ensure compliance with proper processing of order for each day.	

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F 365	Continued From page 29 assistance for eating The care plan lacked a revision to include the speech therapist's recommendations except for therapeutic diet type, consistency and assistance needed. The nursing assistant (NA) care guide provided by the facility on 10/25/16, indicated R38 required nectar thick liquids, mechanical soft diet but did not reflect the speech therapists eating recommendations. The care plan further lacked the risk for choking based off the 8/2/16, assessment. A resident dietary serving guide or "cheat sheet" dated 10/5/16, located in the kitchen cabinet and used by dietary staff when preparing/serving meals, indicated R38 was to receive a regular diet and thin liquids. On 10/24/16, at 5:23 p.m. R38 was observed seated at a dining room table with a regular textured meal of chili and French bread and coffee/water of thin consistency. NA-D was seated next to R38 and provided verbal cues to eat/drink. -At 5:26 p.m. R38 took a drink of coffee and started coughing. NA-D asked R38 if she was OK in which R38 responded, yes. NA-D stated sometime R38 coughed when eating/drinking. -At 5:35 p.m. NA-D poured R38 more coffee and walked away from the table. R38 took a drink of the coffee and proceeded to cough twice, the cough was moist. -From 5:35 p.m. until 5:39 p.m. R38 continued to drink the coffee with an occasional need to clear her throat. No nursing staff were present in the dining room. On 10/25/16, at 4:58 p.m., R38 was observed at the dining room table with a glass of regular	F 365	QAPI created on 11/23/16 to ensure that all nursing assistants in conjunction with dietary personnel are trained to monitor the dining room and the residents therein to ensure supervision is provided to those residents whom are individually care planned as a risk for choking. All Dietary personnel whom work in the kitchenettes within the LTC settings and the C.N.A's will receive a mandatory re-education on the signs and symptoms to monitor for in regards to swallowing. In addition the re-education will include the expectation to report those signs immediately to the charge nurse(CORRECTED with all staff during mandatory meeting scheduled on 12/07/16).	

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F 365	Continued From page 30	F 365		

consistency water and orange wedges. A dietary assistant (DA)-A was the only staff member in the dining room. At 5:00 p.m. DA-A served R38 her meal which consisted of a ham steak, potato salad and a tomato slice. DA-A cut up R38's ham which appeared dry. DA-A stated R38 was to receive a regular diet with thin liquids. R38 independently started eating her meal. No other staff members were present in the dining room.
-At 5:15 p.m. NA-E entered the dining room and asked R38 how she was doing.
-At 5: 30 p.m. NA-E exited the dining room leaving no staff present. DA-A stated she could help R38 and proceeded to give R38 a bite of ham. R38 took a drink of water proceeded by a loud, hacking, moist cough. DA-A continued to put food onto R38's fork and provide verbal cues instructing R38 to take bites of food.
-At 5:34 p.m. NA-E entered the dining room and again asked how R38 was. NA-E assist R38 to take more bites of ham.
-At 5:37 p.m. NA-E was asked what type of diet R38 required. NA-E referenced her pocket care guide and stated R38 required a mechanical soft diet with thickened liquids, R38 was at risk for choking and required supervision when eating. NA-E stated the care guides were updated daily by the health unit coordinator. NA-E also stated R38 had been coughing during the meal tonight after taking bites of food but not after drinking. NE-A stated some DA's were able to supervise and assist during meal times because some were certified nursing assistants.
-At 5:42 p.m. DA-A stated she used to be a NA, however was no longer current on the NA registry.

On 10/25/16, at 11:04 a.m. family member (FM)-A stated R38 had swallowing difficulties and a

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pureed diet had been recommended but R38 had not tolerated due to weight loss. FM-A was unaware of what consistency liquid had been recommended and stated it seemed to change frequently as sometimes thickened was served and other times it was regular liquids.

On 10/25/16, at 5:49 p.m. registered nurse (RN)-D stated R38 was on a mechanical soft diet with regular consistency liquids, RN-D did not think R38 needed thickened liquids. RN-D stated R38's diet had been pureed, however, had lost weight therefore it was discontinued.

On 10/27/16, at 10:30 a.m. the speech therapist stated recommended interventions were expected to be added to the care plan and felt there was a communication flaw between departments.

On 10/27/16, at 12:15 p.m. the dietary manager (DM) stated the speech therapy recommendations should have been added to the care plan by either nursing or dietary. The DM stated the care plan guide in the cupboard of the kitchen was not correct related to an error that occurred on their spreadsheet when another resident was removed from it. The DM stated there was a communication problem between speech therapy, nursing and dietary departments.

On 10/27/16, the director of nursing (DON) stated the care plan should be updated with assessed interventions and recommendations and confirmed the communication gap between departments would be resolved. The DON stated if there were increased signs and symptoms of choking the speech therapist should be notified and care planned interventions should be

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F 365	Continued From page 32 implemented. The facility Resident Plan of Care policy last revised 10/5/16 indicated the care plan would be developed and maintained by the MDS coordinator and the nursing team, the care plan would aid in preventing or reducing declines in the resident's functional status and/or functional levels. The policy informed and directed staff assessment of residents were ongoing and care plans and pocket care plans were revised as information about the resident and the resident's condition arose. The facility's Dysphagia policy dated 8/15/11, indicated if a resident had suspected difficulty swallowing, staff would obtain and order for a speech therapy evaluation in which the staff would attempt to follow recommendations by the speech therapists.	F 365		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.	F 373		11/14/16

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F 373	Continued From page 33 A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.	F 373		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure paid feeding assistants had not fed residents with identified swallowing difficulties for 1 of 1 resident (R3) who had identified swallowing difficulty.

Findings include:

Review of R3's Admission Record revealed admission diagnoses that included, but were not limited to: Pick's disease, (a type of frontotemporal dementia, characterized as a rare neurodegenerative disease that causes progressive destruction of nerve cells in the brain. Symptoms include dementia and loss of language.) gastro-esophageal reflux disease, and dementia with behavioral disturbance.

R3's Minimum Data Set (MDS) dated 8/11/16, indicated R3 had memory loss, could not verbally communicate needs, was totally dependant on two persons for mobility, and required full physical assistance of one person to eat. The MDS identified R3 had coughing/ choking during meals and when swallowing medications.

R3 was observed on 10/25/2016, at 5:05 p.m. during the evening meal while his wife assisted him to eat a pureed diet. R3 was noted to have numerous spastic movements with his arms

CORRECTIVE ACTION:

Paid feeding assistants were re-educated verbally IMMEDIATELY as to which residents they could assist with feeding (COMPLETED ON 10/26/16).

Paid feeding assistants were immediately instructed (COMPLETED ON 10/26/16) that they could not assist R3.

R3 has the C.N.A's assisting him with feeding (and spouse when she is present for mealtime). (COMPLETED ON 10/26/16). This was audited for compliance by the DON throughout the remaining days of the Paid Feeding Assistant position.

RECURRENCES WILL BE PREVENTED BY:

Director of Senior Services discontinued the Paid Feeding Assistant role at Bigfork Valley in conjunction with the Administrator. (COMPLETED ON 10/31/16 WITH THE LAST DAY WORKING IN POSITION AS OF 11/14/16)- DUE TO 2 week notice to employees for elimination of Paid Feeding Assistant position.

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raised to mid chest level for extended periods of time and R3 was noted to cough numerous times while swallowing the pureed food. The wife of R3 was interviewed on 10/26/2016, at 11:53 a.m. and verified R3 had swallowing difficulty as a result of Pick's disease and told the facility staff she did not want R3 assessed for swallowing ant further because there was no further interventions available due to R3's degenerative diagnoses.

R3 was observed during the breakfast meal on 10/26/2016, at 8:03:10 a.m. while paid feeding assistant (PFA)-A assisted R3 with eating. R3 was noted to have swallowing difficulty and coughed many times while swallowing. PFA-A was interviewed during this time and stated that she had completed a course that taught skills for assisting residents to eat in April 2015, and was able assist R3 during meals and knew R3 had difficulty swallowing.

R3's most recent swallowing evaluation completed on 11/17/15, identified R3 at a low risk for choking and may be fed by a paid feeding assistant. The assessment had not identified R3 had difficulty chewing food or swallowing.

R3's undated care plan indicated R3 was served a regular diet with puree texture and thickened liquids. R3 liked mashed potatoes and gravy. R3's wife was very involved in cares, R3 sat in a wheelchair at meal time, used a cover up and R3's family fed R3 favorite foods with regular textures. R3's wife had requested no swallowing evaluations to be done. Please let the natural progression of the disease take its course.

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R3's Health Status Note Text dated 10/17/15, indicated at approximately 12:10 p.m. R3 started to cough and shake after lunch. He had seven episodes lasting 30 seconds or less within a 20 minute time frame. R3 had had slight wheezing inspiratory in his left upper lobe. After coughing and wheezing gone, R3 was able to relax. R3 laid down, Vital signs and oxygen level checked. Laid elder down in bed, changed and cleaned him up - slept most of afternoon." No further episodes were documented in R3's medical record.

On 10/26/2016, at 2:20 nursing assistant (NA)-H established she worked the evening shift and R3 had swallowing difficulty and coughed during most meals and it used to scare her but NA-H has gotten used to R3 coughing while eating.

Registered Nurse (RN)-F who was assigned to R3's care on 10/26/16, was interviewed at 12:26 p.m. and stated she had been a consistent care provider to R3 since October 2015, and reported R3 had swallowing difficulty and coughing spells since October 2015 when RN-F had been responsible for R3's care.
The facility policy for PAID FEEDING ASSISTANTS dated 5/7/15, indicated PFA's will not feed residents with complex feeding problems (i.e., dysphagia, history of aspiration, enteral/parenteral feedings) or other residents precluded by the RN, RD, or Speech and Language Pathologist.
The director of nursing (DON) was interviewed on 10/26/16, at 12:26 p.m. confirmed R3 had swallowing difficulties and when R3's wife refused further swallowing evaluations after 11/17/15, R3 should not have continued to be assisted with eating by a paid feeding assistant because there

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F 373	Continued From page 37 was no formal assessment to determine R3's ability to swallow.	F 373		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Bigfork Valley Communities Nursing Home 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/23/2016

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

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K 000	Continued From page 1 St. Paul, MN 55101-5145, OR Or by email to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bigfork Valley Communities Nursing Home was built in three stages. The original building was constructed in 1972 and is a 1-story building without a basement of Type II (111) construction. In 1985 a 1-story addition was constructed to the north of the original building and was determined to be Type II (111) construction. In 1999, a 1-story addition with a basement was constructed off the east wing of the original building and was determined to be type II (000) construction. 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	K 000		

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K 000	Continued From page 2 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 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 47 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current fire evacuation policy in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.2.2. This deficient practice could affect 44 of 44 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 3:00 p.m.	K 048	CORRECTIVE ACTION: Plant Operations Director and Emergency Preparedness Director updated the Fire Policy/Evacuation Policy specific to long term care/nursing home and Facility wide policy to include manual dialing of 911 in the event of a fire (See attachment A, B). (CORRECTED 11/22/16). All staff will be re-educated in a mandatory inservice scheduled for	11/22/16

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K 048	Continued From page 3 on 10/26/2016, during the documentation review it was revealed that the facility's Fire Emergency Evacuation Plan did not address all eight element outlined in the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.7.2.2. The element that was not provided in the plan presented at the time of the inspection was, transmission of the fire alarm to the fire department. This deficient condition was verified by the Maintenance Supervisor.	K 048	12-13-16. All emergency preparedness binders located on the nursing stations of the nursing home have up to date policies as of 11-22-16. RECURRENCE WILL BE PREVENTED BY: Emergency preparedness Director was educated as to all of the Life Safety Codes in LTC. (Corrected 11/01/16).	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 1 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2, during the last 12-month period. This deficient practice could affect 44 of 44 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 050	CORRECTIVE ACTION: Plant Services Director immediately re-educated maintenance staff to perform the fire drills as per life safety code - at least quarterly on each shift (CORRECTED 10/26/16). RECURRENCES WILL BE PREVENTED BY:	10/26/16

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K 050	Continued From page 4 On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility did not conducted the overnight fire drill in the second calendar quarter. This deficient condition was verified by the Maintenance Supervisor.	K 050	The Director of Plant Operations will schedule the fire drill with maintenance staff, fill out the log form for drills then check IMMEDIATELY to verify the drill took place and that the log is filled out appropriately. (CORRECTED 10/26/16)	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 44 of 44 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, during a review of all available fire	K 052	CORRECTIVE ACTION: The Director of Plant Operations re-educated the Maintenance staff who perform the digital alarm communicator transmitter testing monthly that documentation of said testing must be completed accurately and timely to comply with Life Safety Code. (CORRECTED 10/28/16). RECURRENCE WILL BE PREVENTED BY: The Director of Plant Operations will partake in a QAPI (QUALITY ASSURANCE PERFORMANCE IMPROVEMENT) -(CORRECTED	10/28/16

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K 052	Continued From page 5 alarm maintenance/testing documentation for the last 12 months and an interview with the Administrator, it was revealed that the facility failed to document and/or verify 3 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by the Maintenance Supervisor.	K 052	11/23/16) to ensure compliance is achieved on a monthly basis. Director will perform audits on the log sheet for documenting the DACT.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility is cooking food items that produces grease-laden vapors in 3 of 3 neighborhood kitchen open to the dining rooms without the proper exhaust hood equipment and extinguishing system in accordance with NFPA 101(00), Sections 9.2.3, 19.3.2.6 and NFPA 96(98) 1-3.1. This deficient practice could affect 44 of 44 residents, as well as an undetermined number of staff, and visitors Findings Include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, it was observed that there are 3 neighborhood kitchens that are open to the dining rooms located within the facility. it was also observed that the stoves are accessible to the residents. During the facility tour a resident was found unattended in one of the neighborhood kitchens and the stove was still energized from the power shutoff to the controls located on the stoves. The neighborhood kitchens are equipped with a lockable power shutoff but according to a	K 069	CORRECTIVE ACTION: Dietary Manager and Director of Senior Services re-educated all Cooks that the proper procedure must be followed when leaving the neighborhood kitchens: All stoves must be shut down via the power shutoff and the key must be removed from the shutoff each time the kitchen is left unattended. (CORRECTED 10/26/16). RECURRENCE WILL BE PREVENTED BY: A QAPI (QUALITY ASSURANCE PERFORMANCE IMPROVEMENT)was initiated by the Director of Senior Services on 10/27/16. Audits in alternating kitchens will be performed by the Director of Senior Services/Dietary Manager or designee 5 times per week until compliance is met. Once compliance is met audits will continue on a regular basis to ensure stoves are "shut off with key removed" when unattended by Cooks. (Corrected	10/26/16

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 _____	**10/26/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069	Continued From page 6 kitchen staff member the lockable power shutoffs "are not turned off when the stoves are unattended". Upon closer investigation it was determined that there is still power flowing to the controls that are located on the stoves, and the stoves and griddle tops were unattended while they were still extremely hot. This deficient condition was verified by a Maintenance Supervisor.	K 069	10/26/16) with ongoing audits in place. Education will be provided to all new dietary and annual employees via the Dietary Manager regarding the process noted above.	
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 44 of 44 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler	K 154	CORRECTIVE ACTION: The Plant Operations Director immediately wrote a new policy titled, "Fire Protection System out of Service (see ATTACHMENT C); with the "Fire Watch Log sheet" attached to policy(see ATTACHMENT D). All language contained is based on K154. (CORRECTED ON 11/17/16). The Plant Operations Director immediately educated all Maintenance personnel who perform duties listed in the Fire Protection System out of Service policy (CORRECTED ON 11/17/16). RECURRENCES WILL BE PREVENTED BY:	11/17/16

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 _____	**10/26/2016**

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K 154	Continued From page 7 system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated. This deficient condition was verified by the Maintenance Supervisor.	K 154	All Maintenance personnel will receive new hire and annual education per the Director of Plant Operations regarding the Fire Protection system out of service policy going forward.	
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 44 of 44 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service	K 155	CORRECTIVE ACTION: The Plant Operations Director immediately wrote a new policy titled, "Fire Protection System out of Service (see ATTACHMENT C); with the "Fire Watch Log sheet" attached to policy(see ATTACHMENT D). All language contained is based on K155. (CORRECTED ON 11/17/16). The Plant Operations Director immediately educated all Maintenance personnel who perform duties listed in the Fire Protection System out of Service policy (CORRECTED ON 11/17/16). RECURRENCES WILL BE PREVENTED BY: All Maintenance personnel will receive new hire and annual education per the	11/17/16

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	245529	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/26/2016**

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K 155	Continued From page 8 and the need for a fire watch to be initiated This deficient condition was verified by the Maintenance Supervisor.	K 155	Director of Plant Operations regarding the Fire Protection system out of service policy going forward.	

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

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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 **03 - ASPEN CIRCLE** B. WING _____	**10/26/2016**

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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 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Bigfork Valley Communities/Aspen Circle was found in substantial compliance with the requirements for participation not in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/23/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. BUILDING **03 - ASPEN CIRCLE** B. WING _____	**10/26/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 St. Paul, MN 55101-5145, OR Or by email to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bigfork Valley Communities/Aspen Circle. It is a one story building with no basement. The construction type is determined to be type II(000). The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire doors. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility is licensed for 47 beds, with a census of 44 at the time of inspection.	K 000		

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	245529	A. BUILDING **03 - ASPEN CIRCLE** B. WING _____	**10/26/2016**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a)) is NOT MET.	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA Life Safety Code 101 (2000 edition), section 18.3.6.3.2. This deficient practice could affect 18 of 44 residents, staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, it was observed revealed that resident room 3 located in the Aspen Circle Unit has a corridor door that did not close and latch into the frame. This deficient condition was verified by the Maintenance Supervisor.	K 018	CORRECTIVE ACTION: Plant Operations Director immediately adjusted the door to Rm 3 in Aspen to ensure it would close and latch securely into the frame (CORRECTED 10/27/16). RECURRENCES WILL BE PREVENTED BY: Plant Operations Director and maintenance personnel will perform regular audits on corridor doors to ensure they close and latch securely into the frame.	10/27/16
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 048		11/22/16

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K 048	Continued From page 3 There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current fire evacuation policy in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.7.2.2. This deficient practice could affect 44 of 44 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, during the documentation review it was revealed that the facility's Fire Emergency Evacuation Plan did not address all eight element outlined in the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 18.7.2.2. The element that was not provided in the plan presented at the time of the inspection was, transmission of the fire alarm to the fire department. This deficient condition was verified by the Maintenance Supervisor.	K 048	CORRECTIVE ACTION: Plant Operations Director and Emergency Preparedness Director updated the Fire Policy/Evacuation Policy specific to long term care/nursing home/Aspen Circle and Facility wide policy to include manual dialing of 911 in the event of a fire (See attachment A, B). (CORRECTED 11/22/16). All staff will be re-educated in a mandatory inservice scheduled for 12-13-16. All emergency preparedness binders located on the nursing stations of the nursing home/Aspen Circle have up to date policies (attachment A, B) as of 11-22-16. RECURRENCE WILL BE PREVENTED BY: Emergency preparedness Director was educated as to all of the Life Safety Codes in LTC. (Corrected 11/01/16).	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established	K 050		10/26/16

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K 050	Continued From page 4 routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 1 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.7.1.2, during the last 12-month period. This deficient practice could affect 44 of 44 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility did not conducted the overnight fire drill in the second calendar quarter. This deficient condition was verified by the Maintenance Supervisor.	K 050	CORRECTIVE ACTION: Plant Services Director immediately re-educated maintenance staff to perform the fire drills as per life safety code - at least quarterly on each shift (CORRECTED 10/26/16). RECURRENCES WILL BE PREVENTED BY: The Director of Plant Operations will schedule the fire drill with maintenance staff, fill out the log form for drills then check IMMEDIATELY to verify the drill took place and that the log is filled out appropriately. (CORRECTED 10/26/16)	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7,	K 052		10/28/16

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K 052	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) Sections 18.3.4., 18.3.6.3.2, 18.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 44 of 44 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, during a review of all available fire alarm maintenance/testing documentation for the last 12 months and an interview with the Administrator, it was revealed that the facility failed to document and/or verify 3 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by the Maintenance Supervisor.	K 052	CORRECTIVE ACTION: The Director of Plant Operations re-educated the Maintenance staff who perform the digital alarm communicator transmitter testing monthly that documentation of said testing must be completed accurately and timely to comply with Life Safety Code. (CORRECTED 10/28/16). RECURRENCE WILL BE PREVENTED BY: The Director of Plant Operations will partake in a QAPI (QUALITY ASSURANCE PERFORMANCE IMPROVEMENT) -(CORRECTED 11/23/16) to ensure compliance is achieved on a monthly basis. Director will perform audits on the log sheet for documenting the DACT.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility is cooking food items that produces grease-laden vapors in 3 of 3 neighborhood kitchen open to the dining rooms without the proper exhaust hood equipment and	K 069	CORRECTIVE ACTION: Dietary Manager and Director of Senior Services re-educated all Cooks that the proper procedure must be followed when	10/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 069	Continued From page 6 extinguishing system in accordance with NFPA 101(00), Sections 9.2.3, 18.3.2.6 and NFPA 96(98) 1-3.1. This deficient practice could affect 44 of 44 residents, as well as an undetermined number of staff, and visitors Findings Include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, it was observed that there are 3 neighborhood kitchens that are open to the dining rooms located within the facility. it was also observed that the stoves are accessible to the residents. During the facility tour a resident was found unattended in one of the neighborhood kitchens and the stove was still energized from the power shutoff to the controls located on the stoves. The neighborhood kitchens are equipped with a lockable power shutoff but according to a kitchen staff member the lockable power shutoffs "are not turned off when the stoves are unattended". Upon closer investigation it was determined that there is still power flowing to the controls that are located on the stoves, and the stoves and griddle tops were unattended while they were still extremely hot. This deficient condition was verified by a Maintenance Supervisor.	K 069	leaving the neighborhood kitchen in Aspen Circle: Stove must be shut down via the power shutoff and the key must be removed from the shutoff each time the kitchen is left unattended. (CORRECTED 10/26/16). RECURRENCE WILL BE PREVENTED BY: A QAPI (QUALITY ASSURANCE PERFORMANCE IMPROVEMENT)was initiated by the Director of Senior Services on 10/27/16. Audits in the Aspen Kitchen will be performed by the Director of Senior Services/Dietary Manager or designee 5 times per week until compliance is met. Once compliance is met audits will continue on a regular basis to ensure stoves are "shut off with key removed" when unattended by Cooks. (Corrected 10/26/16) with ongoing audits in place. Education will be provided to all new dietary and annual employees via the Dietary Manager regarding the process noted above.	
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service.	K 154		11/17/16

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

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K 154	Continued From page 7 9.7.6.1. This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 44 of 44 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated. This deficient condition was verified by the Maintenance Supervisor.	K 154	CORRECTIVE ACTION: The Plant Operations Director immediately wrote a new policy titled, "Fire Protection System out of Service (see ATTACHMENT C); with the "Fire Watch Log sheet" attached to policy(see ATTACHMENT D). All language contained is based on K154. (CORRECTED ON 11/17/16). The Plant Operations Director immediately educated all Maintenance personnel who perform duties listed in the Fire Protection System out of Service policy (CORRECTED ON 11/17/16). RECURRENCES WILL BE PREVENTED BY: All Maintenance personnel will receive new hire and annual education per the Director of Plant Operations regarding the Fire Protection system out of service policy going forward.	
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by:	K 155		11/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. BUILDING **03 - ASPEN CIRCLE** B. WING _____	**10/26/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 155	Continued From page 8 Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 44 of 44 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 10/26/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by the Maintenance Supervisor.	K 155	CORRECTIVE ACTION: The Plant Operations Director immediately wrote a new policy titled, "Fire Protection System out of Service (see ATTACHMENT C); with the "Fire Watch Log sheet" attached to policy(see ATTACHMENT D). All language contained is based on K155. (CORRECTED ON 11/17/16). The Plant Operations Director immediately educated all Maintenance personnel who perform duties listed in the Fire Protection System out of Service policy (CORRECTED ON 11/17/16). RECURRENCES WILL BE PREVENTED BY: All Maintenance personnel will receive new hire and annual education per the Director of Plant Operations regarding the Fire Protection system out of service policy going forward.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 15, 2016

Mr. Aaron Saude, Assistant Administrator
Bigfork Valley Communities
258 Pine Tree Drive, PO Box 258
Bigfork, Minnesota 56628

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5529029 and H5529005

Dear Mr. Saude:

The above facility was surveyed on October 24, 2016 through October 28, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5529005. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us**.

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

Please 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00834	A. BUILDING: _____ B. WING _____	C 10/28/2016

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 24, 25, 26, 27, and 28, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. An investigation for complaint H5529005 was conducted and was unsubstantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings	2 000		

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2 000	Continued From page 2 are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan interventions related to the use and monitoring of side effects of Plavix (a platelet inhibitor used to prevent blood clots) for 1 of 2 residents (R17) reviewed for non-pressure related skin concerns. Findings include:	2 560	**CORRECTED	12/13/16

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2 560	Continued From page 3 R17's Face Sheet indicated R17 was diagnosed with heart disease and history of a stroke. R17's quarterly Minimum Data Set (MDS) dated 10/11/16 indicated R17 had no cognitive impairment, required supervision from staff for transfers, walking and dressing, and was independent with toileting, hygiene and repositioning in bed. R17's physician orders indicated R17 received Plavix (medications that inhibits blood clots) 75 milligrams (mg) one time of day related to transient cerebral ischemic attack (stroke). R17's current care plan failed to address R17's use of Plavix and to monitor for possible adverse reactions such as bleeding, bruising and thrombotic thrombocytopenic purpura (rare blood disorder characterized by clotting in small blood vessels). R17's progress note dated 10/13/16, at 9:43 a.m. authored by the MDS nurse reported R17's skin was dry and thin and R17 was encouraged to use lotion. The note identified bruising on arms which R17 had contributed to bumping into things. R17 was encouraged to wear long sleeves for protection. The note indicated the care plan would be updated. The progress note did not include extent or stages of healing of the bruising and it was not evident the care plan was revised to include the interventions for the dry skin or the use of long sleeves to aide in protection against bruising. R17's quarterly review progress note authored by the MDS nurse dated 10/25/16, at 9:41 a.m. informed R17's skin was dry but intact with	2 560		

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2 560	Continued From page 4 bruising. The progress note did not include location, extent, or stages of healing of bruising and did not indicate a plan of care for the dry skin or the bruising. On 10/25/16, at 11:18 a.m. R17 was observed to wear a three-quarter length sleeve shirt with arms visible to elbows. R17 was noted to have bilateral upper extremity profuse bruising at different stages of healing. The bruises were also noted to range in sizes from dime size to lemon size. R17's skin was also thin and frail in appearance. R17 stated her skin was thin and bruised easily and R17 did not know if on medications that increased risk for bruising, and did not know why she bruised easily. On 10/26/16, at 9:26 a.m. registered nurse (RN)-A stated she missed the increased risk for bruising and skin injury related to the Plavix medication and should have added it to the care plan. RN-A indicated the interventions that should have been added to the care plan included wearing long sleeved shirts or sleeve protectors and encourage her to lotion every night. On 10/27/16, at 9:51 a.m. RN-E stated if a resident was on a blood thinning medication it should be in the care plan. On 10/27/16, at 1:31 p.m. the director of nursing (DON) stated blood thinning medication use should be in the care plan and progress notes should include wound demographics which would include location, size, and color. The DON reviewed R17's documentation of the bruises and indicated the identification and the documentation of the bruising was insufficient. The DON stated if there was a problem with extensive bruising the physician should be notified.	2 560		

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2 560	Continued From page 5 No policy regarding the development of the care plan was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident was developed to include medications and medication side effects to be monitored. The director of nursing or designee could develop a system to educate staff, and develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning and bowel incontinence care were provided as directed by the care plan for 1 of 3 residents (R26) reviewed who were dependent on staff for repositioning and incontinence care.	2 565	**CORRECTED	12/13/16

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2 565	Continued From page 6 Findings include: R26's Care Plan dated 10/13/16, indicated R26 had functional incontinence related to progressive dementia and directed staff to check and change R26 every two hours. The care plan also indicated R26 was at moderate risk for pressure ulcers and skin issues due to immobility and incontinence. The Care Plan directed staff to provide skin care with light layer of barrier cream after each incontinent episode and to check R26's skin during weekly bath. The nursing assistant (NA) pocket care plan dated 10/25/16, directed staff R26 required a scheduled repositioning plan every two hours. On 10/26/16, from 7:02 a.m. until 10:16 a.m. R26 was continuously observed. -7:02 a.m. nursing assistant (NA)-A and NA-B transferred R26 into a wheelchair and wheeled R26 to the common area in front of the television. -At 7:40 a.m. R26 was wheeled into the dining room. -At 8:36 a.m. NA-A wheeled R26 to the common area and placed her back in front of the television where she remained until 10:16 a.m. -At 10:11 a.m. NA-B stated R26 should be repositioned and checked and changed every two hours. NA-B indicated R26 was last repositioned/checked and changed when she was assisted up at 7:00 a.m. -At 10:16 a.m. NA-B wheeled R26 to her room. NA-A entered the room with a mechanical lift. Registered nurse (RN)-B entered R26's room and donned gloves. After donning gloves, both NA-A and NA-B proceeded to transfer R26 into bed. NA-B removed and discarded gloves and left the	2 565		

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2 565	Continued From page 7 room. RN-B and NA-A opened R26's incontinent brief. NA-A stated R26 was dry, but incontinent of stool. NA-A proceeded to cleanse R26. Upon completion of the cares, both NA-A and RN-B removed their gloves and washed their hands appropriately. NA-A stated R26 should be repositioned, checked and changed every two hours and confirmed this was not provided as directed, and confirmed R26 went a total of three hours and 15 minutes without being repositioning or incontinent product checked or changed. On 10/27/2016, at 11:11 a.m. the director of nursing (DON) confirmed R26 should be repositioned, checked and changed for incontinence every two hours. The DON verified she expected staff to follow the resident care plan and R26 should have been repositioned, checked and changed every two hours as directed by care plan. No policy related to implementation of the care plan was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff, and develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 570	Continued From page 8	2 570		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised 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, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise a care plan to include speech therapy recommendations related to safe eating practices for 1 of 3 residents (R38) who had difficulty swallowing and had speech therapy recommendations not identified on the care plan. Findings included: R38's undated Face Sheet indicated R38 had diagnoses which included Parkinson's and chronic obstructive pulmonary disease. R38's significant change Minimum Data Set (MDS) dated 8/3/16, indicated R38 had difficulty swallowing, and had loss of liquids/solids from mouth with eating and drinking and also coughed or choked during meals or when swallowing medications. This was a change since the last MDS dated 6/21/16, which reflected no	2 570	**CORRECTED	12/13/16

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2 570	Continued From page 9 swallowing difficulty. R38's nutrition Care Area Assessment (CAA) dated 8/4/16 indicated R38 had a swallowing problem and required a mechanically altered diet. The CAA further indicated R38 required supervision with an overall goal objective to avoid complications. R38's swallowing assessment dated 8/2/16, indicated R38 had been showing an increased risk of choking while eating and should be supervised when eating. R38 chewed food well but did not take small bites. R38's speech therapy note dated 10/13/15, revealed recommendations for R38's safe swallowing which consisted of R38 to sit up straight at 90 degrees when eating, to sit up for 30 minutes following meal, group supervision during meal, monitor lung sounds after meal, and consider providing Sinemet (Parkinson's medication which assists with motor control) one hour before meals. On 10/13/16, the speech therapist had also recommended a mechanical soft diet with nectar thickened liquids, however, on 11/2/15, the recommendation for thickened liquids had changed to thin liquid per patient request. R38's physician orders revealed a diet order dated 10/15/15, which read R38 was to have a low fat, mechanical soft textured diet with nectar consistency liquids. Physician's orders were inconsistent with speech therapy recommendations. R38's care plan lacked revision of all speech therapist interventions except for the therapeutic diet type and consistency. The nursing assistant	2 570		

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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) COMPLETE DATE
2 570	Continued From page 10 care guide provided by the facility on 10/25/16, indicated R38 required nectar thickened liquids but did not reflect the speech therapist recommendations. The care plan further lacked revision to include increased risk for choking based off the 8/2/16, assessment. On 10/27/16, at 10:30 a.m. speech language pathologist (SLP) indicated recommended interventions were expected to be added to the nursing care plan. SLP indicated there was a communication flaw between departments. On 10/27/16, at 12:15 p.m. certified dietary manager (CDM) indicated the speech therapy recommendations should have been added to the care plan by either nursing or dietary. CDM confirmed a communication flaw between speech therapy, nursing, and dietary departments existed. On 10/27/16, at 1:23 p.m. the director of nursing (DON) explained the care plan should be updated with assessed interventions and recommendations and explained the identified communication flaws would be resolved. Facility policy Resident Plan of Care last revised 10/5/16 indicated the care plan would be developed and maintained by the MDS coordinator and the nursing team, the care plan would aid in preventing or reducing declines in the resident's functional status and/or functional levels. The policy informed and directed staff assessment of residents were ongoing and care plans and pocket care plans were revised as information about the resident and the resident's condition arose.	2 570		

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2 570	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive skin assessment was completed related to identified upper extremity bruising for 1 of 2 residents (R17) reviewed for non pressure	2 830	**CORRECTED	12/13/16

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2 830	Continued From page 12 related skin concerns and observed to have profuse upper extremity bruising. findings include: R17's Face Sheet indicated R17 was diagnosed with heart disease and history of a stroke . R17's quarterly Minimum Data Set (MDS) dated 10/11/16 indicated R17 had no cognitive impairment, required supervision from staff for transfers, walking and dressing, and was independent with toileting, hygiene and repositioning in bed. R17's physician orders indicated R17 received Plavix (medications that inhibits blood clots) 75 milligrams (mg) one time of day related to cerebral ischemic attack (stroke). R17's current care plan informed staff of R17's goal revised on 10/12/16, which indicated R17 was to have intact skin, free of redness, blisters or discoloration. Interventions included complete a skin check weekly before or after bath/shower and change positions frequently with a start date of 7/13/16. The care plan failed to address R17's risk for bruising related to Plavix use and frail skin. R17's skin check evaluations dated 10/10/16, 10/20/16, and on 10/26/16 did not identify any skin conditions or concerns. R17's progress note dated 10/13/16, at 9:43 a.m. authored by the MDS nurse reported R17's skin was dry and thin and R17 was encouraged to use lotion. The note identified bruising on arms which	2 830		

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2 830	Continued From page 13 R17 had contributed to bumping into things. R17 was encouraged to wear long sleeves for protection. The note indicated the care plan would be updated. The progress note did not include extent or stages of healing of the bruising and it was not evident the care plan was revised to include the interventions for the dry skin or the use of long sleeves to aide in protection against bruising. R17's quarterly review progress note authored by the MDS nurse dated 10/25/16, at 9:41 a.m. informed R17's skin was dry but intact with bruising. The progress note did not include location, extent, or stages of healing of bruising and did not indicate a plan of care for the dry skin or the bruising. R17's record lacked documentation of ongoing monitoring, identification, and assessment/evaluation of existing or new bruising. Progress notes were requested and not received by the facility. On 10/25/16, at 11:18 a.m. R17 was observed to wear a three-quarter length sleeve shirt with arms visible to elbows. R17 was noted to have bilateral upper extremity profuse bruising at different stages of healing. The bruises were also noted to range in sizes from dime size to lemon size. R17's skin was also thin and frail in appearance. R17 stated her skin was thin and bruised easily and R17 did not know if on medications that increased risk for bruising, and did not know why she bruised easily. On 10/26/16, at 9:26 a.m. registered nurse (RN)-A reported the information used to complete	2 830		

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2 830	Continued From page 14 the MDS was gathered from progress notes and did not physically assess R17's skin. RN-A stated she missed the increased risk for bruising and skin injury related to the Plavix medication and should have added it to the care plan. RN-A indicated the interventions that should have been added to the care plan included wearing long sleeved shirts or sleeve protectors and encourage her to lotion every night. On 10/27/16, at 9:51 a.m. RN-E stated skin was evaluated at a very minimum on bath days and nursing assistants (NAs) also looked at skin daily with cares. RN-E explained if there were any issues, the NAs were directed to report to a nurse. RN-E stated documentation should be descriptive and every shift the bruises should be monitored until they are gone. RN-E stated if a resident was on a blood thinning medication it should be in the care plan. RN-E then looked at the bruises on R17's arms and asked if the documentation from the progress notes was sufficient, RN-E reported the documentation was not sufficient and should include size and locations of the bruises so they could have been monitored. On 10/27/16, at 1:31 p.m. the director of nursing (DON) indicated acknowledgement of a system issue with skin monitoring and indicated the process was going to be a part of risk management. The DON stated skin condition should have been monitored and documented at minimum once daily but ideally every shift and assessed weekly. The DON stated blood thinning medication use should be in the care plan and progress notes should include wound demographics which would include location, size, and color. The DON reviewed R17's documentation of the bruises and indicated the	2 830		

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2 830	Continued From page 15 identification and the documentation of the bruising was insufficient. The DON stated if there was a problem with extensive bruising the physician should be notified. Facility policy on non-pressure related skin injuries was requested and not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring non-pressure related skin issues. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensure residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty One (21) Days	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 905	**CORRECTED	12/13/16

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2 905	Continued From page 16 review, the facility failed to ensure timely repositioning was provided for 1 of 2 residents (R26) who was as risk for developing a pressure ulcer and required every two hour repositioning assistance. Findings include: R26's annual Minimum Data Set (MDS) dated 10/9/16, indicated R26 had severe cognitive impairment and diagnoses which included Alzheimer's disease, hypertension and atrial fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow). The MDS also indicated R26 required extensive assist of two people for bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS further indicated R26 was at risk for the development of pressure ulcers. R26's Pressure Ulcer Care Area Assessment (CAA) dated 10/10/16, indicated R26 was at risk for pressure ulcers due to incontinence and immobility. The CAA also indicated R26 was immobile and was able to make simple positions changes but was not able to stand and relieve pressure adequately. R26's Braden Scale for predicting pressure sore risk dated 10/5/16, indicated R26 at risk for pressure related sores. R26's Care Plan dated 10/13/16, indicated R26 was at moderate risk for pressure ulcers and skin issues due to immobility and incontinence. The plan directed staff to provide skin care with light	2 905		

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2 905	Continued From page 17 layer of barrier cream after each incontinent episode and to check R26's skin during weekly bath. The nursing assistant (NA) pocket care plan dated 10/25/16, directed staff R26 required repositioning every two hours. On 10/26/16, from 7:02 a.m. until 10:16 a.m. R26 was continuously observed. -7:02 a.m. NA-A and NA-B transferred R26 into a wheelchair and wheeled R26 to the common area in front of the television. -At 7:40 a.m. R26 was wheeled into the dining room. -At 8:36 a.m. NA-A wheeled R26 to the common area and placed her back in front of the television where she remained until 10:16 a.m. -At 10:11 a.m. NA-B stated R26 should be repositioned every two hours. NA-B indicated R26 was last repositioned when she was assisted up at 7:00 a.m. -At 10:16 a.m. NA-B wheeled R26 to her room. NA-A entered the room with a mechanical lift. Registered nurse (RN)-B entered R26's room and donned gloves. After donning gloves, both NA-A and NA-B proceeded to transfer R26 into bed. NA-B removed and discarded gloves and left the room. RN-B and NA-A opened R26's incontinent brief. NA-A stated R26 was dry, but incontinent of stool. NA-A proceeded to cleanse R26. Upon completion of the cares, both NA-A and RN-B removed their gloves and washed their hands appropriately. NA-A stated R26 should be repositioned every two hours and confirmed this was not provided as directed by the care plan.	2 905		

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2 905	Continued From page 18 NA-A confirmed R26 went a total of three hours and 15 minutes without being repositioned. On 10/27/2016, at 11:11 a.m. the director of nursing (DON) confirmed R26 should have been repositioned every two hours. The DON verified she expected staff to follow the resident care plan and R26 should have been repositioned as directed on care plan. The undated Pressure Ulcer Prevention policy indicated frequent turning, increased mobility if able, restorative program, protection for heels and elbows and pressure support surfaces for bed or chair bound residents would be implemented for Braden scores determined At Risk (score of 15-18). For residents identified at Moderate Risk (score of 13-14) the interventions were identified as same as above and use of body pillows, wedges with orders to provide 30 degree positioning. The policy indicated RN/LPN [registered nurse/licensed practical nurse] would implement pressure ulcer prevention protocols. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents receive the repositioning assistance according the assessed need. The DON or designee could develop an auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 905		

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2 920	Continued From page 19	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely incontinence care for 1 of 1 resident (R26) who was incontinent and dependent upon staff for bowel incontinence care. Findings include: R26's annual Minimum Data Set (MDS) dated 10/9/16, indicated R26 had severe cognitive impairment and diagnoses which included Alzheimer's disease, hypertension and atria fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow). The MDS also indicated R26 required extensive assist of two people for bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS further indicated R26 was always incontinent of bowel and bladder. R26's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/7/16, indicated R26 had functional incontinence (could not get to toilet in tame due to	2 920	**CORRECTED	12/1/16

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2 920	Continued From page 20 physical disability, external obstacles, or problems thinking or communicating). The CAA indicated incontinence would be addressed in the care plan to avoid skin issues and to minimize the risk of dignity issues. R26's Bowel and Bladder assessment dated 10/5/16, indicated R26 had advanced dementia with the inability to tell staff when needed to defecate. The assessment indicated bowel/bladder functioning interventions would include a dignity program (incontinent product used and checked/changed on appropriate schedule). R26's Care Plan dated 10/13/16, indicated R26 had functional incontinence related to progressive dementia and directed staff to check and change R26 every two hours. On 10/26/16, from 7:02 a.m. until 10:16 a.m. R26 was continuously observed. -7:02 a.m. nursing assistant (NA)-A and NA-B transferred R26 into a wheelchair and wheeled R26 to the common area in front of the television. -At 7:40 a.m. R26 was wheeled into the dining room. -At 8:36 a.m. NA-A wheeled R26 to the common area and placed her back in front of the television where she remained until 10:16 a.m. -At 10:11 a.m. NA-B stated R26 should have incontinent product checked and changed every two hours. NA-B indicated R26 was last checked and changed when she was assisted up at 7:00 a.m.	2 920		

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2 920	Continued From page 21 -At 10:16 a.m. NA-B wheeled R26 to her room. NA-A entered the room with a mechanical lift. Registered nurse (RN)-B entered R26's room and donned gloves. After donning gloves, both NA-A and NA-B proceeded to transfer R26 into bed. NA-B removed and discarded gloves and left the room. RN-B and NA-A opened R26's incontinent brief. NA-A stated R26 was dry, but incontinent of stool. NA-A proceeded to cleanse R26. Upon completion of the cares, both NA-A and RN-B removed their gloves and washed their hands appropriately. NA-A stated R26 should be checked and changed every two hours and confirmed this was not provided as directed, as R26 went a total of three hours and 15 minutes without having incontinent product checked or changed. On 10/27/16, at 11:11 a.m. the director of nursing (DON) confirmed R26 should have incontinent product checked for incontinence and changed every two hours. The DON verified she expected staff to follow the resident care plan as directed. No policy related to bowel incontinence was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review ADL policies for providing assistance with toileting with direct care staff members and provide education as needed. The DON or designee could then develop and implement an auditing system as part of their quality assurance to ensure on-going compliance.	2 920		

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2 920	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 955	MN Rule 4658.0530 Subp. 3 Assistance with Eating - Risk of Choking Subp. 3. Risk of choking. A resident identified in the comprehensive resident assessment, and as addressed in the comprehensive plan of care, as being at risk of choking on food must be continuously monitored by nursing personnel when the resident is eating so that timely emergency intervention can occur if necessary. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facilty failed to serve the correct therapeutic diet and provide supervision with eating for 1 of 1 resident (R38) who required mechanically altered food and had swallowing difficulties with a risk for choking which required supervision when eating. Findings include: R38's undated Face Sheet indicate R38 was diagnosed with Parkinson ' s and chronic obstructive pulmonary disease. R38's significant change Minimum Data Set	2 955	**CORRECTED	11/14/16

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2 955	Continued From page 23 (MDS) dated 8/3/16, indicated R38 had severe cognitive impairment and required limited physical assist from staff for eating. The MDS also indicated R38 had difficulty swallowing, had loss of liquids/solids from mouth when eating and drinking and also coughed or choked during meals or when swallowing medications. The was a change from the last MDS dated 6/21/16, which indicated R38 had no swallowing difficulty. R38's Nutritional Care Area Assessment (CAA) dated 8/4/16, indicated R38 had a swallowing problem and required a mechanically altered diet and supervision when eating in order to avoid complications. R38's Swallowing assessment dated 8/2/16, indicated R38 had been showing an increased risk of choking while eating and should be supervised when eating. The assessment also indicated R38 chewed food well but did not take small bites. R38's speech therapy note dated 10/13/15, revealed recommendations for R38's safe swallowing which indicated R38 should sit up at 90 degrees when eating and remain sitting up for 30 minutes following, group supervision during meal, monitor lungs after eating and consider providing Sinemet (Parkinson's medication which assist with motor control) one hour before the meal. On 10/13/16, the speech therapist had also recommended a mechanical soft diet with nectar thick liquids however, on 11/2/15, the recommendation for thickened liquids was changed to thin liquid per resident request, therefore R38 was to receive regular consistency liquids. R38's physician orders revealed a diet order	2 955		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 955	Continued From page 24 dated 10/15/15, which read R38 was to have a low fat, mechanical soft textured diet with nectar consistency liquids. Physician's orders were inconsistent with speech therapy recommendations. R38's October 2016, Medication Administration record (MAR) indicated R38 received Sinemet at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m. and 10:p.m. daily. R38's care plan dated 8/5/16, indicated R38 required meal set up and supervision and some assistance for eating The care plan lacked a revision to include the speech therapist's recommendations except for therapeutic diet type, consistency and assistance needed. The nursing assistant (NA) care guide provided by the facility on 10/25/16, indicated R38 required nectar thick liquids, mechanical soft diet but did not reflect the speech therapists eating recommendations. The care plan further lacked the risk for choking based off the 8/2/16, assessment. A resident dietary serving guide or "cheat sheet" dated 10/5/16, located in the kitchen cabinet and used by dietary staff when preparing/serving meals, indicated R38 was to receive a regular diet and thin liquids. On 10/24/16, at 5:23 p.m. R38 was observed seated at a dining room table with a regular textured meal of chili and French bread and coffee/water of thin consistency. NA-D was seated next to R38 and provided verbal cues to eat/drink. -At 5:26 p.m. R38 took a drink of coffee and started coughing. NA-D asked R38 if she was OK in which R38 responded, yes. NA-D stated	2 955		

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	00834	A. BUILDING: _____ B. WING _____	C 10/28/2016

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2 955	Continued From page 25 sometime R38 coughed when eating/drinking. -At 5:35 p.m. NA-D poured R38 more coffee and walked away from the table. R38 took a drink of the coffee and proceeded to cough twice, the cough was moist. -From 5:35 p.m. until 5:39 p.m. R38 continued to drink the coffee with an occasional need to clear her throat. No nursing staff were present in the dining room. On 10/25/16, at 4:58 p.m., R38 was observed at the dining room table with a glass of regular consistency water and orange wedges. A dietary assistant (DA)-A was the only staff member in the dining room. At 5:00 p.m. DA-A served R38 her meal which consisted of a ham steak, potato salad and a tomato slice. DA-A cut up R38's ham which appeared dry. DA-A stated R38 was to receive a regular diet with thin liquids. R38 independently started eating her meal. No other staff members were present in the dining room. -At 5:15 p.m. NA-E entered the dining room and asked R38 how she was doing. -At 5: 30 p.m. NA-E exited the dining room leaving no staff present. DA-A stated she could help R38 and proceeded to give R38 a bite of ham. R38 took a drink of water proceeded by a loud, hacking, moist cough. DA-A continued to put food onto R38's fork and provide verbal cues instructing R38 to take bites of food. -At 5:34 p.m. NA-E entered the dining room and again asked how R38 was. NA-E assist R38 to take more bites of ham. -At 5:37 p.m. NA-E was asked what type of diet R38 required. NA-E referenced her pocket care guide and stated R38 required a mechanical soft diet with thickened liquids, R38 was at risk for choking and required supervision when eating. NA-E stated the care guides were updated daily by the health unit coordinator. NA-E also stated	2 955		

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2 955	Continued From page 26 R38 had been coughing during the meal tonight after taking bites of food but not after drinking. NE-A stated some DA's were able to supervise and assist during meal times because some were certified nursing assistants. -At 5:42 p.m. DA-A stated she used to be a NA, however was no longer current on the NA registry. On 10/25/16, at 11:04 a.m. family member (FM)-A stated R38 had swallowing difficulties and a pureed diet had been recommended but R38 had not tolerated due to weight loss. FM-A was unaware of what consistency liquid had been recommended and stated it seemed to change frequently as sometimes thickened was served and other times it was regular liquids. On 10/25/16, at 5:49 p.m. registered nurse (RN)-D stated R38 was on a mechanical soft diet with regular consistency liquids, RN-D did not think R38 needed thickened liquids. RN-D stated R38's diet had been pureed, however, had lost weight therefore it was discontinued. On 10/27/16, at 10:30 a.m. the speech therapist stated recommended interventions were expected to be added to the care plan and felt there was a communication flaw between departments. On 10/27/16, at 12:15 p.m. the dietary manager (DM) stated the speech therapy recommendations should have been added to the care plan by either nursing or dietary. The DM stated the care plan guide in the cupboard of the kitchen was not correct related to an error that occurred on their spreadsheet when another resident was removed from it. The DM stated there was a communication problem between	2 955		

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2 955	Continued From page 27 speech therapy, nursing and dietary departments. On 10/27/16, the director of nursing (DON) stated the care plan should be updated with assessed interventions and recommendations and confirmed the communication gap between departments would be resolved. The DON stated if there were increased signs and symptoms of choking the speech therapist should be notified and care planned interventions should be implemented. The facility Resident Plan of Care policy last revised 10/5/16 indicated the care plan would be developed and maintained by the MDS coordinator and the nursing team, the care plan would aid in preventing or reducing declines in the resident's functional status and/or functional levels. The policy informed and directed staff assessment of residents were ongoing and care plans and pocket care plans were revised as information about the resident and the resident's condition arose. The facility's Dysphagia policy dated 8/15/11, indicated if a resident had suspected difficulty swallowing, staff would obtain and order for a speech therapy evaluation in which the staff would attempt to follow recommendations by the speech therapists. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review ADL policies for providing assistance with eating and providing the appropriate diet for residents with swallowing difficulties and educate staff, as needed. The DON or designee could then develop and implement an auditing system as part of their quality assurance to ensure on-going compliance.	2 955		

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2 955	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 955		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800		11/23/16

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21800	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most current nursing home Bill of Rights, revised in March 2016, was posted and used by the facility. This had the potential to affect all 44 residents residing in the facility. Findings include: During the initial tour on 10/24/16, at 2:00 p.m. the Resident Bill of Rights was observed posted on the Tamarak unit and dated 1995. On 10/26/16, at 12:45 p.m. Social worker (SW)-A provided a copy of the Resident Bill of Rights that was provided to the residents upon admission, this was dated July 1, 2007. SW-A was unaware of any updated Resident Bill of Rights. An undated facility policy entitled Bill of Rights for Residents, indicated The Bill of Rights would be posted in the facility and a copy would be provided on admission. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents receive the current resident bill of rights, and develop a system to ensure the current resident bill of rights are posted for all residents, family, and staff	21800	**CORRECTED	

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21800	Continued From page 30 members. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21800		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medical records were provided for review within twenty-four hours of request for 1 of 1 resident (R5) family member who requested review of clinical records.	21860	**CORRECTED	11/23/16

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21860	Continued From page 31 Findings include: On 10/25/16, at 1:36 p.m. R10's power of attorney (POA) stated on 10/28/16, she had requested the last two months of R10's medical records after the facility had reported an altercation with another resident and had not yet seen the records. POA stated the facility had reported one of the progress notes contained the other resident's name that needed to be removed. Review of R10's progress notes for the last two months did not reflect mention of another resident's name. R10's progress note dated 10/18/16, at 2:18 p.m. authored by licensed social worker (LSW) indicated R10's POA had requested to have a print out of all his progress notes for September and October 2016. R10's progress note dated 10/21/16, at 10:44 a.m. authored by LSW reported R10's POA was informed staff had been working on getting the progress notes, however needed to make sure there had not been names identified in the notes to protect confidentiality. Progress note indicated POA reported understanding and would continue to wait. On 10/26/16, at 5:06 p.m. LSW stated the facility had been in contact with the software company of their electronic health records system to request the name be removed from the document and that was what was taking so long to provide the documents to R10's POA. LSW reported she had been in contact with R10's POA to update her on the progress.	21860		

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21860	Continued From page 32 The resident Combined Bill of Rights dated 12/4/15 included; 1. The resident or his or her legal representative has the right, upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and 2. After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. Facility policy Release of Protected Health Information last revised 5/2016, did not reflect current standards outlined in the resident Bill of Rights. Policy indicated routine requests for health information would be processed on a regular basis and completed within 10 working days and had to be in writing. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or a designee could inservice staff regarding the regulation and the resident's rights to access personal medical records. A periodic audit could be conducted to ensure compliance and the findings could be communicated to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21860		