DEPARTMENT OF HEALTH

19. DETERMINATION OF ELIGIBILITY

	_	ARE/MEDICALI TO BE COMPL	_					ID: UGO4 Facility ID: 00834
MEDICARE/MEDICAID PROVIDER N (L1) 245529 2.STATE VENDOR OR MEDICAID NO. (L2) 048545405	3. NAME AND AD (L3) BIGFORK V (L4) 258 PINE TI (L5) BIGFORK , 1	VALLEY COM REE DRIVE, 1	IMUNITIE	58	56628	4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWN (L9) 6. DATE OF SURVEY 12/15/201 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	PPLIER CATEC 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 14 CORF 15 ASC 16 HOSPICE	22 CLIA	7. On-Site Visit 8. Full Survey After FISCAL YEAR ENDING 12/31	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	47 (L18) 47 (L17)	B. Not in Comp	nce With equirements e Based On: cceptable POC	am	2. Tecl 3. 24 F 4. 7-D: 5. Life	nnical Personnel	The Following Requirem 6. Scope of Se 7. Medical Di NF) 8. Patient Roo 9. Beds/Room (L12)	ervices Limit rector
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 47	19 SNF	ICF	IID		15. FACILITY 1		(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK See Attached Remarks	(L39) S (IF APPLICA	(L42) ABLE SHOW LTC CA	(L43)	DATE):				
17. SURVEYOR SIGNATURE		Date :		Ţ		RVEY AGENCY		Date:
Lyla Burkman, Unit Superv	isor	0	1/27/2017	(L19) ı	Mark W	seath, E	nforcement Specialis	01/27/2017

21. 1. Statement of Financial Solvency (HCFA-2572)

X 1. Facility is Eligible to Participate 2. Facility is not Eligible		RIGHTS ACT:	2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)3. Both of the Above :			
2. Facility is not Eligibl	e (L21)		_	_		
22. ORIGINAL DATE OF PARTICIPATION 05/01/1988 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEMENT BEGINNING DATE (L41) 27. ALTERNATIVE SANCTION A. Suspension of Admissions: B. Rescind Suspension Date:	(L44)	26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement OTHER 07-Provider Status Change 00-Active		
28. TERMINATION DATE: 31. RO RECEIPT OF CMS-1539	03001 (L28) 32. DETERMINA 12/13/2016	(L31) ATION OF APPROVAL DATE	30. REMARKS			
	(L32)	(L33)	DETERMINATION APPROVAL			

20. COMPLIANCE WITH CIVIL



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 Weath

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



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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	ISIT
IDENTIFICATION NUMBER	A. Building				
245529 _{Y1}	B. Wing	,	Y2	12/15/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
BIGFORK VALLEY COMMUNIT	ΓIES	258 PINE TREE DRIVE, PO BOX 258			
		BIGFORK, MN 56628			
<u> </u>				<u> </u>	

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).

ITE Y4			DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix			Correction	ID Prefix	-		Correction	ID Prefix			Correction
Reg. #	483.10(b)(2)		Completed	Reg. #	483.10 483.10	(b)(5) - (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), 48 (2)	33.10(k)	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 Reg. #	F0365 483.35(d)(3)		Correction Completed	ID Prefix Reg. #	F0373 483.35		Correction	ID Prefix Reg. #			Correction Completed
LSC			12/07/2016	LSC			11/14/2016	LSC			
ID Prefix Reg. #			Correction Completed	ID Prefix Reg. #			Correction Completed	ID Prefix Reg. #			Correction Completed
LSC				LSC				LSC			
REVIEWI STATE A		REVIEW (INITIAL	^ \	DATE		SIGNATURE OF	SURVEYOR			DATE	
REVIEWI CMS RO		REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOW 10/28/20	UP TO SURVE	Y COMPLI	ETED ON			R ANY UNCORRECTED DEFICIENCI				YE	s 🗆 NO

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - NURSING HOME			
245529 _{Y1}	B. Wing	Y2	12/15/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
BIGFORK VALLEY COMMUNITIES	S	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).

ITEN	И	DATE	ITEM	DATE	ITEM			DATE
Y4		Y5	Y4	Y5	Y4			Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	01 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. #	01 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			
REVIEWEI		REVIEWED BY (INITIALS) TL/mm	DATE 01/27/2017	SIGNATURE OF SURVEYOR 272	200		DATE 12/1	5/2016
REVIEWEI	D ВҮ	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWU 10/26/201	IP TO SURVEY CO	OMPLETED ON		ANY UNCORRECTED DEFICIENCIES TED DEFICIENCIES (CMS-2567) SEN			YES	по по

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 03 - ASPEN CIRCLE			
245529 _{Y1}	B. Wing	Y2	12/15/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
BIGFORK VALLEY COMMUNITIES	S	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).

ITEI		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	FPA 10	1	Completed	Reg. #	NFPA 101		Completed
LSC	K0018	10/27/2016	LSC K	0048		11/22/2016	LSC	K0050		10/26/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	FPA 10	01	Completed	Reg.#	NFPA 101		Completed
LSC	K0052	10/28/2016	LSC K	0069		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			
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/mm	DATE 01/27/20	017	SIGNATURE OF SI	JRVEYOR 272	00		DATE 12/1	15/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW L 10/26/20 ²	JP TO SURVEY CO	DMPLETED ON			NY UNCORRECTE ED DEFICIENCIES				YE	s 🔲 no

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	UGO4
Fac	ility ID: 00834

MEDICARE/MEDICAID PROVIDE							
. MEDICARE/MEDICAID PROVIDER NO. (L1) 245529 3. NAME AND ADDRESS OF FACILIT (L3) BIGFORK VALLEY COMMU					es.	4. TYPE OF ACTION: <u>2 (</u> L8)	
2.STATE VENDOR OR MEDICAID N	NO.	(L4) 258 PINE TI	REE DRIVE, P	O BOX 25	58	1. Initial 2. Recertification 3. Termination 4. CHOW	
(L2) 048545405		(L5) BIGFORK ,	MN		(L6) 56628	5. Validation 4. Criow 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	IPPLIER CATEGO	ORY	<u>02</u> (L7)	7. On-Site Visit 9. Other	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint	
	8/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		12/31	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	' IS CERTIFIED A	AS:			
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of	The Following Requirements:	
To (b):		_	equirements e Based On:		2. Technical Personnel	- •	
		· ·	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director IF) 8. Patient Room Size	
12. Total Facility Beds	47 (L18)		eceptable 1 OC		5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	47 (L17)	X B. Not in Con	npliance with Programmed and/or Applied Wa		•	(L12)	
14. LTC CERTIFIED BED BREAKDO	own	Requirements	and/of Applied Wa	arvers.	* Code: B * 15. FACILITY MEETS	(L12)	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
47	17 5141	ICI	Ш		1001 (c) (1) 01 1001 (j) (1).	(
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION D.	ATE):			_
See Attached Remarks				,			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Vienna Andresen, HFE NEII		1	1/29/2016	(L19)	Mark Meath	, Enforcement Specialist	.20)
PA	DT II TO DE	COMPLETED I	DV HCEA DE				.20)
	KI II - IU DE	COMILETEDI	DI HUFA KE	GIONAL	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBIE		20. COM	IPLIANCE WITH		21. 1. Statement of Fina	ncial Solvency (HCFA-2572)	
	JTY	20. COM			21. 1. Statement of Fina	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)	
19. DETERMINATION OF ELIGIBIE	LITY Participate	20. COM	IPLIANCE WITH		21. 1. Statement of Final 2. Ownership/Control	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)	
19. DETERMINATION OF ELIGIBIE _X 1. Facility is Eligible to F	LITY Participate	20. COM	IPLIANCE WITH		21. 1. Statement of Final 2. Ownership/Control	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)	
19. DETERMINATION OF ELIGIBIE _X 1. Facility is Eligible to F	LITY Participate	20. COM RIGH	IPLIANCE WITH	CIVIL	21. 1. Statement of Fina 2. Ownership/Contro 3. Both of the Above	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:	
19. DETERMINATION OF ELIGIBII X 1. Facility is Eligible to I 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION	Participate (L21)	20. COM RIGH MENT 24	IPLIANCE WITH HTS ACT:	CIVIL ENT E	21. 1. Statement of Fina 2. Ownership/Contre 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00	ncial Solvency (HCFA-2572) col Interest Disclosure Stmt (HCFA-1513) color: (L30) INVOLUNTARY	
19. DETERMINATION OF ELIGIBIE _X1. Facility is Eligible to F2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 05/01/1988	Participate (L21) 23. LTC AGREED BEGINNING	20. COM RIGH MENT 24	IPLIANCE WITH HTS ACT: 4. LTC AGREEMI ENDING DATI	CIVIL ENT E	21. 1. Statement of Fina 2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) : (L30) INVOLUNTARY 05-Fail to Meet Health/Safety	
19. DETERMINATION OF ELIGIBII _X1. Facility is Eligible to II2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 05/01/1988 (L24)	23. LTC AGREED BEGINNING (L41)	20. COM RIGH MENT 24 G DATE	IPLIANCE WITH HTS ACT: 4. LTC AGREEMI	CIVIL ENT E	21. 1. Statement of Final 2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 000 01-Merger, Closure 02-Dissatisfaction W/ Reimburs	ncial Solvency (HCFA-2572) col Interest Disclosure Stmt (HCFA-1513) :	
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19. DETERMINATION OF ELIGIBIE	23. LTC AGREED BEGINNING (L41) 27. ALTERNATI	20. COM RIGH MENT 24 G DATE	IPLIANCE WITH HTS ACT: 4. LTC AGREEMI ENDING DATI	CIVIL ENT E	21. 1. Statement of Fina 2. Ownership/Contre 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	ncial Solvency (HCFA-2572) col Interest Disclosure Stmt (HCFA-1513) :	
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19. DETERMINATION OF ELIGIBIE	23. LTC AGREED BEGINNING (L41) 27. ALTERNATI A. Suspension	20. COM RIGH MENT 24 5 DATE VE SANCTIONS a of Admissions:	IPLIANCE WITH HTS ACT: 4. LTC AGREEMI ENDING DATI (L25)	CIVIL ENT E	21. 1. Statement of Fina 2. Ownership/Contre 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	incial Solvency (HCFA-2572) color Interest Disclosure Stmt (HCFA-1513) color (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement on OTHER 07-Provider Status Change	
19. DETERMINATION OF ELIGIBIE	23. LTC AGREED BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind St	20. COM RIGH MENT 24 5 DATE VE SANCTIONS a of Admissions:	IPLIANCE WITH HTS ACT: 4. LTC AGREEMI ENDING DATI (L25) (L44) (L45)	CIVIL ENT E	21. 1. Statement of Fina 2. Ownership/Contre 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	incial Solvency (HCFA-2572) color Interest Disclosure Stmt (HCFA-1513) color (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement on OTHER 07-Provider Status Change	
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19. DETERMINATION OF ELIGIBII _X1. Facility is Eligible to II 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 05/01/1988 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREED BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind St	20. COM RIGH MENT 24 G DATE VE SANCTIONS n of Admissions: uspension Date:	IPLIANCE WITH HTS ACT: 4. LTC AGREEMI ENDING DATI (L25) (L44) (L45)	CIVIL ENT E	21. 1. Statement of Fina 2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	incial Solvency (HCFA-2572) color Interest Disclosure Stmt (HCFA-1513) color (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement on OTHER 07-Provider Status Change	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00834

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 emplaint 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.



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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor 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

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

PRINTED: 11/29/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		TE SURVEY MPLETED
		245529	B. WING _		/28/2016
	PROVIDER OR SUPPLIER K VALLEY COMMUNI	TIES		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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	signature is not req page of the CMS-2	led in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as	F 00	0	
	revisit of your facilit validate that substa	acceptable POC an on-site y may be conducted to intial compliance with the en attained in accordance with			
F 153 SS=D	completed along wi The complaint was 483.10(b)(2) RIGH	T TO ACCESS/PURCHASE	F 15	3	11/4/16
	the right upon an or access all records princluding current cli (excluding weekend receipt of his or her purchase at a cost standard photocopi	or her legal representative has ral or written request, to pertaining to himself or herself inical records within 24 hours ds and holidays); and after records for inspection, to not to exceed the community es of the records or any ion request and 2 working ite to the facility.			
	by: Based on interview	NT is not met as evidenced v and document review, the ure medical records were		CORRECTIVE ACTION: R10's Power of Attorney was immediately	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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.

TITLE

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		E SURVEY PLETED
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F 153	provided for revier request for 1 of 1 who requested re Findings include: On 10/25/16, at 1 attorney (POA) strequested the lass records after the faltercation with an seen the records. reported one of thother resident's name. Review of R10's progress not authored by licens indicated R10's Print out of all his and October 2016 R10's progress not authored by informed staff had progress notes, hithere had not beet to protect confide POA reported und to wait. On 10/26/16, at 5	w within twenty-four hours of resident (R5) family member view of clinical records. 36 p.m. R10's power of ated on 10/28/16, she had t two months of R10's medical facility had reported an nother resident and had not yet POA stated the facility had re progress notes contained the ame that needed to be progress notes for the last two flect mention of another ote dated 10/18/16, at 2:18 p.m. sed social worker (LSW) OA had requested to have a progress notes for September	F 1	provided (ON 10/27/16) with medical records upon compact Authorization to Release Maction form. *See attachment(A) policy "Authorization to Release Maccords Senior Communition updated on 11/22/16 to include resident or his/her legal rephas the right upon an oral corequest, to access all records himself or herself including clinical records within 24 howeekends and holidays". Domitted to the compact of the c	pleting the edical Records titled, Medical ies" which was lude "the presentative or written and pertaining ing current purs (excluding PATE). PREVENTED don'this policy meeting on — dent Notice arack with the ledical Records on in a pocket 0 10/31/16. 11/4/16 to ased as per der records through audits neeting monthly	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 153	that was what was	red from the document and taking so long to provide the	F 15	3		
	had been in contact on the progress.	s POA. LSW reported she t with R10's POA to update her				
	The resident Comb 12/4/15 included;	ined Bill of Rights dated				
	has the right, upon access all records proceed including current cli (excluding weekens 2. After receipt of himspection, to purch the community stan records or any portions.	an oral or written request, to pertaining to himself or herself nical records within 24 hours ds and holidays); and is or her records for mase at a cost not to exceed adard photocopies of the ions of them upon request and ance notice to the facility.				
F 156 SS=C	Information last rev current standards of Rights. Policy indica health information varied regular basis and of days and had to be 483.10(b)(5) - (10),	ase of Protected Health ised 5/2016, did not reflect outlined in the resident Bill of ated routine requests for would be processed on a completed within 10 working in writing. 483.10(b)(1) NOTICE OF SERVICES, CHARGES	F 15	6		12/1/16
	and in writing in a la understands of his regulations governing responsibilities duri facility must also prenotice (if any) of the	form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the e State developed under Act. Such notification must be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 156	resident's stay. Re any amendments to writing. The facility must intentitled to Medicaid of admission to the resident becomes ditems and services facility services und which the resident other items and services and for which the retident of chartinform each resident items and servicial (i)(A) and (B) of this the time of admitted the time of admitted the time of admitted the resident's stay, facility and of chargincluding any chargest and servicial the time of admitted the resident's stay, facility and of chargincluding any chargest and services.	form each resident who is denoted be been been been been been been been	F 15	6		
	legal rights which in A description of the funds, under parage A description of the for establishing eligible the right to request 1924(c) which deternon-exempt resour institutionalization a	e manner of protecting personal raph (c) of this section; e requirements and procedures gibility for Medicaid, including an assessment under section remines the extent of a couple's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 258 PINE TREE DRIVE, PO BOX 2 BIGFORK, MN 56628	CODE		
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F 156	toward the cost of medical care in his down to Medicaid and to Medicare and Medicare in his down to Me	red available for payment the institutionalized spouse's or her process of spending eligibility levels. s, addresses, and telephone tinent State client advocacy e State survey and certification licensure office, the State am, the protection and and the Medicaid fraud control ent that the resident may file a State survey and certification gresident abuse, neglect, and if resident property in the ampliance with the advance	F 18	56			
	by: Based on observa review, the facility current nursing ho March 2016, was p	into its not met as evidenced ation, interview and document failed to ensure the most me Bill of Rights, revised in posted and used by the facility.		CORRECTIVE ACTION: The Resident Rights large dated 1995 was removed location IMMEDIATELY (C	from the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED					
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F 156	residing in the facility Residents, include: During the initial to the Resident Bill of on the Tamarak under the Tamara	bur on 10/24/16, at 2:00 p.m. f Rights was observed posted nit and dated 1995. 2:45 p.m. Social worker (SW)-A f the Resident Bill of Rights that he residents upon admission, y 1, 2007. SW-A was unaware esident Bill of Rights. To policy entitled Bill of Rights for ed The Bill of Rights would be ty and a copy would be	F 15	ON 10/25/16)- (during the sum The current Combined Federa Bill of Rights dated 12/04/15 who be posted in the entryway to Nursing home by the DON offi (CORRECTED ON 10/25/16), currently remains in this location. The Licensed Social Worker in replaced (CORRECTED ON 10/25/16), currently remains in this location. The Admission packet with the current dated 12/04/15. RECURRENCES WILL BE PFBY: The Licensed Social Worker where education and have available the most current Combined Festate Bill of Rights (dated 12/01/13th, 2016). Those residents not in attended have a copy of the most current Combined Federal and State If (12/04/15) provided to them and to them by the Licensed Social 12/1/16. Licensed Social Worker has soundates via email from the MER Rights for LTC website link to she will have the most current available for the admission paupdate all current residents wireleases of the Combined Federals.	al and State vas verified of the ce and on. mmediately 0/26/16)the Bill of Rights he most REVENTED vill provide copies of ederal and 04/16) in the gron ence will not Bill of Rights and explained all Worker by igned up for DH Resident ensure that version ckets and to th future					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BI		BE	(X5) COMPLETION DATE
F 279 SS=D	to develop, review a comprehensive plan. The facility must de plan for each reside objectives and time medical, nursing, an needs that are identificated assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any significant to develop the second	(1) DEVELOP E CARE PLANS he results of the assessment and revise the resident's	F 1		State Bill of Rights. (CORRECTED 10/28/16) CORRECTIVE ACTION MONITOR BY: A QAPI is developed (COMPLETED 11/23/16) to ensure the most currer of the Combined Federal and State Rights is posted in a visible location the Resident Notices Board), and is current in the Admission packet. ONGOING MONITORING OF cont placement of policy on board and it packet will be completed by the DO and/or Director of Senior Services of daily and monthly basis.	ED ont copy Bill of on (on one kept inued on	12/7/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 279	§483.10, including under §483.10(b)(4	the right to refuse treatment	F 279			
	Based on observareview, the facility finterventions relate side effects of Play prevent blood clots	tion, interview and document ailed to develop care plan d to the use and monitoring of ix (a platelet inhibitor used to) for 1 of 2 residents (R17) ressure related skin concerns.		CORRECTIVE ACTION: R17's care plan was immediately u on (CORRECTED ON 10/28/16); TINCLUDE geri- sleeves, senile purp frail skin and signs and symptoms monitor for as a side effect of the ouse of Plavix. (See attachment C-F corrected care plan).	O pura, o ngoing	
	R17's quarterly Min 10/11/16 indicated impairment, require transfers, walking a independent with to repositioning in bed R17's physician ord Plavix (medications milligrams (mg) one transient cerebral is R17's current care use of Plavix and to reactions such as be thrombotic thrombot	ndicated R17 was diagnosed and history of a stroke. Simum Data Set (MDS) dated R17 had no cognitive ed supervision from staff for and dressing, and was bileting, hygiene and d. ders indicated R17 received a that inhibits blood clots) 75 et time of day related to schemic attack (stroke). plan failed to address R17's o monitor for possible adverse bleeding, bruising and ocytopenic purpura (rare blood zed by clotting in small blood		New policy was written (CORRECT ON 11/01/16) to reflect that interver side effects and proper diagnoses a included on the care plan. (Policy T Long Term Care Resident Plan of C (see attachment D). Staff education was immediately completed as to the new policy note above (attachment D) with MDS Coordinator as she manages care (CORRECTED ON 10/28/16). R17's care plan was updated to add bruises (CORRECTED 10/28/16). R17's bruises are monitored weekly the IDT and the Infection Prevention Nurse. (CORRECTED 10/28/16) Documentation is located in the new created Infection Preventionist/Skir note in PCC (See Attachment F for form created). (CORRECTED 10/2	ntions, are are itle: Care ed blans dress / by on/Skin wly Nurse new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245529	B. WING _		10/	28/2016	
NAME OF I	PROVIDER OR SUPPLIE	₹	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	•	20/2010	
BIGFOR	K VALLEY COMMUN	NITIES		258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	3		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	I SHOULD BE	(X5) COMPLETION DATE	
F 279	R17's progress no authored by the M was dry and thin a lotion. The note ic R17 had contribut was encouraged the protection. The note include extent or and it was not evito include the interest of long sleeves bruising. R17's quarterly rethe MDS nurse dainformed R17's skinding. The proglocation, extent, of and did not indicated or the bruising. On 10/25/16, at 1' wear a three-quary visible to elbows. upper extremity postages of healing. The progressible to elbows. upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity postages of healing. The progressible to elbows. Upper extremity	ote dated 10/13/16, at 9:43 a.m. IDS nurse reported R17's skin and R17 was encouraged to use lentified bruising on arms which ted to bumping into things. R17 to wear long sleeves for ote indicated the care plan at the progress note did not stages of healing of the bruising dent the care plan was revised rventions for the dry skin or the esto aide in protection against eview progress note authored by ated 10/25/16, at 9:41 a.m. Arm was dry but intact with gress note did not include r stages of healing of bruising te a plan of care for the dry skin enter length sleeve shirt with arms R17 was noted to have bilateral rofuse bruising at different. The bruises were also noted to m dime size to lemon size. So thin and frail in appearance. In was thin and bruised easily now if on medications that bruising, and did not know why	F 27	,	monitoring and Policy Title: Adown attachment E). (Licensed and De completed e education of D, E) Pere reviewed by the MDS ensure and procedure on and Care din policies E). PREVENTED compliance of entation will be yor designee No monitor for care plan to notions for skin attached. The monitor of the ongoing of th		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245529	B. WING		10/	/28/2016
	PROVIDER OR SUPPLIER	TIES		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	Continued From pa	_	F 279			
	wearing long sleeve and encourage her On 10/27/16, at 9:5	o the care plan included ed shirts or sleeve protectors to lotion every night. 51 a.m. RN-E stated if a blood thinning medication it re plan.		QAPI noted above will include or compliance monitoring for prope documentation per policy noted attached. DON or designee will monthly audits.	r skin and	
	(DON) stated blood should be in the ca should include wou include location, siz reviewed R17's dod indicated the identi- of the bruising was	If p.m. the director of nursing thinning medication use re plan and progress notes and demographics which would be, and color. The DON cumentation of the bruises and fication and the documentation insufficient. The DON stated if m with extensive bruising the enotified.				
F 280 SS=D	plan was provided 483.20(d)(3), 483.1	the development of the care 0(k)(2) RIGHT TO NNING CARE-REVISE CP	F 280			12/7/16
	incompetent or othe incapacitated unde	r the laws of the State, to ing care and treatment or				
	within 7 days after comprehensive ass interdisciplinary tea physician, a registe for the resident, an disciplines as deter	care plan must be developed the completion of the sessment; prepared by an arm, that includes the attending ered nurse with responsibility d other appropriate staff in rmined by the resident's needs, practicable, the participation of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245529	B. WING		10/	10/28/2016	
	PROVIDER OR SUPPLIER K VALLEY COMMUNI	TIES		STREET ADDRESS, CITY, STATE, ZI 258 PINE TREE DRIVE, PO BOX BIGFORK, MN 56628	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 280	legal representative and revised by a te each assessment. This REQUIREME	age 10 sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 2	80			
	facility failed to revi speech therapy rec eating practices for had difficulty swalld			DON immediately (correct the diet order in the EHR order in the care plan (At pocket care plan (Attachidietary and the physician	oted 10/26/16) , updated the diet tachment G) and ment H), notified		
	diagnoses which in chronic obstructive R38's significant ch (MDS) dated 8/3/16 swallowing, and ha mouth with eating a or choked during medications. This wallowing difficulty R38's nutrition Cardated 8/4/16 indicated by the company of the compan	e Area Assessment (CAA) ted R38 had a swallowing ed a mechanically altered diet. dicated R38 required		DON immediately (corrected and of the correct diet order: with thin liquids. R38's care plan was upder (corrected on 10/26/16) was ection to reflect the mediating requirement, and reading requirement, and rected on 11/23/16) to category/problem in a set titled, "Risk for choking". That nursing will be flagger regarding the risk for choking (Attachment G).	d unlicensed staff mechanical soft atted immediately within the dietary chanical soft with pervision while risk for choking. atted once again to include a new parate section This will ensure ed in the EHR oking.		
		overall goal objective to avoid		ALL resident records hav for proper diet order by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245529	B. WING		10/28/2016	
	PROVIDER OR SUPPLIER K VALLEY COMMUNI	TIES		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE COMPLÉTION	
F 280	R38's swallowing a indicated R38 had risk of choking whil supervised when experienced but did not take sm. R38's speech thera revealed recommens swallowing which constraight at 90 degres 30 minutes following during meal, monitor consider providing medication which a hour before meals. The the therapist had also resoft diet with nectation 11/2/15, the recolliquids had change request. R38's physician or dated 10/15/15, who which is the table of the term of the table of table of the table of table of table of the table of t	ssessment dated 8/2/16, been showing an increased e eating and should be ating. R38 chewed food well all bites. The property of the therapeutic stency. The nursing assistant d by the facility on 10/25/16, ired nectar hickened liquids he speech therapist The care plan further lacked ncreased risk for choking well and solve a speech therapist The care plan further lacked ncreased risk for choking	F 280	(corrected by 12/01/16). DON met with Speech therapy on (11/01/16) to develop new process policies for referrals, orders and recommendations. See policy titled "Speech Therapy Evaluation for LT (Attachment I).(CORRECTED 11/0 DON created new a new policy titled "LTC Physician Order Communication" (Attachment J) to ecompliance with order processing icompleted by the licensed nursing (CORRECTED ON 11/20/16) Mandatory education will be provided the DON on 12/07/16 and will inclusticensed nursing staff and will cover policies noted above (Attachments RECURRENCES WILL BE PREVERY: QAPI was created by DON (CORRECTED on 11/01/16) to mospeech therapy orders. Monitoring DON will be monthly. QAPI will be created by DON (CORRECTED on 11/23/16) to mospeech to more processing policy. Monitoring will be performed DON on a monthly basis.	I, C" 1/16). ed, ensure s staff. ed by de all er new G, I, J) ENTED nitor by	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245529	B. WING _		10/	28/2016
	PROVIDER OR SUPPLIER VALLEY COMMUNI	TIES		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	On 10/27/16, at 10 pathologist (SLP) ir interventions were nursing care plan. Scommunication flav. On 10/27/16, at 12 manager (CDM) increcommendations care plan by either confirmed a communication flav. On 10/27/16, at 1:2 (DON) explained the with assessed interrecommendations communication flav. Facility policy Residual for the resident's funct levels. The policy ir assessment of resiplans and pocket computations and pocket computations.	30 a.m. speech language adicated recommended expected to be added to the SLP indicated there was a vibetween departments. 15 p.m. certified dietary dicated the speech therapy should have been added to the nursing or dietary. CDM unication flaw between speech and dietary departments 3 p.m. the director of nursing e care plan should be updated	F 28			
F 282 SS=D	condition arose. 483.20(k)(3)(ii) SEI	RVICES BY QUALIFIED	F 28	32		12/7/16
	must be provided b	led or arranged by the facility y qualified persons in och resident's written plan of				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245529	B. WING _		10/:	28/2016
NAME OF F	PROVIDER OR SUPPLIER	२		STREET ADDRESS, CITY, STATE, ZIP C		
BIGFOR	K VALLEY COMMUN	NITIES		258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	Continued From p	page 13	F 28	2		
	by: Based on observ review, the facility repositioning and provided as direct residents (R26) re	ENT is not met as evidenced ation, interview and document failed to ensure timely bowel incontinence care were led by the care plan for 1 of 3 eviewed who were dependent on ling and incontinence care.		CORRECTIVE ACTION: R26'S Care plan and pocked were reviewed by the DON abe accurate for toileting and every 2 hours(CORRECTED)	and found to I repositioning	
	had functional inc dementia and dire R26 every two hor indicated R26 was ulcers and skin is incontinence. The provide skin care	dated 10/13/16, indicated R26 ontinence related to progressive ected staff to check and change urs. The care plan also is at moderate risk for pressure is sues due to immobility and its Care Plan directed staff to with light layer of barrier cream		DON provided immediate reindividualized care plan for F caregivers in Aspen (CORF 10/27/16). Staff will provide repositioning every 2 hours. DON created a new policy ti Bowel and Bladder Program K) to ensure compliance wit individualized resident need and repositioning. (CORREC 11/01/16).	R26 to all RECTED toileting and itled, "LTC n" (Attachment th s for toileting	
	after each incontin R26's skin during The nursing assis dated 10/25/16, d scheduled reposit On 10/26/16, from was continuously -7:02 a.m. nursing transferred R26 in R26 to the commodate 7:40 a.m. R26 room.	nent episode and to check weekly bath. tant (NA) pocket care plan irected staff R26 required a ioning plan every two hours.		DON educated Licensed nu immediately (CORRECTED monitor toileting and reposit throughout their shift by doc toileting in their electronic he for individual residents. All other residents within As audited for compliance with toileting and repositioning pl DON or designee on an ong Mandatory staff meeting for new policy (attachment K) a expectations including audit	O 10/27/16) to cioning cumenting ealth record pen are being their individual lans by the going basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245529	B. WING			10/2	28/2016
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES		TIES		2	TREET ADDRESS, CITY, STATE, ZIP CODE 58 PINE TREE DRIVE, PO BOX 258 IGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	area and placed he where she remained -At 10:11 a.m. NA-I repositioned and chours. NA-B indicate repositioned/check was assisted up at -At 10:16 a.m. NA-I NA-A entered the received and I not the state of the state	er back in front of the television and until 10:16 a.m. B stated R26 should be necked and changed every two lated R26 was last ed and changed when she	F 2	282	(observational and record/documen review) will be held on (CORRECTE 12/07/16). RECURRENCES WILL BE PREVEIBY: QAPI is created by DON on (CORRECTED 11/23/16) which will measure compliance with individual toileting and repositioning plans for residents within LTC through observational and record review aud noted below on 5 residents per wee weeks, per unit, and per shift. At the of the 4 week period of time DON we review the audits noted above for ox 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 part QAPI on five residents per shift, per on a weekly basis to measure compliance with toileting and repositioning. At the end of the 4 we period of time DON will review the after overall compliance and will deter further frequency needs for audits a additional interventions.	ized all dits as k x 4 e end vill verall er ational per unit	
F 309 SS=D	plan was provided. 483.25 PROVIDE (CARE/SERVICES FOR	F 3	09			12/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245529	B. WING		10/28/2016	
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 309	Continued From pa	age 15 t receive and the facility must	F 309	9		
	or maintain the hig mental, and psych	ary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment				
	by: Based on observareview, the facility comprehensive skirelated to identified of 2 residents (R17 related skin concerprofuse upper extra	n assessment was completed l upper extremity bruising for 1 ') reviewed for non pressure rns and observed to have		CORRECTIVE ACTION: R17's care plan was immediately up on (CORRECTED ON 10/28/16); To INCLUDE geri- sleeves, senile purp frail skin and signs and symptoms to monitor for as a side effect of the or use of Plavix. (See attachment C-Freedrected care plan).	O bura, o ngoing	
	with heart disease R17's quarterly Mir 10/11/16 indicated impairment, require	indicated R17 was diagnosed and history of a stroke . nimum Data Set (MDS) dated R17 had no cognitive ed supervision from staff for		New policy was written (CORRECT ON 11/01/16) to reflect that interven side effects and proper diagnoses a included on the care plan. (Policy Ti Long Term Care Resident Plan of C (see attachment D). Staff education was immediately	ntions, are itle: care	
	independent with to repositioning in beau R17's physician or Plavix (medications	ders indicated R17 received s that inhibits blood clots) 75 e time of day related to		completed as to the new policy note above (attachment D) with MDS Coordinator as she manages care p (CORRECTED ON 10/28/16). R17's care plan was updated to adobruises (CORRECTED 10/28/16) R17's bruises are monitored weekly the IDT and the Infection Prevention	olans dress / by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′			E SURVEY PLETED
		245529	B. WING_		10/:	28/2016
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES			STREET ADDRESS, CITY, STATE, ZIF 258 PINE TREE DRIVE, PO BOX 2 BIGFORK, MN 56628	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	R17's current care goal revised on 10 was to have intact or discoloration. Ir a skin check weel and change positi of 7/13/16. The carisk for bruising reskin. R17's skin check 10/20/16, and on skin conditions or R17's progress not authored by the M was dry and thin a lotion. The note id R17 had contribut was encouraged to protection. The not would be updated include extent or sand it was not evicto include the interest of long sleeves bruising. R17's quarterly rethe MDS nurse dainformed R17's skin check 10/20/16, and on skin conditions or line was different or sand it was not evictoricle to include the interest of long sleeves bruising. R17's quarterly rethe MDS nurse dainformed R17's skin proglocation, extent, or and did not indicator the bruising.	e plan informed staff of R17's 0/12/16, which indicated R17 skin, free of redness, blisters atterventions included complete (ly before or after bath/shower ons frequently with a start date are plan failed to address R17's lated to Plavix use and frail evaluations dated 10/10/16, 10/26/16 did not identify any concerns. The dated 10/13/16, at 9:43 a.m. IDS nurse reported R17's skin and R17 was encouraged to use entified bruising on arms which ed to bumping into things. R17 to wear long sleeves for the indicated the care plan. The progress note did not stages of healing of the bruising dent the care plan was revised eventions for the dry skin or the test to aide in protection against eview progress note authored by sted 10/25/16, at 9:41 a.m. in was dry but intact with press note did not include a stages of healing of bruising the a plan of care for the dry skin ed documentation of ongoing	F 30	Nurse. (CORRECTED 10 Documentation is located created Infection Preventinote in PCC (See Attachm form created). (CORRECTED 11/01/16) to include proped documentation of bruising Long Term Care Skin Bree Prevention Program (See Mandatory Staff education Unlicensed personnel) with on 12/07/16) and will include mew policies (Attachment All residents Care Plans wand found to be compliant Coordinator and Infection Preventionist/Skin Nurse compliance with new policies regarding skin documenta plan requirements (as not attached (Attachments D. (CORRECTED 11/21/16) DON created a new policing pressure ulcers titled, "Loskin Breakdown Preventi (See attachment E). This how licensed personnel was document and solve pression impairments. RECURRENCES WILL Bey:	in the newly ionist/Skin Nurse ment F for new TED 10/28/16) CORRECTED or monitoring and g. Policy Title: eakdown e attachment E). In (Licensed and II be completed ude education of t D, E) Were reviewed to by the MDS to ensure cy and procedure eation and Care ted in policies (E). Ty in regards to ong Term Care on Program" policy covers will assess, sure ulcers or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245529	B. WING	·····	10/:	28/2016	
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628			1 16/26/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	bruising. Progress notes we by the facility. On 10/25/16, at 11 wear a three-quarte visible to elbows. If upper extremity prostages of healing, range in sizes from R17's skin was also R17 stated her skin and R17 did not knincreased risk for its she bruised easily. On 10/26/16, at 9:2 (RN)-A reported the MDS was gathed did not physically a she missed the incoskin injury related to should have added indicated the intervadded to the care is sleeved shirts or sleeved shirts or sleeved shirts or sleeved at a very nursing assistants with cares. RN-E e issues, the NAs we nurse. RN-E stated descriptive and every monitored until the resident was on a light state of the state of	re requested and not received 18 a.m. R17 was observed to er length sleeve shirt with arms R17 was noted to have bilateral ofuse bruising at different The bruises were also noted to a dime size to lemon size. The truises were also noted to a dime size to lemon size. The bruises were also noted to a dime size to lemon size. The bruises were also noted to a dime size to lemon size. The bruises were also noted to a dime size to lemon size. The bruises were also noted to a dime size to lemon size. The bruises were also noted to a dime size to lemon size. The bruises were also noted to a dimension and	F 309	Ongoing weekly audits for comcare plans and skin documentate completed by the DON and/or on an ongoing basis. QAPI is created by the DON (CORRECTED 11/23/16)to moweekly for ongoing compliance care plan to include side effects interventions for skin bruising/frailty/anti-coagulant documentation (including side oper policy noted above and attated DON or designee will perform tweekly audits for compliance. QAPI noted above will include weekly compliance monitoring skin documentation per policy rattached. DON or designee wiweekly skin viewing audits and documentation in record and or	nitor on the s, effects) as ached. he ongoing for proper noted and II perform		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245529	B. WING_		10/	28/2016
			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	the bruises on R17' documentation from sufficient, RN-E report sufficient and slocations of the bruist monitored. On 10/27/16, at 1:3 (DON) indicated accissue with skin morprocess was going management. The should have been right minimum once daily assessed weekly. The medication use should progress notes should documentation of the documentation of the documentation and the bruising was insufficient was a problem with physician should be recility policy on notinguries was requesed 483.25(a)(3) ADL CODEPENDENT RES	It is arms and asked if the in the progress notes was corted the documentation was corted the documentation was could include size and ises so they could have been it is is so they could have been it is is is is included in the document of a system into the part of risk is included in the care plan and included inclu	F 3			12/7/16
	This REQUIREMEN	NT is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER.		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245529	B. WING		10/2	8/2016
	PROVIDER OR SUPPLIER K VALLEY COMMUNI	TIES	:	STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	review, the facility fincontinence care fincontinence care fincontinent and bowel incontinence. Findings include: R26's annual Minin 10/9/16, indicated fimpairment and dia Alzheimer's diseas fibrillation (An irreg commonly causes also indicated R26 two people for bed toilet use and perso indicated R26 was and bladder. R26's Urinary Incor Catheter Care Area 10/7/16, indicated R	tion, interview and document failed to provide timely for 1 of 1 resident (R26) who d dependent upon staff for	F 312	DEFICIENCY)	lan nd to cioning /16). tion of all) g and TC chment leting	
	problems thinking of indicated incontined care plan to avoid strick of dignity issue R26's Bowel and B 10/5/16, indicated findicated	external obstacles, or or communicating). The CAA nce would be addressed in the skin issues and to minimize the est. ladder assessment dated R26 had advanced dementia tell staff when needed to		their electronic health record for indresidents. All other residents within Aspen are audited (through observation and rereview) for compliance with their including and repositioning plans by DON or designee on an ongoing bath	being ecord dividual the asis.	
	defecate. The asse			new policy (attachment K) and expectations including auditing prod		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245529	B. WING		10/	28/2016	
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628			,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 312	used and checked schedule). R26's Care Plan of had functional incomplete had functed had functional incomplete ha	lated 10/13/16, indicated R26 ontinence related to progressive octed staff to check and change urs. 17:02 a.m. until 10:16 a.m. R26 observed. 1 assistant (NA)-A and NA-B to a wheelchair and wheeled on area in front of the television. was wheeled into the dining 1 wheeled R26 to the common er back in front of the television ed until 10:16 a.m. 1 B stated R26 should have oct checked and changed every indicated R26 was last checked in she was assisted up at 7:00 1 B wheeled R26 to her room. In the room with a mechanical lift. (RN)-B entered R26's room and offer donning gloves, both NA-A ded to transfer R26 into bed. discarded gloves and left the	F 312	(observational and record review held on (CORRECTED on 12/0) RECURRENCES WILL BE PREBY: QAPI is created by DON on (CORRECTED 11/23/16) which measure compliance with indivitoileting and repositioning plans residents within LTC. Ongoing monitoring will be perform DON or designee as per QAPI (observational and record review on 5 residents in Tamarack and a weekly basis to measure comwith toileting and repositioning A Re-evaluation on the compliance completed by the DON at the elinitial 4 week period of time. AT the DON will determine the frequency ongoing audits and determine a additional interventions or eduction and interventions or eduction and record review residents in Tamarack and Aspet weekly basis x 4 weeks. Then will re-evaluate the compliance develop a new QAPI plan based results.	will dualized for all primed by (through vaudits) dispen on pliance at 4 weeks. Ince will be and of the this time uency of any ation as at DON will widts w) on 5 en on a the DON and		
	a.mAt 10:16 a.m. NA NA-A entered the Registered nurse donned gloves. A and NA-B proceed NA-B removed an room. RN-B and brief. NA-A stated stool. NA-A proces	-B wheeled R26 to her room. room with a mechanical lift. (RN)-B entered R26's room and fter donning gloves, both NA-A ded to transfer R26 into bed.		perform the pm and noc shift at (observational and record review residents in Tamarack and Aspeweekly basis x 4 weeks. Then will re-evaluate the compliance develop a new QAPI plan based	idits w) on 5 en on a the DON and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION ()	(3) DATE SURVEY COMPLETED
		245529	B. WING		10/28/2016
	NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	.0.20.20
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 312	checked and chang confirmed this was R26 went a total of	age 21 A stated R26 should be ged every two hours and not provided as directed, as three hours and 15 minutes ontinent product checked or	F 312		
	(DON) confirmed F product checked for every two hours. T	11 a.m. the director of nursing R26 should have incontinent or incontinence and changed the DON verified she expected esident care plan as directed.			
F 314 SS=D	provided. 483.25(c) TREATM	b bowel incontinence was MENT/SVCS TO PRESSURE SORES	F 314		12/7/16
	resident, the facility who enters the facility does not develop p individual's clinical they were unavoidad pressure sores recommendation.	orehensive assessment of a must ensure that a resident ality without pressure sores bressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and a healing, prevent infection and from developing.			
	by: Based on observa review, the facility f repositioning was p (R26) who was as	NT is not met as evidenced tion, interview and document failed to ensure timely provided for 1 of 2 residents risk for developing a pressure every two hour repositioning		CORRECTIVE ACTION: R26'S Care plan and pocket care pla were reviewed by the DON and found be accurate for repositioning every 2	d to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245529	B. WING _		10/	28/2016	
	PROVIDER OR SUPPLIE K VALLEY COMMUI			STREET ADDRESS, CITY, STATE, ZIP C 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 314	Continued From passistance. Findings include:	page 22	F 31	hours(CORRECTED 10/27/ DON provided immediate reindividualized care plan for	e-education of		
	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			caregivers in Aspen (CORF 10/27/16). Staff will provide repositioning every 2 hours. DON created a new policy t Bowel and Bladder Program K) to ensure compliance wit individualized resident need repositioning. (CORRECTE DON created a new policy t Skin Breakdown Prevention E) to address individualized schedules in regards to skir and pressure prevention. DON educated Licensed nu immediately (CORRECTED monitor repositioning throu	RECTED toileting and itled, "LTC n" (Attachment th ls for D 11/01/16). itled, "LTC " (Attachment repositioning n protection ursing D 10/27/16) to ghout their		
	R26's Braden Scarisk dated 10/5/16 pressure related s R26's Care Plan 6 was at moderate issues due to immedian directed stafflayer of barrier cre	nmobile and was able to make simple positions hanges but was not able to stand and relieve ressure adequately. 26's Braden Scale for predicting pressure sore sk dated 10/5/16, indicated R26 at risk for ressure related sores. 26's Care Plan dated 10/13/16, indicated R26 as at moderate risk for pressure ulcers and skin usues due to immobility and incontinence. The lan directed staff to provide skin care with light each of barrier cream after each incontinent pisode and to check R26's skin during weekly		shift through observational a reviewing documentation or in their electronic health red individual residents. All other residents within As audited through observation documentation in records a audits per unit, per shift x 4 compliance with their individual repositioning plans by the D designee. Mandatory staff meeting for new policy (attachment K, E expectations including audit	audits and by repositioning ford for spen are being and s follows: 5 weeks for dual PON or spending and spending for the spen		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245529	B. WING			10/2	28/2016
	PROVIDER OR SUPPLIER K VALLEY COMMUNI	TIES		25	TREET ADDRESS, CITY, STATE, ZIP CODE 58 PINE TREE DRIVE, PO BOX 258 IGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	dated 10/25/16, dirrepositioning every On 10/26/16, from was continuously o -7:02 a.m. NA-A and wheelchair and who in front of the televity -At 7:40 a.m. R26 veroom. -At 8:36 a.m. NA-A area and placed he where she remained -At 10:11 a.m. NA-I repositioned every R26 was last repositioned every R26 was last repositioned gloves. After and NA-A entered the received and NA-B proceed NA-B removed and room. RN-B and Na-B removed and room. RN-B and Na-B removed their glove appropriately. NA-A repositioned every was not provided a NA-A confirmed R2	ant (NA) pocket care plan ected staff R26 required two hours. 7:02 a.m. until 10:16 a.m. R26 bserved. d NA-B transferred R26 into a eeled R26 to the common area sion. vas wheeled into the dining wheeled R26 to the common er back in front of the television	F3	14	(observation and record review) wi held on (CORRECTED on 12/07/16) RECURRENCES WILL BE PREVERY: QAPI is created by DON on (CORRECTED 11/23/16) which will measure compliance with individual and repositioning plans for all residuithin LTC. Ongoing monitoring will be perform DON or designee as per QAPI on a weekly basis with 5 resident audits (observational and record review) to completed on each shift to measur overall compliance with toileting an repositioning. At the end of 4 week measuring the DON will determine through QAPI the overall compliant the audits (observational and recorreview) and will determine a further based on the compliance achieved.	S). ENTED Ilized ents eed by a being e d s of ce with d plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245529	B. WING		10/28/2016	
	PROVIDER OR SUPPLIER	TIES	STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 24	F 314	ı		
	nursing (DON) con- repositioned every she expected staff and R26 should har directed on care plan The undated Press indicated frequent to able, restorative pro- and elbows and pre-	ure Ulcer Prevention policy urning, increased mobility if ogram, protection for heels essure support surfaces for				
F 323 SS=D	Risk (score of 15-1 Moderate Risk (scowere identified as s body pillows, wedge degree positioning. [registered nurse/lice	aden scores determined At 8). For residents identified at ore of 13-14) the interventions ame as above and use of es with orders to provide 30. The policy indicated RN/LPN censed practical nurse] would be ulcer prevention protocols.	F 323	3		12/7/16
	environment remain as is possible; and	isure that the resident ns as free of accident hazards each resident receives on and assistance devices to				
	by:	NT is not met as evidenced vand document review, the		CORRECTIVE ACTION:		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245529	B. WING			10/2	28/2016
	PROVIDER OR SUPPLIER			25	FREET ADDRESS, CITY, STATE, ZIP CODE 58 PINE TREE DRIVE, PO BOX 258 IGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X COMPL DA DA	
F 323	facility failed to enassessment was of (R22) who access independently with Findings include: R22's quarterly Mi 7/29/16, indicated included hemipleg indicated R22's shintact but cognitive were moderately incues/supervision. required extensive toileting, and limited personal hygiene. was non-ambulated.	sompleted for 1 of 1 resident ed the community in a electric scooter. nimum Data Set (MDS) dated R22 had diagnoses which ia and aphasia. The MDS nort and long term memory were eskills for daily decision making impaired and R22 required The MDS also indicated R22 eassist with dressing and ed assistance with transfers and The MDS further indicated R22 bry and used a wheelchair (w/c).	F 3	323	R22's care plan was reviewed by the immediately on 10/27/16 for prior so assessment regarding electric scool was found that prior assessment work completed by OT Melissa N. on 8/1 did not include outside of the facility has been addressed by DON and Coreating a new policy titled, "LTC Polymobility Driving Assessments" (Attachment M)(CORRECTED 11/1/2). The new policy assesses the ability resident to safely operate their elect scooter in and outside of the facility assessment will be completed by Coupon admission, new use of an elect scooter, annually or has a change warranting a reassessment. IDT work provide input through the wipe boar process daily which will provide ong monitoring of the use of the electric scooter per individual resident.	afety oter. It as 8/10. It /. This OT by ower 22/16). / of the tric /. The otric ill od going	
	taken away some maintain his indep as not sustaining i building and not be building on his see Plan directed staff when leaving the bindicated R22 tool the parking lot or to make a loop ba (distance approximer Plan also directed gone more than or	re Plan indicated a stroke had of R22's abilities but he tried to endence with goals identified njury while outside of the eing hampered from leaving the other when desired. The Care to remind R22 to sign out building. The Care Plan a scooter [electric w/c] out in he pavement around the school ck to the nursing home. In a staff to look for R22 if he was ne hour while on his scooter if when he left the facility.			The DON created an electronic formula the EHR (PCC) that will automatical populate annually to complete a reassessment of the continued use electric scooter. (Attachment L). Putitled, "LTC Rehabilitation Screening sample electronic form are provided attachment L. (CORRECTED on 11/22/16). R22's LTC Power Mobility Driving Assessment will be completed inside facility by a (CORRECTION date of 12/13/16). Note resident does NOT operate the electric scooter outdoor during the winter months. The assessment for the outdoor use of	of the olicy g" and d in de the	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ¹ A. BUILDI		E CONSTRUCTION		E SURVEY PLETED
		245529	B. WING			10/2	28/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BIGFORE	(VALLEY COMMUNI	TIES		258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	R22's wife confirmed at times. R22's occupational dated 8/10/10, indicinstruction on safe to instructions for a portion of the policy of the	therapy (OT) assessment sated R22 was provided sechnique and operating ower wheelchair and indicated vigate the electric w/c in the ne record lacked in assessment of R22's safety in the outside environment. 55 a.m. nursing assistant orked with R22 and would ing R22 from his regular electric w/c. NA-C stated R22 when going out of the facility. NA-C stated R22 usually sometimes went up town. if R22 signed out before he lding.	F3	23	electric scooter will be completed in spring prior to resident going outdood. All other residents whom operate a electric scooter (4 total) will be reassessed by OT Melissa N. utilizinew assessment form (Attachment 12/07/16.(CORRECTED 12/07/16) REOCCURENCES WILL BE PREVENTED BY: QAPI IS CREATED ON 11/23/16 by DON in conjunction with the Occup Therapist to address the current an ongoing compliance with the LTC Probility Driving Assessment (Attach M) and policy titled, "LTC Rehability Screening" (Attachment L). Audits will be performed by OT on a monthly basis and PRN (as noted by to determine if further screening or updated screenings are necessary. OT will determine if further assess	ors. n ng the M) by / the ational d cower ment ation a pelow) Daily ment is	
	safely while using the the facility was goin evaluated, going to revise his care plan. No policy regarding	safety assessment for seed the community			to be completed based on the information received in the daily stand up meeting. OT will update DON on compliance findings immediately to ensure safe the residents whom utilize the elect scooters. DON will be updating during daily Sup meeting with IDT if there are any changes in condition which warrant	ings. ety of ric	
F 365		IN FORM TO MEET	F 3	65	changes in condition which warrant immediate reassessment by OT fol the policies above.		12/7/16

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	PROVIDER OR SUPPLIER K VALLEY COMMUN		2	STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	food prepared in a individual needs. This REQUIREME by: Based on observareview, the facilty full therapeutic diet an eating for 1 of 1 remechanically alteredifficulties with a risupervision when expervision when expervision with Parabetructive pulmor R38's significant of (MDS) dated 8/3/1	eives and the facility provides form designed to meet ENT is not met as evidenced ation, interview and document failed to serve the correct d provide supervision with sident (R38) who required food and had swallowing sk for choking which required feating. The Sheet indicate R38 was rkinson's and chronic fary disease. Thange Minimum Data Set 6, indicated R38 had severe	F 365	,	the diet G) and iotified /16) ed staff al soft ediately dietary oft with while		
	physical assist fror also indicated R38 loss of liquids/solid drinking and also of meals or when swa a change from the indicated R38 had R38's Nutritional C dated 8/4/16, indic problem and require	ent and required limited in staff for eating. The MDS had difficulty swallowing, had its from mouth when eating and coughed or choked during allowing medications. The was last MDS dated 6/21/16, which no swallowing difficulty. Eare Area Assessment (CAA) ated R38 had a swallowing red a mechanically altered diet nen eating in order to avoid		R38's care plan was updated once (corrected on 11/23/16) to include a category/problem in a separate set titled, "Risk for choking". This will a that nursing will be flagged in the E regarding the risk for choking. (Attachment G). ALL resident records have been refor proper diet order by the DON (corrected by 12/01/16).	a new ction ensure HR		

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		245529	B. WING_		10/:	28/2016	
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP	•		
BIGFOR	K VALLEY COMMU	NITIES		258 PINE TREE DRIVE, PO BOX 29 BIGFORK, MN 56628	58		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 365	complications. R38's Swallowing indicated R38 had risk of choking who supervised when indicated R38 chosmall bites. R38's speech the revealed recommodity swallowing which 90 degrees when 30 minutes follow meal, monitor lumproviding Sineme assist with motor meal. On 10/13/ralso recommendation changed to thin litherefore R38 waliquids. R38's physician of dated 10/15/15, who fat, mechanic consistency liquid inconsistent with recommendations. R38's October 20 record (MAR) ind 6:00 a.m., 10:00 for 10:p.m. daily.	g assessment dated 8/2/16, d been showing an increased hile eating and should be eating. The assessment also ewed food well but did not take example and remain sitting up for ving, group supervision during gs after eating and consider et (Parkinson's medication which control) one hour before the 16, the speech therapist had ed a mechanical soft diet with les however, on 11/2/15, the for thickened liquids was quid per resident request, s to receive regular consistency orders revealed a diet order which read R38 was to have a cal soft textured diet with nectar dis. Physician's orders were speech therapy	F 36	DON met with Speech their (11/01/16)to develop new propolicies for referrals, order recommendations. See possible seech Therapy Evaluation (Attachment I). (CORRECT This policy addresses dyspontial DON created new a new possible seech Therapy Evaluation (Attachment Communication (Attachment Communication) (Attachment Compliance with order processing staff and policies noted above (Attachment Completed by the licensed (CORRECTED ON 11/20/16) (CORRECTED ON 11/20/16) (CORRECTED ON 11/01/16) (CORRECTED ON 11/0	crocess and s and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COI 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE DATI		
F 365	assistance for ear revision to include recommendations type, consistency nursing assistant facility on 10/25/1 thick liquids, mec reflect the speech recommendations the risk for chokin assessment. A resident dietary dated 10/5/16, locused by dietary st meals, indicated I diet and thin liquid On 10/24/16, at 5 seated at a dining textured meal of coffee/water of th seated next to R3 eat/drink. At 5:26 p.m. R38 started coughing, in which R38 responetime R38 co-At 5:35 p.m. NA-walked away from the coffee and procough was moist. From 5:35 p.m. udrink the coffee wher throat. No nurdining room. On 10/25/16, at 4	ting The care plan lacked a e the speech therapist's sexcept for therapeutic diet and assistance needed. The (NA) care guide provided by the 6, indicated R38 required nectar hanical soft diet but did not a therapists eating soft. The care plan further lacked and based off the 8/2/16, serving guide or "cheat sheet" cated in the kitchen cabinet and the aff when preparing/serving R38 was to receive a regular disc. 123 p.m. R38 was observed a room table with a regular chili and French bread and in consistency. NA-D was and provided verbal cues to a took a drink of coffee and NA-D asked R38 if she was OK conded, yes. NA-D stated and the table. R38 took a drink of coeded to cough twice, the	F3	QAPI created on 11/23/16 all nursing assistants in condictory personnel are trained the dining room and the rest to ensure supervision is presidents whom are indiviplanned as a risk for chook personnel whom work in the within the LTC settings and will receive a mandatory regards to swallowing. In re-education will include the to report those signs immediately charge nurse (CORRECTI during mandatory meeting 12/07/16).	onjunction with med to monitor esidents therein rovided to those dually care sing. All Dietary the kitchenettes of the C.N.A's e-education on so monitor for in addition the he expectation ediately to the ED with all staff		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245529	B. WING			10/:	28/2016
	PROVIDER OR SUPPLIER			258	EET ADDRESS, CITY, STATE, ZIP CODE PINE TREE DRIVE, PO BOX 258 FORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 365	consistency water assistant (DA)-A with dining room. At 5: meal which consists salad and a tomate which appeared dreceive a regular of independently starts at ff members well-At 5:15 p.m. NA-Easked R38 how shows asked R38 how shows asked R38 and procham. R38 took at loud, hacking, moi put food onto R38' instructing R38 took at loud, hacking, moi put food onto R38' instructing R38 took at 5:34 p.m. NA-Eagain asked how real take more bites of At 5:37 p.m. NA-Eagain asked how real take more bites of At 5:37 p.m. NA-Eagain asked how real take more bites of At 5:37 p.m. NA-Eagain asked how real take more bites of At 5:37 p.m. NA-Eagain asked how real take more bites of At 5:37 p.m. NA-Eagain asked to consider taking bites of NE-A stated some and assist during recretified nursing as At 5:42 p.m. DA-Ahowever was no long to the part of the process of the pr	and orange wedges. A dietary ras the only staff member in the 00 p.m. DA-A served R38 her ted of a ham steak, potato of slice. DA-A cut up R38's ham by. DA-A stated R38 was to liet with thin liquids. R38 ted eating her meal. No other represent in the dining room. Expended the dining room and rewas doing. Experienced the dining room esent. DA-A stated she could reded to give R38 a bite of drink of water proceeded by a set cough. DA-A continued to so fork and provide verbal cues take bites of food. Experienced the dining room and R38 was. NA-Experienced take bites of food. Experienced the dining room and R38 was. NA-Experienced take bites of food. Experienced the dining room and R38 was. NA-Experienced take bites of food. Experienced her pocket care R38 required a mechanical soft liquids, R38 was at risk for red supervision when eating. The guides were updated daily coordinator. NA-Experienced to supervise meal times because some were	F3	65			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245529	B. WING _		10	/28/2016	
	PROVIDER OR SUPPLIER K VALLEY COMMUN			STREET ADDRESS, CITY, STATE, ZIP COD 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 365	pureed diet had be not tolerated due to unaware of what corecommended and frequently as some and other times it was a commended. The commended is think R38 needed R38's diet had bee weight therefore it. On 10/27/16, at 10 stated recommended there was a commended there was a commender was a commender was a commender of the care plan by either stated the care plan kitchen was not conformed on their stated the care plan kitchen was remothere was a commender wa	ben recommended but R38 had be weight loss. FM-A was consistency liquid had been a stated it seemed to change etimes thickened was served was regular liquids. 49 p.m. registered nurse was on a mechanical soft diet tency liquids, RN-D did not thickened liquids. RN-D stated in pureed, however, had lost was discontinued. 30 a.m. the speech therapist led interventions were ded to the care plan and felt unication flaw between	F 36	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· /	(X3) DATE SURVEY COMPLETED	
		245529	B. WING _		10/	28/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 365	revised 10/5/16 incomplete and many coordinator and the would aid in preventhe resident's functional levels. The policy in assessment of resplans and pocket of information about the condition arose. The facility's Dysplandicated if a resident swallowing, staff where would attempt to form the speech therapy events would attempt to form the speech therapists. As 3.35(h) FEEDIN TRAINING/SUPER A facility may use a defined in §488.30 assistant has succestate-approved transplanting the consistent with Staff and the	Int Plan of Care policy last dicated the care plan would be intained by the MDS enursing team, the care plan inting or reducing declines in tional status and/or functional informed and directed staff idents were ongoing and care care plans were revised as the resident and the resident's interested and the resident's interested and order for a calculation in which the staff ollow recommendations by the CASST - RVISION/RESIDENT The paid feeding assistant, as 1 of this chapter, if the feeding essfully completed a completed in a course that meets the complete staff of the staff of the staff of this chapter, if the feeding essfully completed a course that meets the course of feeding assistants is the law.	F 36			11/14/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245529	B. WING _		10	/28/2016
	PROVIDER OR SUPPLIER	TIES		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 373	A facility must ensure feeds only resident feeding problems. Complicated feeding not limited to, difficaspirations, and tule. The facility must be charge nurse's assilatest assessment. NOTE: One of the regulatory requirent feeding assistants program with the fospecified at §483.1 o A State-approve feeding assistants hours of training in Feeding technic Assistance with Communication Appropriate resident rights. Recognizing chain consistent with the importance of reposupervisory nurse. A facility must main used by the facility	are that a feeding assistant is who have no complicated on problems include, but are ulty swallowing, recurrent lung on parenteral/IV feedings. The assert resident selection on the resident's and plant paid the resident selection on the resident's and plant paid the resident's and plant paid the resident selection on the resident's and plant paid th	F 37	73		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245529	B. WING		10/28/2016
	PROVIDER OR SUPPLIER K VALLEY COMMUNI	TIES		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 373	Continued From pa	nge 34	F 373	3	
	by: Based on observa review, the facility f assistants had not	NT is not met as evidenced tion, interview and document ailed to ensure paid feeding fed residents with identified es for 1 of 1 resident (R3) who owing difficulty.		CORRECTIVE ACTION: Paid feeding assistants were re-ed verbally IMMEDIATELY as to which residents they could assist with fee (COMPLETED ON 10/26/16). Paid feeding assistants were immeinstructed (COMPLETED ON 10/26 that they could not assist R3.	ding diately
	admission diagnos limited to: Pick's dis frontotemporal den neurodegenerative progressive destructions symptoms include	nentia, characterized as a rare disease that causes ction of nerve cells in the brain. dementia and loss of esophageal reflux disease, and		R3 has the C.N.A's assisting him w feeding (and spouse when she is p for mealtime). (COMPLETED ON 10/26/16). This was audited for compliance by the DON throughou remaining days of the Paid Feeding Assistant position. RECURRENCES WILL BE PREVE BY:	t the
	indicated R3 had m communicate need two persons for mo assistance of one p identified R3 had of and when swallowing			Director of Senior Services discont the Paid Feeding Assistant role at I 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 F	o Sigfork
	during the evening him to eat a pureed	on 10/25/2016, at 5:05 p.m. meal while his wife assisted I diet. R3 was noted to have movements with his arms		Assistant position.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION IG		FE SURVEY MPLETED
		245529	B. WING _		10	/28/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 373	raised to mid chesitime and R3 was n while swallowing the was interviewed or verified R3 had swallow Pick's disease and not want R3 asses because there was available due to R3	t level for extended periods of loted to cough numerous times are pureed food. The wife of R3 in 10/26/2016, at 11:53 a.m. and allowing difficulty as a result of told the facility staff she did sed for swallowing ant further is no further interventions B's degenerative diagnoses.	F 37	73		
	10/26/2016, at 8:03 assistant (PFA)-A a was noted to have coughed many time was interviewed dushe had completed assisting residents	during the breakfast meal on 3:10 a.m. while paid feeding assisted R3 with eating. R3 swallowing difficulty and es while swallowing. PFA-A uring this time and stated that d a course that taught skills for to eat in April 2015, and was ng meals and knew R3 had g.				
	completed on 11/1 for choking and ma assistant. The ass	wallowing evaluation 7/15, identified R3 at a low risk ay be fed by a paid feeding essment had not identified R3 ing food or swallowing.				
	a regular diet with liquids. R3 liked ma R3's wife was very wheelchair at meal R3's family fed R3 textures. R3's wife evaluations to be diet.	plan indicated R3 was served puree texture and thickened ashed potatoes and gravy. involved in cares, R3 sat in a I time, used a cover up and favorite foods with regular had requested no swallowing lone. Please let the natural disease take its course.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		E SURVEY IPLETED
		245529	B. WING _		10/	28/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 373	indicated at approto to cough and shake episodes lasting 3 minute time frame inspiratory in his leand wheezing gondown, Vital signs a elder down in bed, slept most of after were documented. On 10/26/2016, at established she we had swallowing diffmost meals and it has gotten used to Registered Nurse R3's care on 10/26 p.m. and stated shorovider to R3 since R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 had swallowing since October 201 responsible for R3 The facility policy fassistered Nurse R3 had swallowing since October 201 responsible for R3 had swal	R Note Text dated 10/17/15, kimately 12:10 p.m. R3 started e after lunch. He had seven 0 seconds or less within a 20. R3 had had slight wheezing off upper lobe. After coughing e, R3 was able to relax. R3 laid and oxygen level checked. Laid changed and cleaned him up-noon." No further episodes in R3's medical record. 2:20 nursing assistant (NA)-Horked the evening shift and R3 ficulty and coughed during used to scare her but NA-Horked to scare her but NA-Horked R3 coughing while eating. (RN)-F who was assigned to 6/16, was interviewed at 12:26 he had been a consistent care be October 2015, and reported a difficulty and coughing spells 5 when RN-F had been 's care. or PAID FEEDING and 5/7/15, indicated PFA's will with complex feeding problems story of aspiration, feedings) or other residents RN, RD, or Speech and	F 37	3		
	further swallowing should not have co	ies and when R3's wife refused evaluations after 11/17/15, R3 ontinued to be assisted with eding assistant because there				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		245529	B. WING		10/	/28/2016
	PROVIDER OR SUPPLIER		25	TREET ADDRESS, CITY, STATE, ZIP CODE 58 PINE TREE DRIVE, PO BOX 258 IGFORK, MN 56628	100	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 373		age 37 essment to determine R3's	F 373			

F5299026

PRINTED: 11/30/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG 01 - Nursing Home		E SURVEY PLETED	
		245529	B. WING_	<u>_</u>	10/	26/2016	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		ODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
K 000	ALLEGATION OF DEPARTMENT'S SIGNATURE AT TOMS-2567 FORM VERIFICATION OF UPON RECEIPT ON-SITE REVISITY CONDUCTED TO SUBSTANTIAL OF REGULATIONS HACCORDANCE WERE SAFETY A Life Safety Code Minnesota Depart Fire Marshal Divise Bigfork Valley Communication Medicare/Medication of National (NFPA) Standard Chapter 19 Existing PLEASE RETURN	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR THE BOTTOM OF THE I WILL BE USED AS OF COMPLIANCE. OF AN ACCEPTABLE POC, AN I OF YOUR FACILITY MAY BE O VALIDATE THAT OMPLIANCE WITH THE HAS BEEN ATTAINED IN VITH YOU VERIFICATION. The Survey was conducted by the ment of Public Safety, State sion. At the time of this survey mmunities Nursing Home 01 Is found not in substantial the requirements for participation caid at 42 CFR, Subpart Infety from Fire, and the 2000 I Fire Protection Association 101, Life Safety Code (LSC), the Health Care. N THE PLAN OF OR THE FIRE SAFETY K-TAGS) TO: Inspections In Division	K 00		OC		

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.

If continuation sheet Page 1 of 9

11/23/2016

Electronically Signed

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION 1 - NURSING HOME		PLETED
		245529	B, WING		10/	26/2016
	245529 ME OF PROVIDER OR SUPPLIER GFORK VALLEY COMMUNITIES (4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		1 10/20/20 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	St. Paul, MN 5510 Or by email to bot Marian. Whitney@and Angela. Kappenma THE PLAN OF CODEFICIENCY MUFOLLOWING INF 1. A description of to correct the definition of the correct the definition of the constructed in 19 without a baseme In 1985 a 1-story north of the origin to be Type II (111) addition with a base wing of the codetermined to be building is divided minute and 2-hou building has a constructed.	ch: estate.mn.us an@state.mn.us ORRECTION FOR EACH IST INCLUDE ALL OF THE FORMATION: f what has been, or will be, done ciency. oroposed, completion date. for title of the person orrection and monitoring to rence of the deficiency. mmunities Nursing Home was es. The original building was 72 and is a 1-story building ent of Type II (111) construction. addition was constructed to the hall building and was determined of construction. In 1999, a 1-story is ement was constructed off the original building and was type II (000) construction. The d into 4 smoke zones with 30 are fire barriers. The original mmon 2-hour fire barrier				

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			TE SURVEY MPLETED
		245529	B. WING			/26/2016
	PROVIDER OR SUPPLIER	ITIES		25	REET ADDRESS, CITY, STATE, ZIP CODE 8 PINE TREE DRIVE, PO BOX 258 GFORK, MN 56628	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	system installed in Standard for the In 1999 edition. The f that includes corrid additional detection in accordance with Alarm Code" 1999 department notifica automatic fire dete system in accordance Fire Code 2007 ed Because the origin meet the construct buildings, this facil building Type II (00 The facility has a construct of the construct of	accordance with NFPA 13 stallation of Sprinkler Systems facility has a fire alarm system for smoke detection, with in in all common areas installed NFPA 72 "The National Fire edition, with automatic fire edition. All hazardous areas have ction that is on the fire alarm ince with the Minnesota State ition. al building and its additions ion type allowed for existing ity was surveyed as one	K	0000		
K 048 SS=F	The requirement a NOT MET. NFPA 101 LIFE SA There is a written patients and for the an emergency. This STANDARD Based on observate facility has failed to current fire evacuathe NFPA 101 "The edition (LSC) section practice could affe an undetermined reservance.	t 42 CFR, Subpart 483.70(a) is AFETY CODE STANDARD clan for the protection of all eir evacuation in the event of 19.7.1.1 is not met as evidenced by: ation and staff interview, the coprovide a complete and ation policy in accordance with the Life Safety Code" 2000 on 19.7.2.2. This deficient ct 44 of 44 residents, as well as number of staff, and visitors.		048	CORRECTIVE ACTION: Plant Operations Director and Emergence 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).	
	Findings include: On facility tour bet	ween 11:00 a.m. to 3:00 p.m.			All staff will be re-educated in a mandatory inservice scheduled for	

NAME OF PRO		TATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME		(X3) DATE SURVEY COMPLETED	
NAME OF PRO		245529	B. WING		10/2	26/2016	
BIGFORK V	OVIDER OR SUPPLIER	TIES		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
or it v ou 20 ele pr tra	was revealed that vacuation Plan did utlined in the NFP 000 edition (LSC) lement that was nesented at the ting.	ing the documentation review the facility's Fire Emergency do not address all eight element A 101 "The Life Safety Code" sections 19.7.2.2. The ot provided in the plan the of the inspection was, fire alarm to the fire	К0	12-13-16. All emergency preparedness bi located on the nursing stations nursing home have up to date pof 11-22-16. RECURRENCE WILL BE PREBY:	of the policies as		
K 050 NI SS=F Fi sii cc tir or ar ro cc pe W 6: in 18 TI E in to the	laintenance Supe IFPA 101 LIFE SA ire drills include the ignal and simulation onditions. Fire drill mes under varying neach shift. The nd is aware that doutine. Responsible onducting drills is ersons who are qualities are considered of audible and a stead of audible and a stead on review of the conduct 1 of 12 one NFPA 101 "The dition (LSC) section of 144 resignal includes a section of 144 resignal includes a section of 150 conduct 1 of 12 one NFPA 101 "The dition (LSC) section of 144 resignal includes a section of 144 resignal include	retransmission of a fire alarm on of emergency fire ls are held at unexpected g conditions, at least quarterly staff is familiar with procedures it is are part of established ility for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and nnouncement may be used	K	Emergency preparedness Directly educated as to all of the Life Sain LTC. (Corrected 11/01/16). CORRECTIVE ACTION: Plant Services Director immed re-educated maintenance staff the fire drills as per life safety (least quarterly on each shift (CORRECTED 10/26/16). RECURRENCES WILL BE PRBY:	iately to perform code - at	10/26/16	

			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME		(X3) DATE SURVEY COMPLETED		
		245529	B. WING			10/2	26/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE.	(X5) COMPLETION DATE
O oi fii M	n 10/26/2016, dur re drill documenta /laintenance Supe	ween 11:00 a.m. to 3:00 p.m. ing the review of all available tion and interview with the rvisor it was revealed that the ucted the overnight fire drill in	K	050	The Director of Plant Operations we schedule the fire drill with maintena staff, fill out the log form for drills the check IMMEDIATELY to verify the took place and that the log is filled appropriately. (CORRECTED 10/2)	ance nen drill out	
K 052 SS=F A b N N a m a 9 T E fa s the e 1 S a a u fa	Maintenance Supe IFPA 101 LIFE SA fire alarm system te, tested, and ma IFPA 70 National I Mational Fire Alarm available. The systemaintenance and trapplicable requirence of the STANDARD of the STANDARD of the NFPA 101 "The Edition (LSC) Sections 7.1. The	ition was verified by the rvisor. FETY CODE STANDARD required for life safety shall intained in accordance with Electric Code and NFPA 72 Code and records kept readily em shall have an approved esting program complying with ment of NFPA 70 and 72. Is not met as evidenced by: tion and staff interview, the sall and maintain the fire alarm more with the requirements of a Life Safety Code" 2000 ons 19.3.4., 19.3.6.3.2, as well as 1999 NFPA 72, se deficient practices could be functioning of the fire alarm delay the timely notification and a for the facility thus negatively residents as well as an ber of staff, and visitors to the	K	052	CORRECTIVE ACTION: The Director of Plant Operations re-educated the Maintenance staff perform the digital alarm commun transmitter testing monthly that documentation of said testing mus completed accurately and timely to comply with Life Safety Code. (CORRECTED 10/28/16). RECURRENCE WILL BE PREVE BY: The Director of Plant Operations of partake in a QAPI (QUALITY)	icator st be o	10/28/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME			(X3) DATE SURVEY COMPLETED	
		245529	B. WING		<u>=</u> =	10/2	26/2016
	PROVIDER OR SUPPLIER K VALLEY COMMUNI	TIES		25	TREET ADDRESS, CITY, STATE, ZIP CODE 58 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 052	last 12 months and Administrator, it wa failed to document	e/testing documentation for the lan interview with the as revealed that the facility and/or verify 3 of 12 monthly alarm communicator	K	052	11/23/16) to ensure compliance is achieved on a monthly basis. Dire perform audits on the log sheet for documenting the DACT.		
K 069 SS=F	Maintenance Supe NFPA 101 LIFE SA Cooking facilities a with 9.2.3. 19.3.2 This STANDARD Based on observa facility is cooking for grease-laden vapo kitchen open to the proper exhaust how extinguishing system 101(00), Sections 9 96(98) 1-3.1. This	re protected in accordance 2.6, NFPA 96 is not met as evidenced by: tions and staff interview, the cod items that produces rs in 3 of 3 neighborhood e dining rooms without the cod equipment and em in accordance with NFPA 9.2.3, 19.3.2.6 and NFPA deficient practice could affect as well as an undetermined	K	069	CORRECTIVE ACTION: Dietary Manager and Director of S Services re-educated all Cooks th proper procedure must be followed leaving the neighborhood kitchens stoves must be shut down via the shutoff and the key must be remove from the shutoff each time the kitch left unattended. (CORRECTED 10)	nat the d when i: All power ved hen is	10/26/16
	on 10/26/2016, it was neighborhood kitch rooms located with observed that the stresidents. During found unattended is kitchens and the state power shutoff to stoves. The neighborhood kitchens and the stoves.	ween 11:00 a.m. to 3:00 p.m. yas observed that there are 3 nens that are open to the dining in the facility. it was also stoves are accessible to the the facility tour a resident was n one of the neighborhood tove was still energized from o the controls located on the borhood kitchens are equipped wer shutoff but according to a			RECURRENCE WILL BE PREVE BY: A QAPI (QUALITY ASSURANCE PERFORMANCE IMPROVEMEN' initiated by the Director of Senior S on 10/27/16. Audits in alternating will be performed by the Director of Services/Dietary Manager or design times per week until compliance is Once compliance is met audits we continue on a regular basis to ensistoves are "shut off with key remowhen unattended by Cooks. (Corr	T)was Services kitchens of Senior gnee 5 s met. ill ure ved"	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME		SURVEY	
		245529	B. WING _		10/2	6/2016	
	PROVIDER OR SUPPLIER	ITIES		STREET ADDRESS, CITY, STATE, ZIP C 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 069	kitchen staff memb "are not turned off unattended". Upor determined that the controls that are lo	per the lockable power shutoffs when the stoves are n closer investigation it was ere is still power flowing to the cated on the stoves, and the tops were unattended while	K 06	9 10/26/16) with ongoing audi Education will be provided to dietary and annual employe Dietary Manager regarding noted above.	o all new es via the		
K 154 SS=F	Maintenance Super NFPA 101 LIFE SA Where a required a out of service for neriod, the authority and the building is watch system is prunprotected by the system has been rathis STANDARD Based on a record facility has failed to acceptable written be followed in the sprinkler system has for four or more had deficient practice of for early response would affect the sa well as an undeter visitors to the facility findings include. On facility tour bet on 10/26/2016, du	automatic sprinkler system is nore than 4 hours in a 24-hour ty having jurisdiction is notified, evacuated or an approved fire rovided for all parties left shutdown until the sprinkler returned to service. 9.7.6.1 is not met as evidenced by: d review and staff interview, the provide a complete and policy containing procedures to event that the automatic fire as to be placed out-of-service ours in a 24 hour period. This could affect the facility's ability and notification of a fire and afety of 44 of 44 residents as mined number of staff, and	K 15	CORRECTIVE ACTION: The Plant Operations Direction Protection System out (see ATTACHMENT C); with Watch Log sheet" attached ATTACHMENT D). All lang is based on K154. (CORRECTI/17/16). The Plant Operations Direction immediately educated all Material personnel who perform dutation frie Protection System out policy (CORRECTED ON 1).	olicy titled, t of Service th the "Fire I to policy(see uage contained ECTED ON ctor faintenance ties listed in the of Service 11/17/16).	11/17/16	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' ′		E CONSTRUCTION 01 - NURSING HOME		SURVEY
		245529	B. WING			10/2	6/2016
	PROVIDER OR SUPPLIER VALLEY COMMUNI	TIES		2	TREET ADDRESS, CITY, STATE, ZIP CODE 58 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 154	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. All Maintenance personnel will receive new hire and annual education per the Director of Plant Operations regarding the Fire Protection system out of service		he ng the				
K 155 SS=F	Maintenance Supe NFPA 101 LIFE SA	FETY CODE STANDARD	К	155	policy going forward.		11/17/16
	service for more the the authority having building is evacuate provided for all part shutdown until the returned to service. This STANDARD Based on a record facility has failed to acceptable written be followed in the esystem has to be provided in the esystem has to be provided and affect the safety of	ire alarm system is out of an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been . 9.6.1.8 is not met as evidenced by: I review and staff interview, the provide a complete and policy containing procedures to event that the Fire Alarm blaced out-of-service for four or hour period. This deficient ct the facility's ability for early ication of a fire and would 44 of 44 residents as well as number of staff, and visitors to			CORRECTIVE ACTION: The Plant Operations Director immediately wrote a new policy titled "Fire Protection System out of Servic (see ATTACHMENT C); with the "Fir Watch Log sheet" attached to policy ATTACHMENT D). All language con is based on K155. (CORRECTED C 11/17/16). The Plant Operations Director	ce re (see ntained	
	on 10/26/2016, dui interview with the Macility did not have system out of servicurrent State Fire I	ween 11:00 a.m. to 3:00 p.m. ring a records review and an Maintenance Supervisor, the e an acceptable fire alarm ice policy that included the Marshal's contact information in e sprinkler being out of service			immediately educated all Maintenan personnel who perform duties listed Fire Protection System out of Service policy (CORRECTED ON 11/17/16) RECURRENCES WILL BE PREVEIBY: All Maintenance personnel will receive new hire and annual education per form.	I in the ce . NTED	

STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - NURSING HOME		PLETED
		245529	B. WING			10/2	26/2016
	AME OF PROVIDER OR SUPPLIER IGFORK VALLEY COMMUNITIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		1	25	REET ADDRESS, CITY, STATE, ZIP CODE 8 PINE TREE DRIVE, PO BOX 258 GFORK, MN 56628	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 155	and the need for a	a fire watch to be initiated	K 1	55	Director of Plant Operations regard Fire Protection system out of servi policy going forward.		

F5299026

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION NG 03 - ASPEN CIRCLE		E SURVEY IPLETED
		245529	B, WING _		10/	26/2016
	PROVIDER OR SUPPLIER K VALLEY COMMUNI	TIES		STREET ADDRESS, CITY, STATE, ZIP CO 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	K 00	00		
	FIRE SAFETY					
	ALLEGATION OF DEPARTMENT'S ASIGNATURE AT TICMS-2567 FORM VERIFICATION OF UPON RECEIPT CON-SITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE				
	Minnesota Departr Fire Marshal Divisi Bigfork Valley Com found in substanti requirements for p Medicare/Medicaid 483.70(a). Life Sat edition of National	d at 42 CFR, Subpart fety from Fire, and the 200 Fire Protection Association 101, Life Safety Code (LSC) lealth Care.		EPC	C	
	CORRECTION FO	OR THE FIRE SAFETY				

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.

Facility ID: 00834

If continuation sheet Page 1 of 9

11/23/2016

Electronically Signed

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		PLE CONSTRUCTION G 03 - ASPEN CIRCLE		E SURVEY PLETED
		245529	B. WING	-		10/:	26/2016
	PROVIDER OR SUPPLIER K VALLEY COMMUNI	TIES			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa St. Paul, MN 5510 Or by email to both Marian.Whitney@s and Angela.Kappenma	I-5145, OR :: state.mn.us	K	000			
	DEFICIENCY MUSE FOLLOWING INFO	what has been, or will be, done					
	Bigfork Valley Comone story building value construction type is The building is sepfacility by 2 hour fir & 1/2 hour rated fir The building is fully facility has a comp system, with smok spaces open to the	nmunities/Aspen Circle. It is a with no basement. The s determined to be type II(000). Parated from the rest of the reated construction, with a 1					
	resident rooms had detectors that trans	we single station smoke smit to the nurses station. sed for 47 beds, with a census					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG 03 - ASPEN CIRCLE		SURVEY PLETED
		245529	B. WING_		10/2	26/2016
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From p	age 2	K 00	00		
K 018 SS=F	is NOT MET. NFPA 101 LIFE S. Doors protecting of constructed to rest Clearance between covering is not excimpediment to the devices that relea pulled are permitted positive latching in 18.3.6.3.6 are perprohibited. 18.3.6.3 This STANDARD Based on observing had 1 of several of the requirements (2000 edition), see practice could affect visitors, if smoke the exit access constructed. On facility tour be on 10/26/2016, it resident room 3 is constructed.	AFETY CODE STANDARD corridor openings shall be ist the passage of smoke. In bottom of door and floor ceeding 1 inch. There is no closing of the doors. Hold open se when the door is pushed or ed. Doors shall be provided with ardware. Dutch doors meeting mitted. Roller latches shall be is not met as evidenced by: ation and interview, the facility corridor doors that did not meet of NFPA Life Safety Code 101 ction 18.3.6.3.2. This deficient ect 18 of 44 residents, staff and from a fire were allowed to enter orridors making it untenable.	Κ0	CORRECTIVE ACTION: Plant Operations Director in adjusted the door to Rm 3 in ensure it would close and la into the frame (CORRECTE RECURRENCES WILL BE BY: Plant Operations Director a maintenance personnel will regular audits on corridor do they close and latch secure frame.	n Aspen to atch securely ED 10/27/16). PREVENTED and perform pors to ensure	10/27/16
K 048 SS=F	Maintenance Sup	dition was verified by the ervisor. AFETY CODE STANDARD	K	48		11/22/16

Facility ID: 00834

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		DENTIFICATION NUMBER) MULTIPLE CONSTRUCTION BUILDING 03 - ASPEN CIRCLE			(X3) DATE SURVEY COMPLETED	
		245529	B. WING			10/2	6/2016	
	NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES			25	FREET ADDRESS, CITY, STATE, ZIP CODE 58 PINE TREE DRIVE, PO BOX 258 IGFORK, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
K 048	patients and for the an emergency. 18.7.1.1, 19.7.1.1 This STANDARD Based on observa facility has failed to current fire evacua the NFPA 101 "The edition (LSC) secti practice could affe an undetermined refindings include: On facility tour bet on 10/26/2016, duit was revealed that Evacuation Plan doutlined in the NFF 2000 edition (LSC) element that was represented at the titransmission of the department.	plan for the protection of all beir evacuation in the event of the provide a complete and the evacuation policy in accordance with the Life Safety Code" 2000 on 18.7.2.2. This deficient of 44 of 44 residents, as well as the evacuation of staff, and visitors. The evacuation is a serious and the evacuation of the facility's Fire Emergency of the evacuation of the evac)48	CORRECTIVE ACTION: Plant Operations Director and Emergence Preparedness Director updated the Policy/Evacuation Policy specific to term care/nursing home/Aspen Cir Facility wide policy to include mandialing of 911 in the event of a fire 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 binde located on the nursing stations of nursing home/Aspen Circle have update policies (attachment A, B) as 11-22-16. RECURRENCE WILL BE PREVE BY: Emergency preparedness Directo educated as to all of the Life Safet in LTC. (Corrected 11/01/16).	e Fire o long role and ual (See		
K 050 SS=F	Fire drills include t signal and simulat conditions. Fire dri times under varyin on each shift. The	AFETY CODE STANDARD the transmission of a fire alarm tion of emergency fire tills are held at unexpected g conditions, at least quarterly staff is familiar with procedures drills are part of established		050			10/26/16	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION NG 03 - ASPEN CIRCLE		SURVEY PLETED	
		245529	B. WING		10/2	26/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 050	conducting drills is persons who are of Where drills are conducted instead of audible 18.7.1.2, 19.7.1.2. This STANDARD Based on review interview, it was do to conduct 1 of 12 the NFPA 101 "The edition (LSC) sect 12-month period." affect 44 of 44 resundetermined number on 10/26/2016, dufire drill document Maintenance Supplement of the second calend	polity for planning and assigned only to competent qualified to exercise leadership. Inducted between 9:00 PM and announcement may be used alarms. It is not met as evidenced by: of reports, records and staff etermined that the facility failed fire drills in accordance with e Life Safety Code" 2000 ion 18.7.1.2, during the last This deficient practice could idents, as well as an other of staff, and visitors. In ween 11:00 a.m. to 3:00 p.m. ring the review of all available ation and interview with the ducted the overnight fire drill in lar quarter.	KO	CORRECTIVE ACTION: Plant Services Director imm re-educated maintenance st the fire drills as per life safet least quarterly on each shift (CORRECTED 10/26/16). RECURRENCES WILL BE BY: The Director of Plant Opera schedule the fire drill with m staff, fill out the log form for check IMMEDIATELY to ver took place and that the log i appropriately. (CORRECTE	paff to perform ty code - at PREVENTED tions will aintenance drills then ify the drill s filled out	
K 052 SS=F	A fire alarm syster be, tested, and many NFPA 70 National National Fire Alarm available. The system maintenance and	AFETY CODE STANDARD m required for life safety shall aintained in accordance with Electric Code and NFPA 72 m Code and records kept readily stem shall have an approved testing program complying with ment of NFPA70 and 72.		052		10/28/16

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 03 - ASPEN CIRCLE	(X3) DATE	SURVEY PLETED
		245529	B. WING	-	10/2	26/2016
	PROVIDER OR SUPPLIER VALLEY COMMUNI	TIES		STREET ADDRESS, CITY, STATE, ZIF 258 PINE TREE DRIVE, PO BOX 2 BIGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 052	Based on observation facility failed to instance the NFPA 101 "The edition (LSC) Sections 7.1. The adversely affect the system that could be emergency actions affecting 44 of 44 residuely facility faci	age 5 is not met as evidenced by: tion and staff interview, the tall and maintain the fire alarm nce with the requirements of the Life Safety Code" 2000 ions 18.3.4., 18.3.6.3.2, as well as 1999 NFPA 72, se deficient practices could the functioning of the fire alarm delay the timely notification and the for the facility thus negatively residents as well as an other of staff, and visitors to the	ΚO	CORRECTIVE ACTION: The Director of Plant Opere-educated the Maintena perform the digital alarmetransmitter testing month documentation of said test completed accurately and comply with Life Safety C (CORRECTED 10/28/16) RECURRENCE WILL BE BY: The Director of Plant Opepartake in a QAPI (QUAL)	erations ance staff who communicator by that sting must be if timely to ode. PREVENTED erations will	
	on 10/26/2016, duralarm maintenance last 12 months and Administrator, it was failed to document tests of the digital transmitter (DACT	•		ASSURANCE PERFORM IMPROVEMENT) -(COR 11/23/16) to ensure compachieved on a monthly be perform audits on the log documenting the DACT.	MANCE RECTED bliance is asis. Director will	
K 069 SS=F	Maintenance Supe NFPA 101 LIFE SA Cooking facilities s accordance with 9 18.3.2.6, 19.3.2.6, This STANDARD Based on observa facility is cooking f grease-laden vapo	AFETY CODE STANDARD shall be protected in .2.3. NFPA 96 is not met as evidenced by: ations and staff interview, the ood items that produces ors in 3 of 3 neighborhood e dining rooms without the	K	CORRECTIVE ACTION Dietary Manager and Dir Services re-educated all proper procedure must b	ector of Senior Cooks that the	10/26/16

AND DUAN OF CORRECTION DENTIFICATION NUMBER:		l ` ′		CONSTRUCTION 3 - ASPEN CIRCLE		SURVEY	
		245529	B, WING 10		10/2	0/26/2016	
	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 069	extinguishing system 101(00), Sections 96(98) 1-3.1. This 44 of 44 residents, number of staff, are Findings Include: On facility tour betton 10/26/2016, it woneighborhood kitch rooms located with observed that the residents. During found unattended kitchens and the staff power shutoff is stoves. The neighborhood with a lockable power shutoff is stoves. The neighborhood with a lockable power shutoff is stoves. The neighborhood with a lockable power shutoff is stoves. The neighborhood with a lockable power shutoff is stored. Upon determined that the controls that are lockable power shutoff is stored.	em in accordance with NFPA 9.2.3, 18.3.2.6 and NFPA deficient practice could affect as well as an undetermined ad visitors ween 11:00 a.m. to 3:00 p.m. was observed that there are 3 nens that are open to the dining in the facility. It was also stoves are accessible to the the facility tour a resident was in one of the neighborhood tove was still energized from to the controls located on the borhood kitchens are equipped wer shutoff but according to a per the lockable power shutoffs when the stoves are in closer investigation it was ere is still power flowing to the tops were unattended while	K	069	leaving the neighborhood kitchen Circle: Stove must be shut down power shutoff and the key must be removed from the shutoff each tilk kitchen is left unattended. (CORF 10/26/16). RECURRENCE WILL BE PREVEBY: A QAPI (QUALITY ASSURANCE PERFORMANCE IMPROVEMEN initiated by the Director of Senior on 10/27/16. Audits in the Aspen will be performed by the Director Services/Dietary Manager or destimes per week until compliance Once compliance is met audits we continue on a regular basis to enstoves are "shut off with key remwhen unattended by Cooks. (Cor 10/26/16) with ongoing audits in Education will be provided to all redietary and annual employees via Dietary Manager regarding the proted above.	via the e me the RECTED IT)was Services Kitchen of Senior ignee 5 is met. vill sure oved" rected place. mew a the	
K 154 SS=F	Maintenance Supe NFPA 101 LIFE SA Where a required out of service for r period, the authori notified, and the b	dition was verified by a ervisor. AFETY CODE STANDARD automatic sprinkler system is nore than 4 hours in a 24-hour ty having jurisdiction shall be uilding shall be evacuated or anoth system be provided for all		154			11/17/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					CONSTRUCTION 3 - ASPEN CIRCLE	(X3) DATE COMP	SURVEY
		245529	B. WING			10/2	6/2016
	ROVIDER OR SUPPLIER			25	REET ADDRESS, CITY, STATE, ZIP CODE 8 PINE TREE DRIVE, PO BOX 258 GFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 154	Based on a recorfacility has failed to acceptable written be followed in the sprinkler system in for four or more hedeficient practice for early response would affect the swell as an undetervisitors to the facility four beautiful to the facility did not have system out of servicerent State Fire the event of the finand the need for a This deficient confunction Maintenance Sup NFPA 101 LIFE Swhere a required service for more to the authority having and the building sapproved fire wat parties left unprotifice alarm system been returned to	is not met as evidenced by: d review and staff interview, the o provide a complete and policy containing procedures to event that the automatic fire las to be placed out-of-service ours in a 24 hour period. This could affect the facility's ability and notification of a fire and afety of 44 of 44 residents as rmined number of staff, and ity. Itween 11:00 a.m. to 3:00 p.m. Iring a records review and an Maintenance Supervisor, the re an acceptable fire sprinkler vice policy that included the Marshal's contact information in re sprinkler being out of service a fire watch to be initiated. Idition was verified by the ervisor. AFETY CODE STANDARD fire alarm system is out of than 4 hours in a 24-hour period, and jurisdiction shall be notified, whall be evacuated or an ch shall be provided for all ected by the shutdown until the has		54	CORRECTIVE ACTION: The Plant Operations Director immediately wrote a new policy title "Fire Protection System out of Serv (see ATTACHMENT C); with the "F Watch Log sheet" attached to polic ATTACHMENT D). All language co is based on K154. (CORRECTED C11/17/16). The Plant Operations Director immediately educated all Maintena personnel who perform duties lister Fire Protection System out of Servi policy (CORRECTED ON 11/17/16). RECURRENCES WILL BE PREVE BY: All Maintenance personnel will recense hire and annual education per Director of Plant Operations regard Fire Protection system out of service policy going forward.	nice ire y(see ntained ON nce d in the ice). ENTED eive the ding the	11/17/16

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION D3 - ASPEN CIRCLE	(X3) DATE COMF	SURVEY
		245529	B. WING			10/2	6/2016
	PROVIDER OR SUPPLIER			25	FREET ADDRESS, CITY, STATE, ZIP CODE 58 PINE TREE DRIVE, PO BOX 258 IGFORK, MN 56628		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 155	facility has failed to acceptable written be followed in the exystem has to be properties and notification of the facility. Findings include: On facility tour betton 10/26/2016, duinterview with the lacility did not have system out of servicurrent State Fire the event of the fire and the need for a system.	d review and staff interview, the provide a complete and policy containing procedures to event that the Fire Alarm placed out-of-service for four or hour period. This deficient ct the facility's ability for early fication of a fire and would 44 of 44 residents as well as number of staff, and visitors to ween 11:00 a.m. to 3:00 p.m. ring a records review and an Maintenance Supervisor, the e an acceptable fire alarm ice policy that included the Marshal's contact information in e sprinkler being out of service fire watch to be initiated		155	CORRECTIVE ACTION: The Plant Operations Director immediately wrote a new policy tit "Fire Protection System out of Se (see ATTACHMENT C); with the 'Watch Log sheet" attached to pol ATTACHMENT D). All language of is based on K155. (CORRECTED 11/17/16). The Plant Operations Director immediately educated all Mainterpersonnel who perform duties list Fire Protection System out of Serpolicy (CORRECTED ON 11/17/17). RECURRENCES WILL BE PREVENCES WILL BE PREVENCES WILL BE PREVENCES OF Plant Operations regal Fire Protection system out of serpolicy going forward.	rvice 'Fire icy(see contained) ON nance ted in the rvice 16). VENTED ceive er the arding the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00834



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 <u>only a suggestion</u> 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.

Bigfork Valley Communities November 15, 2016 Page 2

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7.1. 20.25		С	
		00834	B. WING			8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BIGFOR	K VALLEY COMMUNI	HES	TREE DRIVE (, MN 56628	E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infe licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 11/23/16

STATE FORM 6899 If continuation sheet 1 of 33 UGO411

(X6) DATE

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00834	B. WING			C 28/2016
	PROVIDER OR SUPPLIER K VALLEY COMMUNI	TIES 258 PINE		TATE, ZIP CODE E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, th corrected prior to e Minnesota Departm On October 24, 25, surveyors of this Deabove provider and orders are issued. electronic plan of coreviewed these ord they will be completed.	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be electronically submitting to the nent of Health. 26, 27, and 28, 2016, epartment's staff visited the the following correction Please indicate in your orrection that you have ers, and identify the date when ted.	2 000			
	Minnesota Departmenthe State Licensing federal software. To assigned to Minnesoursing Homes. The assigned tag in column entitled "ID statute/rule out of consummary Statement and replaces the "To correction order. The findings which are in after the statement."	nent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute "This Rule is not met as wing the surveyors findings				

Minnesota Department of Health

STATE FORM UGO411 If continuation sheet 2 of 33

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDING.	7. BoileBillo.		
		00834	B. WING		10/2	28/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BIGFORI	BIGFORK VALLEY COMMUNITIES BIGFOR			E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 2	2 000			
	are the Suggested Time period for Cor	Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, NN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			12/13/16
	comprehensive pland objectives and time long- and short-term and mental and psycidentified in the confusessment. The compust include the incompared to the confuse of the c	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on observati review, the facility fainterventions relate side effects of Plavi prevent blood clots	ent is not met as evidenced ion, interview and document ailed to develop care plan d to the use and monitoring of ix (a platelet inhibitor used to) for 1 of 2 residents (R17) ressure related skin concerns.		**CORRECTED		
	Findings include:					

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00024		B. WING		C 10/28/2016		
		00834	I.		10/2	0/2010	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE E, PO BOX 258			
BIGFOR	BIGFORK VALLEY COMMUNITIES BIGFORI						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 560	Continued From pa	ge 3	2 560				
		ndicated R17 was diagnosed and history of a stroke.					
	10/11/16 indicated impairment, require transfers, walking a	imum Data Set (MDS) dated R17 had no cognitive ed supervision from staff for and dressing, and was bileting, hygiene and I.					
	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).						
	authored by the ME was dry and thin an lotion. The note ide R17 had contribute was encouraged to protection. The note would be updated include extent or stand it was not evide to include the interv	e dated 10/13/16, at 9:43 a.m. OS nurse reported R17's skin of R17 was encouraged to use ntified bruising on arms which d to bumping into things. R17 wear long sleeves for e indicated the care plan. The progress note did not ages of healing of the bruising ent the care plan was revised ventions for the dry skin or the to aide in protection against					
	the MDS nurse date	ew progress note authored by ed 10/25/16, at 9:41 a.m.					

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Minnesota Department of Health STATE FORM

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
					С		
		00834	B. WING		10/2	8/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
BIGFOR	K VALLEY COMMUNI	TIEC		E, PO BOX 258			
			, MN 56628	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 560	Continued From pa	ge 4	2 560				
	location, extent, or	ess note did not include stages of healing of bruising a plan of care for the dry skin					
	wear a three-quarter visible to elbows. Fupper extremity prostages of healing. Trange in sizes from R17's skin was also R17 stated her skin and R17 did not know the size of the skin and R17 did not know the size of the siz	18 a.m. R17 was observed to er length sleeve shirt with arms R17 was noted to have bilateral fuse bruising at different The bruises were also noted to dime size to lemon size. In this and frail in appearance, a was thin and bruised easily ow if on medications that ruising, and did not know why					
	(RN)-A stated she r bruising and skin in medication and sho plan. RN-A indicate have been added to wearing long sleeve	6 a.m. registered nurse missed the increased risk for jury related to the Plavix ould have added it to the care d the interventions that should to the care plan included ed shirts or sleeve protectors to lotion every night.					
		1 a.m. RN-E stated if a slood thinning medication it re plan.					
	(DON) stated blood should be in the car should include wou include location, siz reviewed R17's doo indicated the identif of the bruising was	1 p.m. the director of nursing I thinning medication use re plan and progress notes and demographics which would be, and color. The DON cumentation of the bruises and fication and the documentation insufficient. The DON stated if m with extensive bruising the e notified.					

Minnesota Department of Health

STATE FORM UGO411 If continuation sheet 5 of 33

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILBIIVG.		С		
		00834	B. WING			8/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BIGFOR	K VALLEY COMMUNI	HES	TREE DRIVE , MN 56628	E, PO BOX 258			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 560	Continued From pa	ge 5	2 560				
	No policy regarding plan was provided.	the development of the care					
	The director of nurs review and revise p to ensuring the care resident was develoand medication side director of nursing of	THOD OF CORRECTION: sing (DON) or designee could olicies and procedures related e plan for each individual oped to include medications e effects to be monitored. The or designee could develop a staff, and develop a monitoring ngoing compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 565	MN Rule 4658.0408 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			12/13/16	
		omprehensive plan of care personnel involved in the					
	by: Based on observati review, the facility for repositioning and be provided as directed residents (R26) rev	ent is not met as evidenced on, interview and document ailed to ensure timely owel incontinence care were d by the care plan for 1 of 3 iewed who were dependent on ng and incontinence care.		**CORRECTED			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			С	
		00834	B. WING			28/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PICEOP	K VALLEY COMMUNI	TIES 258 PINE	TREE DRIVE	E, PO BOX 258			
ыйгон	K VALLET COMMUNI	BIGFORK	, MN 56628				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 6	2 565				
	Findings include:						
	had functional incordementia and direct R26 every two hour indicated R26 was a ulcers and skin issuincontinence. The provide skin care wafter each incontine R26's skin during was skin during	ted 10/13/16, indicated R26 ntinence related to progressive ted staff to check and change s. The care plan also at moderate risk for pressure les due to immobility and Care Plan directed staff to ith light layer of barrier creament episode and to check reekly bath.					
	dated 10/25/16, dire	ected staff R26 required a ning plan every two hours.					
	On 10/26/16, from 7 was continuously of	7:02 a.m. until 10:16 a.m. R26 oserved.					
	transferred R26 into R26 to the commor -At 7:40 a.m. R26 w roomAt 8:36 a.m. NA-A area and placed he where she remaine -At 10:11 a.m. NA-E repositioned and chours. NA-B indica repositioned/checke was assisted up at -At 10:16 a.m. NA-E NA-A entered the ro Registered nurse (F donned gloves. Aft and NA-B proceeded)	3 stated R26 should be secked and changed every two ted R26 was last ed and changed when she					

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PRINTED: 12/12/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C B. WING 00834 10/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 **BIGFORK VALLEY COMMUNITIES** BIGFORK, MN 56628 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 5 6 5 Continued From page 7 2 565 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

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Minnesota Department of Health STATE FORM

(21) days.

ongoing compliance.

designee could develop a system to educate staff, and develop a monitoring system to ensure

TIME PERIOD FOR CORRECTION: Twenty-one

UGO411 If continuation sheet 8 of 33

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00834	B. WING			C 28/2016
	PROVIDER OR SUPPLIER	TIES 258 PINE		STATE, ZIP CODE E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 8	2 570			
2 570	Plan of Care; Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400, This MN Requirements of the many control of the part 4658.0400,	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least seven days of the revision of resident assessment required		**CORRECTED		12/13/16
	had difficulty swallor recommendations in recommendations in Findings included: R38's undated Face diagnoses which in chronic obstructive R38's significant ch (MDS) dated 8/3/16 swallowing, and harmouth with eating a or choked during m	wing and had speech therapy not identified on the care plan. e Sheet indicated R38 had cluded Parkinson's and pulmonary disease. ange Minimum Data Set 6, indicated R38 had difficulty d loss of liquids/solids from and drinking and also coughed eals or when swallowing was a change since the last				

Minnesota Department of Health

STATE FORM UGO411 If continuation sheet 9 of 33

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
						С	
		00834	B. WING		10/2	28/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BIGFOR	K VALLEY COMMUNI	IIES	TREE DRIVE (, MN 56628	E, PO BOX 258			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 570	Continued From pa	ige 9	2 570				
	swallowing difficulty	<i>/</i> .					
	dated 8/4/16 indica problem and require The CAA further ind	e Area Assessment (CAA) ted R38 had a swallowing ed a mechanically altered diet. dicated R38 required overall goal objective to avoid					
	indicated R38 had I risk of choking while	ssessment dated 8/2/16, been showing an increased e eating and should be ating. R38 chewed food well all bites.					
	revealed recomment swallowing which constraight at 90 degree 30 minutes following during meal, monitor consider providing medication which a hour before meals, therapist had also resoft diet with nectar on 11/2/15, the recommend of the swallowing straight solution.	apy note dated 10/13/15, andations for R38's safe consisted of R38 to sit up these when eating, to sit up for g meal, group supervision for lung sounds after meal, and Sinemet (Parkinson's assists with motor control) one On 10/13/16, the speech recommended a mechanical or thickened liquids, however, commendation for thickened did to thin liquid per patient					
	dated 10/15/15, wh low fat, mechanical	ders revealed a diet order ich read R38 was to have a soft textured diet with nectar . Physician's orders were beech therapy					
	therapist intervention	ked revision of all speech ons except for the therapeutic stency. The nursing assistant					

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		С	
		00834	B. WING			8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BIGFORI	K VALLEY COMMUNI	1165	TREE DRIVE , MN 56628	E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	indicated R38 requibut did not reflect the recommendations. revision to include it based off the 8/2/16. On 10/27/16, at 10: pathologist (SLP) in interventions were enursing care plan. Scommunication flaw. On 10/27/16, at 12: manager (CDM) increcommendations scare plan by either confirmed a communication flaw therapy, nursing, are existed. On 10/27/16, at 1:2 (DON) explained the with assessed interrecommendations a communication flaw. Facility policy Residual form the resident's functional flaw would aid in preventhe resident's functional flaw assessment of residuals and pocket capitals and pocket capitals.	d by the facility on 10/25/16, red nectar thickened liquids he speech therapist. The care plan further lacked increased risk for choking 6, assessment. 30 a.m. speech language indicated recommended expected to be added to the SLP indicated there was a vibetween departments. 15 p.m. certified dietary dicated the speech therapy should have been added to the nursing or dietary. CDM unication flaw between speech and dietary departments. 3 p.m. the director of nursing e care plan should be updated	2 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY PLETED	
			A. BOILDING.		С	
		00834	B. WING		_	28/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BIGFOR	K VALLEY COMMUNI	1165	TREE DRIVI , MN 56628	E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 570	SUGGESTED MET The director of nurs develop and implen related to care plan designee, could pro staff related to the t revisions. The quali committee could pe ensure compliance.	HOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures revisions. The DON or ovide training for all nursing imeliness of care plan ty assessment and assurance erform random audits to	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.		2 830			12/13/16
	by: Based on observati review, the facility fa comprehensive skir related to identified	ent is not met as evidenced on, interview and document ailed to ensure a n assessment was completed upper extremity bruising for 1) reviewed for non pressure		**CORRECTED		

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00924			C		
		00834			10/2	8/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BIGFOR	K VALLEY COMMUNI	HES	, MN 56628	E, PO BOX 258			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 12	2 830				
	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.						
	10/11/16 indicated impairment, require transfers, walking a	imum Data Set (MDS) dated R17 had no cognitive ed supervision from staff for and dressing, and was bileting, hygiene and I.					
	Plavix (medications	lers indicated R17 received that inhibits blood clots) 75 to time of day related to attack (stroke).					
	goal revised on 10/ was to have intact s or discoloration. Int a skin check week! and change position of 7/13/16. The care	plan informed staff of R17's 12/16, which indicated R17 skin, free of redness, blisters erventions included complete y before or after bath/shower ns frequently with a start date e plan failed to address R17's ated to Plavix use and frail					
		valuations dated 10/10/16, 0/26/16 did not identify any oncerns.					
	authored by the MC was dry and thin an	e dated 10/13/16, at 9:43 a.m. OS nurse reported R17's skin of R17 was encouraged to use ntified bruising on arms which					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
		00834	B. WING			C 10/28/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BIGFOR	K VALLEY COMMUNI	HES	TREE DRIVE	E, PO BOX 258			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
2 830	R17 had contributed was encouraged to protection. The note would be updated. include extent or stand it was not evided to include the intervuse of long sleeves bruising. R17's quarterly revithe MDS nurse date informed R17's skir bruising. The progrel location, extent, or and did not indicate or the bruising. R17's record lacked monitoring, identificassessment/evaluations. Progress notes were by the facility. On 10/25/16, at 11: wear a three-quarted visible to elbows. Fupper extremity prostages of healing. Trange in sizes from R17's skin was also R17 stated her skin and R17 did not known increased risk for beshe bruised easily. On 10/26/16, at 9:2	d to bumping into things. R17 wear long sleeves for e indicated the care plan. The progress note did not ages of healing of the bruising ent the care plan was revised rentions for the dry skin or the to aide in protection against. ew progress note authored by ed 10/25/16, at 9:41 a.m. In was dry but intact with less note did not include stages of healing of bruising e a plan of care for the dry skin did documentation of ongoing					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			D. M/NO		С	
		00834	B. WING		10/2	28/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BIGEORK VALLEY COMMINITIES		HES	TREE DRIVE , MN 56628	E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	the MDS was gathed did not physically a she missed the incomposed the incomposed the indicated the intervadded to the care passed shirts or sleeved shirts or sleeved shirts or sleencourage her to loo to 10/27/16, at 9:50 evaluated at a very nursing assistants with cares. RN-E exissues, the NAs we nurse. RN-E stated descriptive and even monitored until they resident was on a should be in the cathe bruises on R17 documentation from sufficient, RN-E report sufficient and slocations of the bruise of the bruises was going management. The should have been reminimum once dail assessed weekly. The	ered from progress notes and ssess R17's skin. RN-A stated reased risk for bruising and of the Plavix medication and it to the care plan. RN-A entions that should have been plan included wearing long seeve protectors and oftion every night. If a.m. RN-E stated skin was minimum on bath days and (NAs) also looked at skin daily explained if there were any ere directed to report to a documentation should be ery shift the bruises should be ery shift the bruises should be ery shift the bruises should be ery are gone. RN-E stated if a plood thinning medication it re plan. RN-E then looked at 's arms and asked if the enthe progress notes was corted the documentation was should include size and ises so they could have been should include size and indicated the to be a part of risk DON stated skin condition monitored and documented at y but ideally every shift and The DON stated blood thinning puld be in the care plan and huld include wound the would include location, size, where the progress is the care plan and huld include wound the would include location, size, where the plan is the care plan and huld include wound the would include location, size, where the plan is the plan is the care plan and huld include wound the would include location, size, where the plan is the plan is the care plan and huld include wound the would include location, size, where the plan is the	2 830			

Minnesota Department of Health

STATE FORM UGO411 If continuation sheet 15 of 33

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00834	B. WING		C 10/28/2016		
NAME OF F					10/2	0/2010	
	PROVIDER OR SUPPLIER	258 DINE		STATE, ZIP CODE E, PO BOX 258			
BIGFORK VALLEY COMMUNITIES 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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE		
2 830	Continued From pa	ge 15	2 830				
	bruising was insufficed was a problem with physician should be Facility policy on no	on-pressure related skin					
	suggested 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 (21) Days	CORRECTION: Twenty One					
2 905	Subp. 4. Positionin positioned in good I of residents unable must be changed a including periods of been put to bed for has documented th hours during this tirt the physician has o	g. Residents must be body alignment. The position to change their own position t least every two hours, if time after the resident has the night, unless the physician at repositioning every two me period is unnecessary or redered a different interval.	2 905			12/13/16	
	by: Based on observati	on, interview and document		**CORRECTED			

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00834	B. WING			C 28/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
BIGFOR	K VALLEY COMMUNI	HES	TREE DRIVE K, MN 56628	E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 905	905 Continued From page 16		2 905			
	repositioning was p (R26) who was as r	ailed to ensure timely rovided for 1 of 2 residents risk for developing a pressure every two hour repositioning				
	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.					
	(CAA) dated 10/10/ for pressure ulcers immobility. The CA immobile and was a	er Care Area Assessment (16, indicated R26 was at risk due to incontinence and A also indicated R26 was able to make simple positions of able to stand and relieve y.				
		e for predicting pressure sore indicated R26 at risk for res.				
	was at moderate ris	ated 10/13/16, indicated R26 sk for pressure ulcers and skin obility and incontinence. The o provide skin care with light				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			7.1. 20.25.110.1			С	
		00834	B. WING			28/2016	
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
BIGFOR	K VALLEY COMMUNI			E, PO BOX 258			
(VA) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	K, MN 56628	PROVIDER'S PLAN OF CORRE	CTION	(V5)	
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP	IOULD BE	(X5) COMPLETE DATE	
2 905	Continued From pa	ge 17	2 905				
		nm after each incontinent ck R26's skin during weekly					
		ant (NA) pocket care plan ected staff R26 required two hours.					
	On 10/26/16, from 7:02 a.m. until 10:16 a.m. R26 was continuously observed.						
	wheelchair and whe in front of the televi -At 7:40 a.m. R26 v roomAt 8:36 a.m. NA-A area and placed he where she remaine -At 10:11 a.m. NA-F repositioned every R26 was last reposup at 7:00 a.mAt 10:16 a.m. NA-F NA-A entered the room. RN-B and NA-B proceeded NA-B removed and room. RN-B and N brief. NA-A stated stool. NA-A proceed completion of the coremoved their glove appropriately. NA-A repositioned every repositioned every repositioned every repositioned every recommendation.	vas wheeled into the dining wheeled R26 to the common r back in front of the television					

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

NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
BIGFOR	K VALLEY COMMUNITIES		TREE DRIVE , MN 56628	E, PO BOX 258	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCI (EACH DEFICIENCY MUST BE PRECEDED B REGULATORY OR LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 18 NA-A confirmed R26 went a total of thr and 15 minutes without being reposition		2 905		
	On 10/27/2016, at 11:11 a.m. the direct nursing (DON) confirmed R26 should be repositioned every two hours. The DO she expected staff to follow the resider and R26 should have been repositioned directed on care plan.	nave been N verified nt care plan			
	The undated Pressure Ulcer Prevention indicated frequent turning, increased mable, restorative program, protection for and elbows and pressure support surfated or chair bound residents would be implemented for Braden scores determing Risk (score of 15-18). For residents ind Moderate Risk (score of 13-14) the intervence identified as same as above and body pillows, wedges with orders to prodegree positioning. The policy indicated [registered nurse/licensed practical nurse/licensed prevention produced in the prevention produced in	nobility if or heels aces for nined At lentified at erventions use of ovide 30 ed RN/LPN rse] would			
	SUGGESTED METHOD OF CORRECT director of nursing (DON) or designee develop, review, and/or revise policies procedures to ensure residents receive repositioning assistance according the need. The DON or designee could devauditing system to ensure compliance.	could and e the assessed relop an			
	TIME PERIOD FOR CORRECTION: (14) days.	ourteen			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:		С	
		00834	B. WING			8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BIGFOR	BIGFORK VALLEY COMMUNITIES 258 PINE BIGFORE			E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 19	2 920			
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			12/1/16
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	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.			**CORRECTED		
	Findings include:					
	10/9/16, indicated Fimpairment and dia Alzheimer's disease fibrillation (An irregucommonly causes palso indicated R26 two people for bed toilet use and personal transfer indicated R26 two peoples for bed toilet use and personal resonance indicated R26 two peoples for bed toilet use and personance indicated R26 two peoples for bed toilet use and peoples for bed	num Data Set (MDS) dated R26 had severe cognitive gnoses which included e, hypertension and atria ular, often rapid heart rate that poor blood flow). The MDS required extensive assist of mobility, transfer, dressing, anal hygiene. The MDS further always incontinent of bowel				
	Catheter Care Area 10/7/16, indicated F	ntinence and Indwelling Assessment (CAA) dated R26 had functional I not get to toilet in tame due to				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00834	B. WING			C 10/28/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
BIGFOR	BIGFORK VALLEY COMMUNITIES 258 PINE BIGFORI			E, PO BOX 258			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 920	Continued From pa	ge 20	2 920				
	problems thinking of indicated incontiner	external obstacles, or or communicating). The CAA nee would be addressed in the skin issues and to minimize the s.					
	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.						
	transferred R26 into R26 to the commor -At 7:40 a.m. R26 w room. -At 8:36 a.m. NA-A area and placed he where she remaine -At 10:11 a.m. NA-E incontinent product two hours. NA-B in	assistant (NA)-A and NA-B o a wheelchair and wheeled area in front of the television. Was wheeled into the dining wheeled R26 to the common r back in front of the television d until 10:16 a.m. B stated R26 should have checked and changed every dicated R26 was last checked she was assisted up at 7:00					

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PRINTED: 12/12/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING 00834 10/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 **BIGFORK VALLEY COMMUNITIES** BIGFORK, MN 56628 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 2 0 Continued From page 21 2 920 -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.

Minnesota Department of Health STATE FORM

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DAT COM			SURVEY PLETED	
		00834	B. WING		C 10/28/2016	
NAME OF I			DDEGG GITY (OTATE ZID OODE	10/2	.0/2010
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE E, PO BOX 258		
BIGFOR	K VALLEY COMMUNI	HES	, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE	
2 920	Continued From pa	ge 22	2 920			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 955	MN Rule 4658.0530 Eating - Risk of Cho	Subp. 3 Assistance with oking	2 955			11/14/16
	the comprehensive addressed in the co being at risk of chol must be continuous personnel when the	resident identified in resident assessment, and as imprehensive plan of care, as king on food sly monitored by nursing a resident is eating so that intervention can occur if				
	by: Based on observation review, the facility fatherapeutic diet and eating for 1 of 1 resumechanically altered	ent is not met as evidenced on, interview and document alled to serve the correct diprovide supervision with ident (R38) who required diprod and had swallowing k for choking which required ating.		**CORRECTED		
	Findings include:					
		e Sheet indicate R38 was kinson ' s and chronic ary disease.				
	R38's significant ch	ange Minimum Data Set				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00834	B. WING			C 10/28/2016	
NAME OF				STATE ZID CODE	1 10/2	.0/2010	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE E , PO BOX 258			
BIGFOR	K VALLEY COMMUNI	HES	MN 56628	-			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE	
2 955	Continued From pa	ge 23	2 955				
	cognitive impairmer physical assist from also indicated R38 loss of liquids/solids drinking and also comeals or when swa a change from the lindicated R38 had r R38's Nutritional Cadated 8/4/16, indicaproblem and require and supervision who complications. R38's Swallowing a indicated R38 had by the swallowing a lindicated R38 ha	is, indicated R38 had severe and and required limited a staff for eating. The MDS had difficulty swallowing, had a from mouth when eating and bughed or choked during llowing medications. The was ast MDS dated 6/21/16, which no swallowing difficulty. The Area Assessment (CAA) are Area Assessment (CAA) ated R38 had a swallowing ed a mechanically altered diet en eating in order to avoid assessment dated 8/2/16, been showing an increased a eating and should be					
	indicated R38 chew small bites.	ating. The assessment also yed food well but did not take					
	revealed recommer swallowing which in 90 degrees when e 30 minutes following meal, monitor lungs providing Sinemet (assist with motor comeal. On 10/13/16 also recommended nectar thick liquids recommendation for changed to thin liquid therefore R38 was liquids.	py note dated 10/13/15, ndations for R38's safe dicated R38 should sit up at ating and remain sitting up for g, group supervision during after eating and consider Parkinson's medication which ontrol) one hour before the the speech therapist had a mechanical soft diet with however, on 11/2/15, the r thickened liquids was id per resident request, to receive regular consistency					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00834	B. WING			C 28/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
RIGEOR	K VALLEY COMMUNI	TIES 258 PINE	TREE DRIVE	, PO BOX 258		
Diai on	K VALLET COMMON	BIGFORI	K, MN 56628			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 955	Continued From pa	ge 24	2 955			
	low fat, mechanical consistency liquids inconsistent with sprecommendations.	ich read R38 was to have a soft textured diet with nectar Physician's orders were seech therapy 6, 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.					
	dated 10/5/16, loca used by dietary stat	erving guide or "cheat sheet" ted in the kitchen cabinet and if when preparing/serving 38 was to receive a regular				
	seated at a dining r textured meal of ch coffee/water of thin seated next to R38 eat/drink. -At 5:26 p.m. R38 to started coughing. N	3 p.m. R38 was observed oom table with a regular ili and French bread and consistency. NA-D was and provided verbal cues to ook a drink of coffee and IA-D asked R38 if she was OK nded, yes. NA-D stated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		00834	B. WING		10/2	; 28/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIO.		258 PINE	TREE DRIVE	E, PO BOX 258		
BIGFORK VALLEY COMMUNITIES BIGFORK		K, MN 56628				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
2 955	sometime R38 coury-At 5:35 p.m. NA-D walked away from the coffee and producing was moistFrom 5:35 p.m. undrink the coffee with her throat. No nursidining room. On 10/25/16, at 4:5 the dining room tab consistency water a assistant (DA)-A wadining room. At 5:0 meal which consists salad and a tomato which appeared dry receive a regular diindependently start staff members were-At 5:15 p.m. NA-E asked R38 how she-At 5:30 p.m. NA-E leaving no staff prehelp R38 and proceham. R38 took a dloud, hacking, mois put food onto R38's instructing R38 to ta-At 5:34 p.m. NA-E again asked how R	ghed when eating/drinking. poured R38 more coffee and he table. R38 took a drink of eeded to cough twice, the til 5:39 p.m. R38 continued to n an occasional need to clear ng staff were present in the 8 p.m., R38 was observed at le with a glass of regular and orange wedges. A dietary as the only staff member in the 10 p.m. DA-A served R38 her ed of a ham steak, potato slice. DA-A cut up R38's ham of DA-A stated R38 was to et with thin liquids. R38 ed eating her meal. No other expresent in the dining room. entered the dining room sent. DA-A stated she could eded to give R38 a bite of rink of water proceeded by a t cough. DA-A continued to fork and provide verbal cues ake bites of food. entered the dining room and 38 was. NA-E assist R38 to	2 955	DEFICIENCY)		
	R38 required. NA-E guide and stated R3 diet with thickened choking and require NA-E stated the cal	was asked what type of diet was asked what type of diet referenced her pocket care as required a mechanical soft liquids, R38 was at risk for ed supervision when eating. The guides were updated daily pordinator. NA-E also stated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
00834		B. WING		C 10/28/2016		
NAME OF					10/2	0/2010
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE E, PO BOX 258		
BIGFOR	K VALLEY COMMUNI	HES	, MN 56628	-, FO BOX 230		
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	(X5) COMPLETE DATE	
2 955	Continued From pa	ge 26	2 955			
	after taking bites of NE-A stated some and assist during m certified nursing as -At 5:42 p.m. DA-A	phing during the meal tonight food but not after drinking. DA's were able to supervise real times because some were sistants. stated she used to be a NA, ager current on the NA				
	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.					
	stated recommende expected to be add	30 a.m. the speech therapist ed interventions were ed to the care plan and felt unication flaw between				
	(DM) stated the specific recommendations is care plan by either stated the care plar kitchen was not coroccurred on their spresident was removed.	15 p.m. the dietary manager eech therapy should have been added to the nursing or dietary. The DM in guide in the cupboard of the crect related to an error that preadsheet when another ared from it. The DM stated unication problem between				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
	CVALLEY COMMUNITIES 258 PINE	E, PO BOX 258			
(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 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	2 955			

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBE		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00834	B. WING		10/2	28/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BIGFOR	K VALLEY COMMUNI	IIES	TREE DRIVE , MN 56628	E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 955	Continued From pa	ae 28	2 955			
21800	(21) days.	R CORRECTION: Twenty-one 651 Subd. 4 Patients &	21800			11/23/16
	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.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BOILDING.		С		
00834		B. WING		10/2	8/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BIGFOR	K VALLEY COMMUNI	IIES	TREE DRIVI (, MN 56628	E, PO BOX 258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 29	21800			
	This MN Requirements by: Based on observation review, the facility for current nursing homomorphisms and parch 2016, was p	ent is not met as evidenced on, interview and document ailed to ensure the most ne Bill of Rights, revised in osted and used by the facility. ial to affect all 44 residents		**CORRECTED		
	Findings include:					
		ur on 10/24/16, at 2:00 p.m. Rights was observed posted t and dated 1995.				
	provided a copy of was provided to the	45 p.m. Social worker (SW)-A the Resident Bill of Rights that residents upon admission, 1, 2007. SW-A was unaware sident Bill of Rights.				
	Residents, indicate	policy entitled Bill of Rights for d The Bill of Rights would be and a copy would be sion.				
	director of nursing (develop, review, an procedures to ensu current resident bill system to ensure the	THOD OF CORRECTION: The (DON) or designee could d/or revise policies and re residents receive the of rights, and develop a ne current resident bill of rights esidents, family, and staff				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED		
00834		B. WING		C 10/28/2016			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BIGEORK VALLEY COMMUNITIES 258 PINE TREE DRIVE, PO BOX 258							
0/0.15	CLIMMA DV CTA		K, MN 56628		ON	()/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21800	Continued From pa	ge 30	21800				
	members.						
	TIME PERIOD FOF (14) days.	R CORRECTION: Fourteen					
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.		21860			11/23/16	
	by: Based on interview facility failed to ensi provided for review request for 1 of 1 re	and document review, the ure medical records were within twenty-four hours of esident (R5) family member ew of clinical records.		**CORRECTED			

PRINTED: 12/12/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C B. WING 00834 10/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 **BIGFORK VALLEY COMMUNITIES** BIGFORK, MN 56628 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21860 Continued From page 31 21860 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.

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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 10/18/16, at 2:18 p.m.

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.

PRINTED: 12/12/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING 00834 10/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 **BIGFORK VALLEY COMMUNITIES** BIGFORK, MN 56628 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21860 Continued From page 32 21860 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

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Minnesota Department of Health STATE FORM

committee.

(21) days.

TIME PERIOD FOR CORRECTION: Twenty-one