Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 25, 2021

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

RE: CCN: 245529
Cycle Start Date: December 29, 2020

Dear Administrator:

On February 23, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
January 11, 2021

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

RE: CCN: 245529
Cycle Start Date: December 29, 2020

Dear Administrator:

On December 29, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 29, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by June 29, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. BUILDING ______ B. WING ______	C 12/29/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/28/20, and 12/29/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5529015C (MN68387) with a deficiency cited at F600. H5529016C (MN68316) H5529017C (MN61370) H5529017C (MN61133) As a result of the investigation, additional citations were issued at F609 & F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		2/10/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 01/11/2021

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

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F 600 Continued From page 1

and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure resident to resident sexual abuse did not occur and implement appropriate interventions to prevent reoccurrence for 2 of 4 residents (R1, R2) reviewed for allegations of sexual abuse.

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 12/16/20, indicated she had severe cognitive impairment and was independent with bed mobility, transfers and ambulation. The MDS indicated R1 exhibited behaviors directed toward others and wandering behaviors one to three days during the assessment period.

R1's care plan dated 12/23/20, indicated she was independent with ambulation using a four wheeled walker and indicated she required staff supervision when ambulating. The care plan further identified exit seeking behaviors and anxiety and indicated R1 got more anxious after supper in the early evening. The care plan directed staff to keep R1 busy after supper. The care plan further directed staff to provide R1 with

F 600

R1 has not made any further sexual advances to male residents. She has not asked about R2 since the incident. She does not display any adverse effects, her demeanor is back to baseline after receiving the increase in her Paroxetine. She had made statements prior to the incident she was lonely and just wanted some human companionship and some hugs. She is not a risk for abusing other vulnerable adults. Care Plan has been revised to reflect this.
R1 Paroxetine dosage was increased to 20mg from the 10mg dosage she had been receiving for her GDR which appears to have helped her to return to her baseline behaviors.
R 2 has been assessed for potential for being abused or being abusive, he has been abusive to his wife in the past and she is on a separate unit in the facility due to his verbal abuse. He has asked the nursing staff to go get R1 and bring her to his room at night on two occasions, which staff has not done. He continues to make sexual remarks to the female staff which

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F 600	Continued From page 2 tasks in the dining room during the evening hours to help with anxiety and seeking sexual behaviors toward males. During observation on 12/29/20, at 8:18 a.m. R1 was seated in a common area. R1 was telling other residents in the group, "my husband is in this building, his name is [R2], that's my husband." A report to the state agency dated 12/21/20, indicated during routine safety rounds at 12:50 p.m., staff found R1 in another residents (R2)'s room. R1 was seated on the edge of a chair with her face and hands near R2's penis and R2's pants were down. R2 was moved off the unit to prevent further incidents. A facility Investigation Report dated 12/23/20, indicated R1 had been found in R2's room. The report indicated neither resident was upset by the action and had consented to the incident and when interviewed later that day both residents said they were fine. R2 was moved to a different unit in the facility and R1 began seeking the attention of a different male resident. The report indicated R2 had a history of inappropriate behaviors with females and would continue to be redirected as needed. The report further identified R1 had a previous gradual dose reduction of medication used to treat her depression and anxiety potentially leading to the new increase in her behaviors. R1's Progress Note(s) indicated the following: - 12/20/20, R1 was out looking for another [unidentified] resident, claiming he was her husband and needed to bring him home. R1	F 600	is also care planned for. He is wheelchair bound and is not able to maneuver his chair by himself, he has not tried to seek out any female residents on his unit. He does not display any adverse effects from his encounter. All these behaviors have been care planned for. Since his CVA prior to admit, he has had these behaviors, so they are not new to him. Care plan was reviewed and revised for R1 and R2. A cognitive evaluation has been ordered for R1 and R2 to determine if they have the capacity to consent to sexual activity. A task was created in the EMR for R1 for staff to monitor her whereabouts and behaviors every half hour. 24-hour report/change of condition form was reinstated, with nursing reeducated on ensuring changes in behaviors and new interventions are to be noted on the form and passed on to oncoming shifts to ensure everyone is aware of the changes. These forms will be on a clipboard for staff to review at the nurse□s station. A Pharmacy review was requested for R1, with no recommended changes. Pharmacist felt the behaviors had been related to her GDR, we will not ask for another GDR, but will document why it is not advised for her. Abuse prevention policy was reviewed and revised. All staff were educated on Abuse Prevention. Don or designee from IDT will sit in on morning report M-F for 4 weeks, then will review at QAPI to determine need for continuing monitoring. 24 hour documentation will be reviewed	

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F 600	Continued From page 3	F 600		

heard the other resident's voice, went into his room and started kissing him while staff was in his room. Staff redirected R1 out of the room and explained the other resident was married and not her husband.

- 12/21/20, R1 was found in [R2's] room after lunch attempting to be intimate with him. Male resident was relocated to another unit.

- 12/23/20, R1 entered a [unidentified] male residents room dressed in a see through night gown while staff were in the room. R1 stated to resident "If you need me, I'm right here." Staff re-directed R1 from the room.

- 12/24/20, R1 walked into a [unidentified] male residents room as staff went to assist him with cares. R1 told male staff member that she had always had deep feelings for him.

R1's medical record lacked a capacity to consent to sexual activity assessment.

R2's quarterly MDS dated 11/23/20, indicated he had moderate cognitive impairment and required assistance of one staff with dressing and bed mobility, required assistance of two staff with transfers and did not ambulate. The MDS indicated R2 exhibited behaviors directed towards others on one to three days during the assessment period.

R2's care plan dated 11/30/20, identified a history of inappropriate sexual comments and touching female staff. The care plan directed staff to remind resident not to touch staff and directed staff to have two staff present at all times during cares.

each day by DON or designee times 4 weeks, then will review at QAPI to determine need for continuing monitoring. All changes in behaviors, potential for abuse will be discussed at morning meeting M-F.

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F 600	Continued From page 4	F 600		

R2's progress note dated 12/21/20, identified R2's family was updated and provided details of a recent incident with R2 and another resident [R1]. R2 was moved to another unit to prevent future incidents.

R2's medical record lacked a capacity to consent to sexual activity assessment.

During interview on 12/29/20, at 8:49 a.m. nursing assistant (NA)-A stated she had heard there had been some kind of incident between R1 and R2 but she was not there that day so she did not know much. She heard R1 was in R2's room. R1 did not display as many behaviors in the morning but R1 made "suggestive" comments a couple times a week and talked about missing physical contact. NA-A stated she had not been aware of the incident when R1 was kissing another male resident nor was she aware R1 entered a male residents room in a see through night gown. In regard to interventions, NA-A stated staff kept an eye on R1, but did not identify a specific frequency. NA-A did not identify any other interventions.

At 8:53 a.m. registered nurse (RN)-A stated she was working when the incident between R1 and R2 occurred. Staff were coming out of the dining room from lunch and R1 had gone into R2's room and the NA's had found them trying to be intimate. R1 had been getting kind of obsessed with R2 and the day before the incident staff had to keep them apart. RN-A stated R1 had been talking about R2 like he was her boyfriend and talking about how she hated to be alone. RN-A stated, "I knew we needed to keep them apart, I kind of knew because of her behavior, the feel of

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F 600	Continued From page 5	F 600		

it was different." RN-A stated she had not been aware of the incident in which R1 had entered a male residents room and was kissing him, nor was she aware R1 had entered a male residents room following the incident with R2.

At 8:59 a.m. NA-B stated she had heard about the incident between R1 and R2 and had also heard about R1 kissing a male resident but did not know who it was. NA-B stated staff were told to keep an eye on her.

At 9:51 a.m. the director of nursing (DON) stated staff had come to her the day of the incident. Staff reported after lunch, staff had gone to R1's room and she was not there so they began checking rooms and found her in R2's room. R2 had his pants down and R1's hands were on his penis and her face was down near his lap. During the previous few days, R1 had began to latch on to R2 so staff felt they needed to keep an eye on R1. The DON stated if R1 entered R2's room and approached him, R2 would "just go with the flow" and stated she was sure R2 encouraged it but indicated he would not have been physically able to remove his own pants. Staff were really monitoring R1 and provided some one to one supervision but did not believe there was any verification the one to ones occurred. In regard to the incident when R1 entered a male residents room wearing a see through night gown, the DON stated that was not R2, but a different male resident. The DON further stated keeping an eye on R1 and adjusting her medications was not doing what it needed to do.

At 12:02 p.m. licensed social worker (LSW)-A stated a capacity to consent assessment would include, "looking at the cognitive portion" and

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F 600	Continued From page 6 stated she looked at the brief interview for mental status scores. LSW-A stated R1 scored pretty low but stated R2 came across as able to consent. LSW-A stated no formal assessment of R1 and R2's capacity to consent had been performed to ensure they were capable of making the decision to have a sexual relationship. At 2:29 p.m. LSW-A stated R1 had been "dolling herself up" and looking for her husband. LSW-A stated the day of the incident staff were looking for R1 and then found her in R2's room. LSW-A stated the nurses had mentioned R1 had been talking and flirting with R2 for a few days prior to the incident. A facility policy Senior Services Abuse Prevention Plan dated 2/20, indicated each individual had the right to be free from verbal, sexual, physical and mental abuse. The policy defined abuse to include: sexual abuse (non-consensual sexual contact of any type with a resident). Further, the policy lacked direction on how the facility would conduct capacity to consent assessments for residents wanting to engage in sexual relationships.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		2/10/21

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F 609	Continued From page 7 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to immediacy report allegations of potential resident abuse to the State agency (SA) for 1 of 5 allegations reported to the SA which had the potential to affect 1 of 5 residents (R7) who's allegation of abuse were reviewed. Findings include: R7's quarterly Minimum Data Set (MDS) dated 10/23/20, indicated he had severe cognitive impairment and required assistance for activities of daily living. R7's MDS indicated he displayed no behaviors and did not display hallucinations or delusions during the assessment period. An e-mail sent to the director of nursing (DON) dated 12/18/20, indicated the previous evening on	F 609	All residents could be affected by this practice. All staff have been re-educated on the policy as well as expected timelines for reporting. Policies and Procedures have been reviewed and revised. DON/Social Worker or designee will conduct random audits of 5 staff per week times 4 weeks to ensure they know when to report, who to report to, timeline for reporting, education will be conducted immediately to staff if needed. Audits will be reviewed at monthly QAPI and further audits will be determined by the QAPI	

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F 609	Continued From page 8 12/17/20, R7's family member had called the nurse on the unit and reported R7 had said he had gotten into an altercation with some guy in the middle of the night on 12/16/20. R7's family member was concerned he had gotten into an altercation with another male resident. A report to the SA dated 12/18/20, at 3:31 p.m. indicated R7 told his daughter some man had come into his room the night before and had hit and punched him and shoved him up against the wall. His daughter called and reported this incident to the nurse. During interview on 12/29/20, at 9:51 a.m. the DON stated R7's daughter had called the nurse on duty and reported the allegation of abuse the previous evening and the nurses reported it to her the next day. The DON stated the nurse had not reported the allegation to her immediately or to the SA because R7 displayed hallucinations so he did not think he had to. A facility policy Senior Services Abuse Prevention Plan dated 2/20, indicated any employee, resident, family/guardian.... who has reasonable cause to believe that a resident has been maltreated must report to the SA within two hours of learning of the suspected abuse.	F 609	team.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		2/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. BUILDING ______ B. WING ______	C **12/29/2020**

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

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F 610	Continued From page 9 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate allegations of abuse to ensure adequate protection for 2 of 5 allegations involving residents (R1, R2, R7) reviewed for resident to resident abuse. Findings include: R1's quarterly Minimum Data Set (MDS) dated 12/16/20, indicated R1 had severe cognitive impairment and was independent with bed mobility, transfers and ambulation. The MDS indicated R1 exhibited behaviors directed toward others and wandering behaviors one to three days during the assessment period. R2's quarterly MDS dated 11/23/20, indicated R2 had moderate cognitive impairment and required assistance of one staff with dressing and bed mobility, required assistance of two staff with transfers and did not ambulate. The MDS indicated R2 exhibited behaviors directed towards others on one to three days during the assessment period.	F 610	R7 has not made any new statements alleging Abuse. R1 and R2 have not had any further contact with each other Ri, R2 and R7 have orders for a cognitive evaluation. There have not been any new reports of suspected abuse. All residents with impaired cognition may have the potential to be affected by this practice. A new investigative form was created A protocol was created to ensure an adequate investigation was completed and documented. Policies and procedures r/t abuse reviewed and revised. Nurses were reeducated on proper documentation and investigation of an allegation or suspected abuse. All staff educated on abuse prevention, reporting and investigating All complaints of suspected abuse investigations will be audited by the DON to ensure they are thoroughly investigated. This will be an ongoing audit.	

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F 610	Continued From page 10 A report to the State agency (SA) dated 12/21/20, indicated during routine safety rounds, staff found R1 in another residents (R2)'s room. R1 was seated on the edge of a chair with her face and hands near R2's penis and R2's pants were down. R2 was moved off the unit to prevent further incidents. A facility Investigation Report dated 12/23/20, indicated R1 had been found in R2's room. The report indicated neither resident was upset by the action and had consented to the incident. When interviewed later that day both residents said they were fine. R2 was moved to a different unit in the facility and R1 began seeking the attention of a different male resident. The report further indicated R2 had a history of inappropriate behaviors with females and would continue to be redirected as needed. The report lacked evidence the facility had initiated a plan to protect the residents who remained on the unit from R1. The internal facility investigation documentation included the following: An untitled note written by nursing assistant (NA) dated 12/21/20, which indicated staff noticed at 12:50 p.m. during safety checks that R1 was not in the sitting area or in her bedroom. The NA along with another staff member checked R2's room and found R1 leaned over R2's lap. R1 was seated on the edge of R2's chair with her face and hands near his penis at which time staff re-directed them. An untitled note written by a second NA dated 12/21/20, indicated at 12:50 p.m. staff noticed upon safety checks that R1 was not in her room or common area. Staff checked rooms and R1	F 610	24 hour charting will be reviewed daily by DON or designee times 4 weeks, then reviewed at QAPI to determine continuance of audits.	

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F 610	Continued From page 11	F 610		

was found in R2's room sitting on the end of R2's recliner with her hands and face on R2's penis and his pants were down. Staff re-directed R1 out of R2's room.

The investigation lacked evidence other staff or residents were interviewed to determine if there was a history of previous sexual encounters, whether other residents had concerns related to R1's behaviors or what was occuring with R1 and R2 prior to the incident. Further, the investigation lacked evidence the facility had assessed R1 and R2 for the capacity to consent to sexual activity.

R7's quarterly MDS dated 10/23/20, indicated R7 had severe cognitive impairment and required assistance for activities of daily living. R7's MDS indicated he displayed no behaviors and did not display hallucinations or delusions during the assessment period.

A report to the SA dated 12/18/20, at 3:31 p.m. indicated R7 told his daughter some man had come into his room the night before and had hit and punched him and shoved him up against the wall. His daughter called and reported this incident to the nurse.

A facility Investigation Report dated 12/22/20, indicated staff had not heard anything loud that would have indicated an altercation. The report indicated R7 was to be provided with female caregivers and television stations would play only music or sports.

The facility internal investigation documentation was reviewed and included the following:

- An e-mail from a staff nurse to the DON dated

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F 610	Continued From page 12	F 610		

12/18/20, which indicated he had spoken to R7's family member who called regarding a story R7 had told her. Family member stated R7 told her he had gotten into some sort of altercation in the middle of the night with some guy and was thrown across this way and that way and up against a wall. Family member stated due to R7's dementia he did at times have an altered perception of reality. The nurse wrote that reports from the night shift indicated R7 had a non-eventful night and was pleasant and cooperative. The nurse further wrote that R7 voiced no complaints and that he did not seem to be feeling unsafe or frightened. The note lacked evidence the nurse spoke with R7 or asked him what occurred.

- A hand written note by the DON dated 12/22/20, which indicated she and the administrator performed a body audit and did not find bruising nor did R7 display any signs of distress. R7 told them a man came in but he did not hear the man talk and did not see him and said it was 1-2 nights prior. R7 reported being shoved around and said he yelled at the man. The note indicated the staff nurse did not see anyone go into the room and heard no signs of a struggle nor did the NA working the shift.

The investigation lacked evidence of interviews with other residents or staff members working on the unit. Nor did the investigation include body audits of those residing on the unit that could not report abuse for themselves.

During interview on 12/29/20, at 9:51 a.m. the DON stated the facility communicated most of their investigations through email. The facility was not routinely keeping all details of their internal investigation to ensure an adequate investigation

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F 610	Continued From page 13	F 610		

was completed by the facility. The DON and social worker completed the internal investigations and stated it was something they needed to work on.

A facility policy Senior Services Abuse Prevention Plan dated 2/20, indicated upon receiving a complaint of alleged mistreatment, the administrator, DON/designee and director of social services will coordinate an investigation to include completion of witness statements and Report of Allegation form. All parties involved, potentially involved or having observed the alleged incident to be interviewed. A plan for further action is determined with input from appropriate personnel. The policy further indicated all efforts would be made to provide for the safety, security and well-being of the resident and other residents with the potential to be affected.

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
January 11, 2021

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

Re: Event ID: SURI11

Dear Administrator:

The above facility survey was completed on December 29, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

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	00834	A. BUILDING: ______ B. WING ______	C 12/29/2020

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 12/28/20, and 12/29/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be in compliance with the MN State Licensure.

The following complaints were found to be substantiated; however, no correction orders

Minnesota Department of Health

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2 000	Continued From page 1 were issued: H5529015C (MN68387) H5529016C (MN68316) H5529017C (MN61370) H5529017C (MN61133) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		