DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 9, 2022

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

RE: CCN: 245529
Cycle Start Date: March 30, 2022

Dear Administrator:

On April 29, 2022, 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, Compliance Analyst
Minnesota Department of Health
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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May 9, 2022

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

Re: Reinspection Results
Event ID: TPIX12

Dear Administrator:

On April 29, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 29, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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Electronically delivered
April 9, 2022

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

RE: CCN: 245529
Cycle Start Date: March 30, 2022

Dear Administrator:

On March 30, 2022, 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"and/or an E tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 June 30, 2022 (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 September 30, 2022 (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
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 03/30/2022

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 3/29/22 through 3/30/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5529023C (MN00081917), with a deficiency cited at F684. As a result of the investigation, additional deficiencies were cited at F609 and F610 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
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	F 609		4/22/22

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

Electronically Signed | 04/15/2022

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 609	Continued From page 1 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 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 ensure allegations of sexual abuse were reported to the State Agency, within 2 hours, for 1 of 1 resident (R4) who reported a male nursing assistant inappropriately touched her. Findings include: R4's quarterly Minimal Data Set (MDS) dated 3/1/22, indicated R4 had diagnoses which included dementia, anxiety disorder and had severe cognitive impairment. Further review of MDS indicated R4 exhibited delusions, physical	F 609	1. OHFC report was filed related to R4. 2. All residents could potentially be affected by this practice. 3. Policies and procedures were reviewed and revised related to VA, reporting requirements. 4. All staff were educated on VA reporting, policies and procedures. Also training using MDH provided materials related to prevention of sex abuse. 5. DON or designee will audit charts daily times 4 weeks, then review at QAPI to determine frequency of further audits.	

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F 609	Continued From page 2 and verbal behaviors. R4's care plan revised 3/17/21, identified R4's target behaviors; behaviors included as hallucinations/delusions, restlessness, crying, and paranoia. R4's care plan did not address or identify R4 had a history of making sexually based allegations regarding staff. On 3/29/22, at 3:28 p.m. nursing assistant (NA)-A reported to state surveyor approximately 3 weeks ago, she had reported to the director of nursing (DON) an allegation of sexual abuse between R4 and NA-D. NA-A indicated the facility had not addressed the allegation at that time. NA-A was not sure on the date of the allegation. NA-A indicated she remembered NA-D had assisted R4 to the bathroom, the two had been in R4's room for "a while". NA-C then brought R4 back into the commons area, NA-A stated R4 appeared "shaky, mopey and head was tilted. NA-A indicated she then saw R4 attempt to self-transfer and R4 told her "I don't care if I fall it is better than him putting himself up and down me" and R4 repeated it again to NA-A. NA-A indicated R4 did not state a name but pointed in the direction of NA-D. NA-A grabbed another staff NA-E, which R4 then stated, "she [R4] was raped". NA-A stated she didn't like the way R4 was shaking, and she was scared. Further, NA-A indicated both her and NA-E reported this allegation to registered nurse (RN)-C and then to the DON. In addition, NA-A stated nothing has been done about this allegation and NA-A indicated on 3/29/22, she reported this incident to the social worker (SW). Review of the facility's reported incidents identified that this allegation was not reported to	F 609		

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F 609	Continued From page 3 the State Agency. On 3/29/22, at 4:33 p.m. state surveyor reported the sexual abuse allegation to SW and Minimum Data Set (MDS) coordinator, as DON and Administrator were not available. SW indicated she was not aware of the allegation until 3:00 p.m. on 3/29/22, and MDS coordinator was not aware prior. On 3/30/22, at 9:29 a.m. DON indicated she was aware of R4's sexual abuse allegation and had completed an investigation already. DON indicated the allegation was not reported to the SA due to the "regulation says reasonable suspicion which myself and other nurses discussed, and I didn't feel it was reasonable." Further, DON stated "if I had any inkling that I thought anything happened I would have reported." When asked what the facility's process was for reporting allegations of abuse, DON indicated most of the time she reports the allegations immediately but, this allegation "was a touchy nature". On 3/30/22, at 3:51 p.m. SW indicated the facility's policy was to report any suspected or allegations related to abuse to the SA within two hours. SW confirmed R4's allegation should have been reported to the SA. SW indicated R4 has a history of delusions, however the accusation alleging rape was new for R4. SW indicated timely reporting to the SA was important to ensure all residents are safe and to prevent future incidents from happening. Review of the facility's internal investigation did not identify a specific date and time of the allegation occurred. The internal investigation	F 609		

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F 609	Continued From page 4 included a statement written by RN-C dated 3/3/22 and statements written by NA-A, NA-E, and DON on 3/8/22. Review of facility's internal investigation included the following: -Statement by RN-C dated 3/3/22, indicated she was the floor nurse on the day of the allegation. NA-D assisted R4 to the restroom. At this time, R4 was exhibiting sun downing and appeared confused and tired. NA-D returned to the commons area with R4 and assisted her into the recliner and R4 appeared calm. Moments later NA-A reported to RN-C R4 stated she "didn't like that man going up and down". RN-C indicated she reported the allegation to the DON. Review of facility's policy titled Senior Services Abuse Prevention Plan revised 7/21, indicated if suspected or alleged abuse (physical, verbal, sexual, financial exploitation) a report must be made to the facility designated SA immediately or no later than 2 hours after the allegation/suspicion.	F 609		
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. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		4/22/22

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F 610	Continued From page 5 §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 interviews and document review, the facility failed to protect and prevent further potential abuse after an allegation of sexual abuse was made by 1 of 1 resident (R4) and failed to ensure the allegation was thoroughly investigated. Findings include: R4's quarterly Minimal Data Set (MDS) dated 3/1/22, indicated R4 had diagnoses which included dementia, anxiety disorder and had severe cognitive impairment. Further review of MDS indicated R4 exhibited delusions, physical and verbal behaviors. Review of the facility's internal investigation did not identify a specific date and time of the allegation occurred. The internal investigation included a statement written by registered nurse (RN)-C dated 3/3/22 and statements written by NA-A, NA-E, and DON on 3/8/22. -Statement by RN-C dated 3/3/22, indicated she was the floor nurse on the day of the allegation. NA-D assisted R4 to the restroom. At this time, R4 was exhibiting sun downing and appeared confused and tired. NA-D returned to the commons area with R4 and assisted her into the recliner and R4 appeared calm. Moments later NA-A reported to RN-C R4 stated she "didn't like	F 610	1. OHFC report was filed related to R4. An investigation was completed, and no findings of abuse were substantiated. R4 care plan was updated to reflect changes to her cognition and increase in behaviors such as yelling, hitting, refusing cares, making statements that staff are out to get her and that she wants to leave the facility. Also, an increase in hallucinations/delusions. New interventions were put in place. All staff were made aware of these changes to the care plan. Alleged incident did occur on 3/8/22 at approximately 4pm. Alleged preparator had already left work for the day prior to allegation. DON did interview alleged preparator the following morning prior to staff person going out onto the floor for the shift. When report was not substantiated staff person was allowed to work. 2. All residents could be affected by this practice. 3. Policies, procedures related to investigating an alleged VA were reviewed and revised. The process in investigating a VA was revised and updated to include all steps to be completed to ensure resident alleged VA was safe and all other residents are also safe, measures such	

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F 610	Continued From page 6 that man going up and down". RN-C indicated she reported the allegation to the DON. -Statement by NA-A dated 3/8/22, indicated at 4:00 p.m. R4 stated "she would rather fall, it would be better than having him put himself up and down her" and appeared to be upset. NA-A reported the allegation to RN-C. - Statement by NA-E dated 3/8/22, indicated R4 reported to NA-E "he took her to the small room [bathroom] and said he was saving her, then cornered her and raped her." NA-E reported this allegation to RN-C and DON. -Statement by DON dated 3/8/22, indicated after speaking with staff there was no evidence that anything happened while she [R4] was toileted, no evidence of rape, as she had no physical or emotional signs. R4 had not shown any signs of distress towards NA-D and R4 had a history of making sexual comments. Further, DON indicated R4 was upset staff were using the sit to stand mechanical lift as she did not like to be moved up and down with it. DON indicated R4 had difficulty in making herself understood due to cognition. DON observed R4 at approximately 4:30 p.m. and R4 appeared to be sleeping and was not anxious. DON interviewed NA-D who denied the allegation and indicated R4 did not have any complaints or concerns while assisting her to the bathroom. Facility lacked evidence of protection measures and/or plan to keep R4 and other residents safe during the investigation. In addition, the facility's investigation did not include nor was it evident in R4's records a completed skin assessment or medical examination after the allegation. On 3/30/22, at 9:29 a.m. When asked how the facility investigated the allegation and what was	F 610	as thorough investigation at time of incident, removal of alleged preparator if there is one, until investigation is completed, documentation of the complete investigation, measures to ensure safety of resident involved and all other residents who could potentially be at risk. Body audit and or exam of resident if pertinent to be completed and documented. 4. All staff were trained on VA investigation process, policies and procedures related to investigating a VA. Audits to be completed daily by DON or designee daily for 4 weeks related to making sure a thorough investigation was completed on all alleged VA incidents. Audits to be reviewed at QAPI to determine continued frequency of audits.	

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F 610	Continued From page 7 put into place for protection, director of nursing (DON) indicated she interviewed and got statements from all staff involved at the time of the allegation. In addition, DON indicated there was no reasonable suspicion the sexual allegation occurred therefore DON confirmed no additional measures were implemented following interviews with staff . Review of facility policy titled Senior Services Abuse Prevention Plan revised 7/21, indicated immediate steps should be taken to ensure no resident remains in danger of mistreatment. Further review of policy indicated Bigfork Valley will prevent further potential abuse from occurring while it investigates the allegation which included but not limited to all parties involved or having observed the alleged incident are interviewed and when a specific staff member is implicated in the alleged even, the person will be removed from the resident care area immediately, suspended pending investigation, and interviewed. The facility's Abuse program polices did not identify or address procedures for investigating sexual abuse allegations.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		4/22/22

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F 684	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan was being followed for 1 of 3 residents (R1) who were reviewed for quality of care, when R1 who required assistance by 2 staff members for transferring due to pain and previous fracture, was transferred by one staff member which resulted in increased pain to fractured arm. Findings include: R1 was admitted to the facility on 3/16/22, with a diagnosis of displaced oblique fracture of shaft of humerus of left arm. R1's 48-hour care plan dated 3/16/22, indicated R1 required assistance of two staff for transfers using a sit to stand lift while supporting R1's arm. Further review of R1's care plan indicated do not touch left arm related to arm fracture which caused pain and discomfort. Review of facility incident report dated 3/18/22, indicated at 6:00 a.m. R1 reported increased pain 6/10 to left arm fracture. R1 reported a nursing assistant (NA) transferred her to the bathroom with the manual sit to stand life and attempted to support R1's fractured left arm without the assistance of a second staff. R1 reported something happened during the transfer due to increased pain to the fractured left arm and requested an x-ray. Review of facility's 5-day investigation to the SA dated 3/21/22, indicated NA-A did not read the 48-hour care plan or ask the floor nurse for information related to R1's care level prior to	F 684	1 All staff were reeducated on proper transfers and restrictions for resident R1. Care plan was reviewed with all staff related to R1. Staff person who did not follow care plan was provided additional trainings. 2 All residents could be affected by this practice. 3. Policies related Care Plans were reviewed and revised. New policies in place to make staff aware that they need to read the temporary care plan and initial it prior to working with any new resident. Nursing staff to make sure all staff are aware of how to care for new residents related to Care Plan, ensure oncoming staff are in report and engaged. Staff were made aware that they also have a responsibility to ask questions and make sure they understand and are aware of how to care for all residents in their care. New processes in place to ensure all staff are aware of changes to any resident's care plan. Transfer training will be provided to all staff, either by therapy staff or Nursing staff as needed. Nurses to use the 24-hour report form when giving report to ensure all changes get relayed to oncoming staff. Clipboard with 2 weeks of 24-hour report, temporary care plans and email updates to be at nurses' station will be available for staff to review in case they have not worked recently or have a question concerning a resident's care plan. All education provided by therapy or nursing will be documented and a roster will be completed to ensure all necessary	

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	245529	A. BUILDING _____ B. WING _____	C 03/30/2022

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F 684	Continued From page 9 assisting R1. Further, after NA-A transferred R1 with the manual sit to stand lift without the assistance of a second staff member to provide support to R1's affected arm, cause increased pain to R1's fracture left arm. Review of mediation administration record (MAR) indicated R1 required oxycodone 10 mg for pain on 3/17/22, at 9:05 p.m. with a pain level of 6/10 and requested additional pain medication on 3/18/22, at 6:13 a.m. with a pain level of 6/10. On 3/29/22, at 10:23 a.m. R1 was observed sitting in her recliner in her room. R1 had a sling on her left arm and appeared comfortable. In addition, on R1's closet appeared to be a paper posted indicating to use extreme caution and to not grab arm or move it away from the body. On 3/29/22, at 10:26 a.m. R1 indicated she was admitted to the facility following a fall at home which resulted in a fracture to her left arm. R1 indicated she put her call light on for assistance to the restroom and NA-A entered her room. NA-A applied a gait belt around R1's waist and began to transfer R1 using the manual sit to stand lift. R1 indicated NA-A placed her hand behind her left arm and began to assist pulling her up to a standing position rather than using the gait belt to aid R1 into a standing position. R1 reported during this transfer there was a lot of pain. Further, R1 indicated she did not report the increased pain to NA-A or mention she required the assistance of 2 staff members at this time. R1 indicated during the night on 3/17/22 into 3/18/22, she indicated her pain level was almost a 10/10 which she then reported the increased pain to NA-B and reported her concern of NA-A's transfer. In addition, R1 reported this incident was	F 684	staff receive the education. 4. All staff were educated on Care Plan policies, procedures. Education provided on how to access the care plan on their Bigfork Valley phones related to use of PCC and POC. 5 Daily audits of 2 residents at random times while receiving care, will be audited by nursing for 4 weeks, then reviewed at QAPI to determine further frequency of audits. These audits will be to ensure staff are following the resident care plan.	

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F 684	Continued From page 10	F 684		

the only occurrence when she was transferred by one staff member.

On 3/29/22, at 1:13 p.m. registered nurse (RN)-A indicated since the incident regarding R1's care plan not being followed, she has not received any additional education regarding communication related to new admission's 48- hour care plans or R1's transfers.

On 3/29/22, at 1:40 p.m. NA-B indicated while she was in R1's room R1 reported to her NA-A tried to stabilize her arm while transferring R1 alone and now her arm hurts. NA-B indicated she reported R1's concern to RN-B. In addition, NA-B indicated she had not received any additional education following the incident.

On 3/29/22, at 1:59 p.m. RN-B indicated at 6:00 a.m. on 3/18/22, NA-B reported R1's arm was hurting really bad, and she hurt it while being toileted by NA-A. RN-B confirmed she had not received any education following the incident.

On 3/29/22, at 2:41 p.m. NA-C indicated since the incident regarding R1's care plan not being followed she had not received any additional training or education.

On 3/29/22, at 3:28 p.m. NA-A indicated a resident's care plan contains each resident's specific needs and would be considered neglect if the resident's care plan was not being followed. NA-A indicated each resident's care plan are in the files at the nursing station and all nursing staff had access to each care plan on the facility phone each staff carry with them if they need to reference it. Further, NA-A indicated staff were expected to review the resident's care plan for a

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F 684	Continued From page 11 new resident and the updates were communicated through report at shift change. NA-A indicated on 3/17/22, when she arrived to her shift, the report was "lacking" and was not given the proper information regarding R1 and her cares. NA-A indicated she entered R1's room and R1 indicated she needed assistance with evening cares. NA-A indicated she applied the gait belt around R1's waist and placed the manual sit to stand lift in front of resident in recliner. R1 placed her right hand on the lift and NA-A was standing on her affected left side. NA-A indicated she braced R1's left arm carefully while assisting with cares. In addition, NA-A confirmed she did not read R1's care plan prior to assisting R1 and did not ask any other staff for additional information. Further, NA-A indicated she received education from the therapy department on R1's transfer following this incident with two other nursing staff. On 3/30/22, at 9:29 a.m. director of nursing (DON) indicated R1 admitted to the facility following an arm fracture. Upon R1's admission, direction was given R1 required assistance by two staff members to transfer using the manual sit to stand lift and do not move R1's left arm. DON indicated a 48-hour care plan was completed and a paper was hung on R1's closet door for reminders. Further, DON indicated RN-B reported NA-A transferred R1 with assist of one instead of two causing increased pain to left arm fracture and was afraid the fracture had shifted. DON indicated staff were expected to review the care plan for each resident prior to assisting with cares or ask the nurse if they feel they didn't get enough information and need clarification. In addition, following the incident NA-A was trained on transferring R1 by therapy, and therapy	F 684		

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F 684	Continued From page 12 provided another training to staff they "could catch". DON stated she did not educate another staff since NA-A was the only staff identified not following R1's care plan. On 3/31/22, at 10:02 a.m. occupational therapist (OT)-A indicated following the incident with R1's care plan not being followed, he provided staff a "brief" education on two separate days related to R1's transfers. Further, OT-A indicated he only trained approximately 5 staff and may have got the same staff twice but confirmed not all staff were trained. Review of facility policy titled Care Plan-Long Term Care (LTC) last revised 2/22, indicated the objective baseline care plan is the completion and implementation within 24-hours of a resident's admission and is intended to promote continuity of care and communication among the nursing home staff, increase resident safety, and safeguard against diverse events that are most likely to occur right after admission. Contents of the care plan will include at minimum instructions needed to provide effective and person-centered care that meets professional standards of quality of care, addresses resident health and safety concerns to prevent decline or injury, and identify the needs for supervision and assistance with activities of daily living.	F 684		

Electronically delivered
April 9, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: TPIX11

Dear Administrator:

The above facility was surveyed on March 29, 2022 through March 30, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/29/22 through 3/30/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5529023C (MN00081917) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan was being followed for 1 of 3 residents (R1) who were reviewed for quality of care, when R1 who required assistance by 2 staff members for transferring due to pain and previous fracture, was transferred by one staff member which resulted in increased pain to fractured arm.	2 830	1 All staff were reeducated on proper transfers and restrictions for resident R1. Care plan was reviewed with all staff related to R1. Staff person who did not follow care plan was provided additional trainings. 2 All residents could be affected by this practice.	4/22/22

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2 830	Continued From page 3 Findings include: R1 was admitted to the facility on 3/16/22, with a diagnosis of displaced oblique fracture of shaft of humerus of left arm. R1's 48-hour care plan dated 3/16/22, indicated R1 required assistance of two staff for transfers using a sit to stand lift while supporting R1's arm. Further review of R1's care plan indicated do not touch left arm related to arm fracture which caused pain and discomfort. Review of facility incident report dated 3/18/22, indicated at 6:00 a.m. R1 reported increased pain 6/10 to left arm fracture. R1 reported a nursing assistant (NA) transferred her to the bathroom with the manual sit to stand life and attempted to support R1's fractured left arm without the assistance of a second staff. R1 reported something happened during the transfer due to increased pain to the fractured left arm and requested an x-ray. Review of facility's 5-day investigation to the SA dated 3/21/22, indicated NA-A did not read the 48-hour care plan or ask the floor nurse for information related to R1's care level prior to assisting R1. Further, after NA-A transferred R1 with the manual sit to stand lift without the assistance of a second staff member to provide support to R1's affected arm, cause increased pain to R1's fracture left arm. Review of mediation administration record (MAR) indicated R1 required oxycodone 10 mg for pain on 3/17/22, at 9:05 p.m. with a pain level of 6/10 and requested additional pain medication on 3/18/22, at 6:13 a.m. with a pain level of 6/10.	2 830	3. Policies related Care Plans were reviewed and revised. New policies in place to make staff aware that they need to read the temporary care plan and initial it prior to working with any new resident. Nursing staff to make sure all staff are aware of how to care for new residents related to Care Plan, ensure oncoming staff are in report and engaged. Staff were made aware that they also have a responsibility to ask questions and make sure they understand and are aware of how to care for all residents in their care. New processes in place to ensure all staff are aware of changes to any resident's care plan. Transfer training will be provided to all staff, either by therapy staff or Nursing staff as needed. Nurses to use the 24-hour report form when giving report to ensure all changes get relayed to oncoming staff. Clipboard with 2 weeks of 24-hour report, temporary care plans and email updates to be at nurses' station will be available for staff to review in case they have not worked recently or have a question concerning a resident's care plan. All education provided by therapy or nursing will be documented and a roster will be completed to ensure all necessary staff receive the education. 4. All staff were educated on Care Plan policies, procedures. Education provided on how to access the care plan on their Bigfork Valley phones related to use of PCC and POC. 5 Daily audits of 2 residents at random times while receiving care, will be audited by nursing for 4 weeks, then reviewed at QAPI to determine further frequency of audits. These audits will be to ensure staff	

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2 830	Continued From page 4 On 3/29/22, at 10:23 a.m. R1 was observed sitting in her recliner in her room. R1 had a sling on her left arm and appeared comfortable. In addition, on R1's closet appeared to be a paper posted indicating to use extreme caution and to not grab arm or move it away from the body. On 3/29/22, at 10:26 a.m. R1 indicated she was admitted to the facility following a fall at home which resulted in a fracture to her left arm. R1 indicated she put her call light on for assistance to the restroom and NA-A entered her room. NA-A applied a gait belt around R1's waist and began to transfer R1 using the manual sit to stand lift. R1 indicated NA-A placed her hand behind her left arm and began to assist pulling her up to a standing position rather than using the gait belt to aid R1 into a standing position. R1 reported during this transfer there was a lot of pain. Further, R1 indicated she did not report the increased pain to NA-A or mention she required the assistance of 2 staff members at this time. R1 indicated during the night on 3/17/22 into 3/18/22, she indicated her pain level was almost a 10/10 which she then reported the increased pain to NA-B and reported her concern of NA-A's transfer. In addition, R1 reported this incident was the only occurrence when she was transferred by one staff member. On 3/29/22, at 1:13 p.m. registered nurse (RN)-A indicated since the incident regarding R1's care plan not being followed, she has not received any additional education regarding communication related to new admission's 48- hour care plans or R1's transfers. On 3/29/22, at 1:40 p.m. NA-B indicated while she was in R1's room R1 reported to her NA-A	2 830	are following the resident care plan.	

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2 830	Continued From page 5	2 830		

tried to stabilize her arm while transferring R1 alone and now her arm hurts. NA-B indicated she reported R1's concern to RN-B. In addition, NA-B indicated she had not received any additional education following the incident.

On 3/29/22, at 1:59 p.m. RN-B indicated at 6:00 a.m. on 3/18/22, NA-B reported R1's arm was hurting really bad, and she hurt it while being toileted by NA-A. RN-B confirmed she had not received any education following the incident.

On 3/29/22, at 2:41 p.m. NA-C indicated since the incident regarding R1's care plan not being followed she had not received any additional training or education.

On 3/29/22, at 3:28 p.m. NA-A indicated a resident's care plan contains each resident's specific needs and would be considered neglect if the resident's care plan was not being followed. NA-A indicated each resident's care plan are in the files at the nursing station and all nursing staff had access to each care plan on the facility phone each staff carry with them if they need to reference it. Further, NA-A indicated staff were expected to review the resident's care plan for a new resident and the updates were communicated through report at shift change. NA-A indicated on 3/17/22, when she arrived to her shift, the report was "lacking" and was not given the proper information regarding R1 and her cares. NA-A indicated she entered R1's room and R1 indicated she needed assistance with evening cares. NA-A indicated she applied the gait belt around R1's waist and placed the manual sit to stand lift in front of resident in recliner. R1 placed her right hand on the lift and NA-A was standing on her affected left side. NA-A indicated she braced R1's left arm carefully while assisting

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	00834	A. BUILDING: _____ B. WING _____	C 03/30/2022

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

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2 830	Continued From page 6 with cares. In addition, NA-A confirmed she did not read R1's care plan prior to assisting R1 and did not ask any other staff for additional information. Further, NA-A indicated she received education from the therapy department on R1's transfer following this incident with two other nursing staff. On 3/30/22, at 9:29 a.m. director of nursing (DON) indicated R1 admitted to the facility following an arm fracture. Upon R1's admission, direction was given R1 required assistance by two staff members to transfer using the manual sit to stand lift and do not move R1's left arm. DON indicated a 48-hour care plan was completed and a paper was hung on R1's closet door for reminders. Further, DON indicated RN-B reported NA-A transferred R1 with assist of one instead of two causing increased pain to left arm fracture and was afraid the fracture had shifted. DON indicated staff were expected to review the care plan for each resident prior to assisting with cares or ask the nurse if they feel they didn't get enough information and need clarification. In addition, following the incident NA-A was trained on transferring R1 by therapy, and therapy provided another training to staff they "could catch". DON stated she did not educate another staff since NA-A was the only staff identified not following R1's care plan. On 3/31/22, at 10:02 a.m. occupational therapist (OT)-A indicated following the incident with R1's care plan not being followed, he provided staff a "brief" education on two separate days related to R1's transfers. Further, OT-A indicated he only trained approximately 5 staff and may have got the same staff twice but confirmed not all staff were trained.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 7 Review of facility policy titled Care Plan-Long Term Care (LTC) last revised 2/22, indicated the objective baseline care plan is the completion and implementation within 24-hours of a resident's admission and is intended to promote continuity of care and communication among the nursing home staff, increase resident safety, and safeguard against diverse events that are most likely to occur right after admission. Contents of the care plan will include at minimum instructions needed to provide effective and person-centered care that meets professional standards of quality of care, addresses resident health and safety concerns to prevent decline or injury, and identify the needs for supervision and assistance with activities of daily living. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		