DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 18, 2023

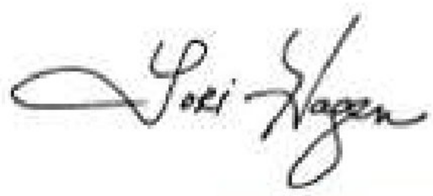
Administrator
Bigfork Valley Communities
258 Pine Tree Drive
Bigfork, MN 56628

RE: CCN: 245529
Cycle Start Date: December 7, 2022

Dear Administrator:

On January 6, 2023, 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.



Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 15, 2022

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

RE: CCN: 245529
Cycle Start Date: December 7, 2022

Dear Administrator:

On December 7, 2022, a survey was completed at your facility by the Minnesota Department of Health, 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 7, 2023 (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 7, 2023 (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,

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 15, 2022

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

Re: Event ID: 2P4L11

Dear Administrator:

The above facility survey was completed on December 7, 2022 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,

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

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 12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIGFORK VALLEY COMMUNITIES	258 PINE TREE DRIVE 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 12/6/22 through 12/7/22, 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 with no deficiencies, however a related deficiency was cited at F609: H55296364C (MN00088918) 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(b)(5)(i)(A)(B)(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 hours after the allegation is made, if the events	F 609		1/6/23

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

Electronically Signed | 12/21/2022

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 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 immediately report to the administrator and no later than 2 hours, to the State Agency (SA) an allegation of staff to resident verbal abuse for 1 of 1 residents (R1) who was reviewed for allegations of abuse. Findings include: R1's annual Minimum Data Set (MDS) dated 10/21/22, indicated R1 had diagnoses which included Alzheimer's, anxiety, depression and was severely cognitively impaired. Identified R1 required staff assistance with bed mobility, transfers, dressing, toileting, personal hygiene, bathing and was independent with eating after set up assistance. R1's care plan revised on 12/5/22, identified R1	F 609	1 Staff person whose complaint was substantiated is no longer working at this facility. 2 All residents are considered vulnerable adults, so are at risk by this practice. 3 Policies, procedures have been reviewed and revised. All staff have been reeducated as to what constitutes abuse, who is required to report, timelines and who to report to. Deficiency was reviewed at QAPI. 4 Audits of all charts will be reviewed daily by DON or designee for potential abuse for 4 weeks, then review at QAPI in January to discuss further actions and need for further audits. Staff will be randomly audited by DON or designee on what constitutes abuse, who is a mandated reporter, timelines and who	

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F 609	Continued From page 2 was a vulnerable adult due to her placement and indicated R1 would have been safe while living at the facility and her basic needs would have been met. The care plan indicated R1 had a diagnoses of dementia with very short term memory and would ask the same question numerous times. The care plan identified R1 required assistance with bed mobility, transfers, dressing, grooming, bathing, toileting and set up help for eating. R1's care plan indicated she had anxiety and depression and demonstrated verbally abusive behavior at times during cares. Review of R1's Initial Incident Report form dated 11/28/22, revealed the following: On 11/27/22, an allegation of verbal abuse occurred in the aspen dining room with R1. Staff reported kitchen staff had been rude and yelling at R1 and telling her to just eat her meal and soup. Review of the Nursing Home Incident Report (NHIR) submitted to the SA identified there was an allegation of emotional/mental abuse. The report indicated on 11/27/22, at 5:00 p.m. nursing assistant (NA) brought R1 soup from the kitchen, when R1 began to yell out she did not like the soup and wanted some salt. The report identified dietary staff yelled at R1, informed her they did not have any salt and it did not matter as they did not believe she would eat the soup anyway. Shortly after the incident a charge nurse entered the dining room where R1 and dietary staff were present and stated to the dietary staff "do I have permission to put duct tape on her mouth?" The charge nurse and the dietary staff laughed after the comment had been made. The NHIR identified the incident occurred on 11/27/22, at 5:00 p.m. and was reported to the SA on 11/28/22, at 1:38 p.m. over 20 hours after the	F 609	to report abuse to and on the spot reeducation will be provided if needed. 5 staff per week to be audited, results to be reviewed at QAPI.	

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F 609	Continued From page 3 incident had occurred. During an interview on 12/6/22, at 4:25 p.m. dietary staff (DS)-B indicated on 11/27/22, she entered the dining room at about 5:00 p.m. and heard R1 using vulgar language while asking for salt. DS-B stated she heard DS-A respond to R1 to "shut up" in a harsh manner. DS-B indicated DS-A walked away from R1 while she continued to call DS-A vulgar names and indicated the words said between R1 and DS-A became very heated. DS-B stated she was not aware of who to report the allegation of abuse to since her boss had already left for the day. During an interview on 12/6/22, at 5:48 p.m. NA-B indicated on 11/27/22, at about 5:10 p.m. R1 was eating chicken noodle soup in the dining room and asked for some salt in a very loud tone of voice. DS-A informed her they did not have any salt and R1 responded the soup was gross and she could not eat it. NA-A indicated the verbal exchange between DS-A and R1 about the salt escalated when DS-A responded in a loud tone of voice " there is no salt, I don't know what to tell you". NA-B stated DS-A proceeded to respond by telling R1 to "shut up" and "I'm tired of feeding you". NA-B indicated she had not reported the allegation of abuse as she did not have the time to write up the report. During an interview on 12/7/22, at 11:26 a.m., the director of nursing (DON) confirmed the above findings and indicated the administrator had called her on the morning of 11/28/22, to report the allegation of abuse to her. The DON indicated the allegation occurred in the dining room on 11/27/22, around 5:00 p.m. when DS-A told R1 to shut up in a loud voice. The DON stated staff	F 609		

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F 609	Continued From page 4 were expected to report any allegation of abuse to their supervisor immediately and to notify her and the administrator right away. The DON indicated staff were to report to the SA within two hours of the incident occurring and she would expect staff to follow the facility policy with any allegation of abuse. During an interview on 12/7/22, at 11:58 a.m. the administrator confirmed the above findings and indicated he had been notified of the allegation involving DS-A on the morning of 11/27/22. The administrator stated the facility's abuse policy instructed staff to report the incident immediately to their supervisor and the supervisor would notify him as soon as possible. The administrator indicated the facility had two hours to report any type of elder abuse to the SA and if the allegation involved a staff member they would have been removed from the schedule until the investigation had been completed. The administrator stated he would expect staff to follow the facility's abuse policy and to report the SA in a timely manner. Review of the facility policy titled, Senior Services Abuse Prevention Plan revised 4/22, indicated if suspected or alleged abuse (physical, verbal, sexual, financial exploitation) a report was expected to be made to the facility designated SA immediately or no later than 2 hours after the allegation/suspicion. The policy instructed staff to call the administrator or the DON immediately.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00834	A. BUILDING: _____ B. WING _____	C 12/07/2022

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/6/22 through 12/7/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H55296364C (MN00088918) with no licensing orders issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. 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		