Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 7, 2025

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

RE: CCN: 245529
Cycle Start Date: October 23, 2024

Dear Administrator:

On December 31, 2024, we notified you a remedy was imposed. On December 4, 2024 and January 3, 2025 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 1, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 31, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 23, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 1, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 6, 2024

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

RE: CCN: 245529
Cycle Start Date: October 23, 2024

Dear Administrator:

On October 23, 2024, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 January 23, 2025 (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 April 23, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@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 10/23/2024

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
E 000	Initial Comments On 10/21/24 through 10/23/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements at 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/21/24 through 10/23/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with no deficiency issued. H55299550C (MN99681) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/14/2024

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 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced	F 676		11/25/24

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F 676	Continued From page 2 by: Based on observation, interview and document review, the facility failed to assist with personal hygiene as directed by the care plan for 1 of 3 (R17) residents reviewed for activities of daily living (ADLs). Findings include: R17's quarterly Minimum Data Set (MDS) dated 10/1/24, identified R17 was cognitively aware with diagnoses that included malignant neoplasm of accessory sinus (sinus cavity cancer), type 2 diabetes, heart failure and hypertension. R17 required set up or clean up assistance with personal hygiene and R17 completed the activity. R17's care plan dated 7/1/24, identified R17 required extensive assist of one staff for personal hygiene. During an observation on 10/21/24 at 6:20 p.m., R17 was lying in bed on his left side. R17 had dried, dark red blood that had oozed from his left nostril to the left corner of his mouth and onto R17's beard. R17 hair was greasy and disheveled. During an observation on 10/22/24 at 9:36 a.m., RN-A administered R17's Lantus injection. R17 was lying in bed and was wearing the same long-sleeved t-shirt and sweatpants as the evening prior. R17's hair continued to be greasy and R17 continued to have the dried dark red blood from his left nostril to the corner of his mouth and bear. R17 attempted to move his pillow under his head but his pillowcase was coming off exposing half of the pillow with an approximately 6-inch diameter circle of dried	F 676	1.Resident 17 was reassessed for increased need in ADL□s, a Significant Change MDS was completed. Care Plan was updated related to changes in care needs. Resident 17 was given a shower, and clean clothes, daily hygiene and room order has been addressed. 2.All residents can be affected by this practice. All residents Care Plans reviewed to ensure all residents hygiene needs are being met. 3.Education to all staff to be provided related to ADL□s, following the care plan and dignity. A policy was created related to ADL□s. 5.Audits to be completed related to residents having clean clothes on daily, hygiene needs addressed per the Plan of Care. DON or designee to audit 7 residents on random shifts weekly times 4 weeks and then reassess. Results to be reviewed at monthly QAPI and further audits will be determined by the QAPI team.	

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F 676	Continued From page 3	F 676		

blood. RN-A stated, "let me help you with that" and, without putting on gloves, replaced the soiled pillowcase on R17's pillow and put it under R17's head. RN-A administered R17's medication but did not offer personal hygiene to R17 nor offered clean linens.
- At 11:45 a.m., R17 was observed outside sitting in his wheelchair with a visitor on the covered porch area. R17 continued to have dried blood from his left nostril down his mustache to the left corner of his mouth and R17's disheveled hair is sticking out of the hood of his Carhart jacket.

During an interview on 10/23/24 at 8:24 a.m., RN-B stated R17 had "sinus cancer" and often had blood draining from his nostril. Sometimes R17 couldn't feel it. RN-B would assist R17 with cleaning up or would ask a nursing assistant to help R17. "You don't leave him like that". R17 was dirty, bloody and needed to be cleaned up after gowning and gloving.

During an interview on 10/23/24 at 8:58 a.m., nursing assistant (NA)-D stated R17 was "pretty independent" with cares because he liked to do things on his own. Staff pretty much just needed to set R17 up. If R17 was dirty or had blood on his face, you just politely told him and offered a washcloth or asked if you could help him. Sometimes, R17 could tell you and other times you had to point it out. NA-D stated you always offer clean linens when a bed was soiled. Who wants to lie in a dirty bed?

During an interview on 10/23/24 at 10:39 a.m., the director of nursing (DON) stated R17 had continuous nose bleeds due to his condition. The DON expected staff to provide immediate basic cares including clean linens for cleanliness and

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F 676	Continued From page 4 comfort. During an interview on 10/23/24 at 12:47 p.m., R17 was lying in bed, was clean, groomed and had clean bed linens. R17 stated he had a shower that morning. Staff him up and R17 took it from there. However, that did not happen every morning. It was more like every 2-3 days, "whatever, "I'm just really tired." A facility policy regarding ADLs was requested but not received.	F 676		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a transfer belt was utilized while transferring 1 of 1 residents (R11) reviewed for ambulation. Findings include: R11's quarterly Minimum Data Set (MDS) dated 7/24/24, identified R11 had severe cognitive impairment and required supervision to touching assistance with walking (Helper provides verbal cues or touching/steadying assistance a resident completes activity). R11 had a diagnosis of	F 689	1.Transfer belt now used routinely on resident 11. Staff reeducation and coaching's were provided. Therapy was consulted related to safe transfers for resident 11. 2.All residents who need help with transfers and ambulation could be affected by this practice. A comprehensive review of all residents requiring assistance with ambulation was conducted to identify any other individuals who may be affected by this practice.	11/25/24

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F 689	Continued From page 5 Alzheimer's and identified a fall without injury since R11's assessment. R11's care plan dated 1/23/24, identified R11 was a limited to extensive assist of one for ambulation and to use a transfer belt. R11's physical therapy discharge note from 2/23/24, identified R11 needed contact guard assist (the caregiver places one or two hands on the patient's body to help with balance and assistance to perform the functional mobility task) with ambulation. R11's fall risk assessment dated 10/17/24, identified R11 was at risk for falls. During an observation on 10/21/24 at 2:15 p.m., activity staff (A)-B offered to assist R11 to walk to an activity. A-B took R11's hand and placed one arm behind R11's back and walked to the activity. R11 was steady on her feet. A transfer belt was not used while R11 ambulated. During an observation on 10/21/24 at 4:52 p.m., R11 was ambulated for 20 feet by trained medication assistant (TMA)-A and nursing assistant (NA)-A. A transfer belt was not used until they noticed the surveyor was present. R11 was taking short steps, was unbalanced and had two staff assisting her. TMA-A and NA-A then stopped and placed a transfer belt on R11 before they continued to the dining room. During an observation on 10/22/24 at 9:47 a.m., R11 was assisted with ambulation by NA-B from the dining room to the common area by holding R11's hand and an arm around her back. R11 was steady during transfer. A transfer belt was	F 689	3.All staff educated on the need to follow the Care Plan related to transfers and ambulation. All staff were reeducated on use of PCC and POC on the facility provided iPhones or computers, a return demo was completed by staff to ensure they were able to access the POC. Staff educated on the importance of use of transfer belts. Policies and Procedures related to safe patient transfers reviewed and will be revised as needed. 4. DON or designee will conduct audits weekly of 7 residents randomly to ensure they are using a transfer belt with transfer and ambulation per the Plan of Care and our policy. Results will be reviewed at monthly QAPI and further audits will be determined by the QAPI team.	

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F 689	Continued From page 6 not used while R11 ambulated. During observation on 10/22/24 at 1:49 p.m., R11 was assisted to bingo by A-A who held R11's hand and had one arm behind R11's back. When they got to bingo, A-A assisted resident to sit in a chair. But R11 attempted to sit before the chair was under her and A-A had to grab at R11's waist band on her pants to guide her to sit in the chair without R11 falling to the floor. A transfer belt was not used. During an interview on 10/23/24 at 9:08 a.m., NA-C stated R11 was a limited to extensive assist for ambulation and required the use of a transfer belt while ambulated due to risk of falls or for sudden weakness. During an interview on 10/23/24 at 1:15 p.m., A-B stated she was trained as a NA and had her certification. A-B said she would assist residents to walk to activities when she was able to. When normally assisting R11 to walk, A-B would assist resident to stand and then place one arm behind her back and hold R11's hand. A-B was unsure of what the care plan stated for ambulation with the resident. A-B had not used a gait belt with R11 because R11 could be resistive, therefore A-B did not offer for R11 to use it. A-B was unable to explain the importance of using the gait belt for R11's safety. During an interview on 10/23/24 at 2:11 p.m., the director of nursing (DON) stated it was the expectation that all staff would follow the residents care plan with ambulation to remain safe. R11 should have been wearing a gait belt to ensure her safety. All staff had initial orientation and annual training regarding patient care and	F 689		

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F 689	Continued From page 7 ambulation. The facility's Care Plan policy dated 5/2023 identified the staff would implement the interventions to assist the resident to achieve care plan goals and objectives.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		11/25/24

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F 756	Continued From page 8 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure they received an appropriate physician response to a gradual dose reduction for use for 1 of 5 (R9) residents reviewed for unnecessary medication. Findings include: R9's quarterly Minimum Data Set (MDS) dated 8/13/24, identified R9 had a moderate cognitive impairment and had diagnoses that included Alzheimer's disease, anxiety and depression. R9's physician orders dated 11/20/23, lorazepam (an antianxiety medication) 0.5 milligram (mg). Give 0.5 mg orally three times a day related to anxiety disorder. R9's Consultant Pharmacist's Medication Review dated 11/8/23, identified R9 was due for a second request for lorazepam GDR. R9's last GDR was rejected by family earlier this year. R9 currently takes lorazepam 0.5 mg orally three times a day for anxiety. Would you like to attempt a lower dose at this time or continue as is? (Could try lorazepam 0.5 mg every morning and at bedtime with 0.25 mg at noon.) A physician response dated 11/8/23, identified to change to lorazepam 0.5 mg every morning and at bedtime with 0.25	F 756	1 Resident 9 has had a successful dose reduction of her lorazepam to 0.5mg po bid from lorazepam 0.5mg po tid. Family has been educated on effects of medication and the need for a GDR. 2 All residents on psychotropic medications could be affected by this practice. Pharmacy has completed a full house medication review. 3 Pharmacy review has been completed on all residents and GDR have been attempted on appropriate residents. MD and nurses have been educated on documenting rationale related to GDR recommendations from pharmacy. Policy related to GDR reviewed and revised as needed. 4 DON and Pharmacist to do monthly and prn audits related to GDR to ensure no unnecessary medications are prescribed. 5.Audits to be reviewed at monthly QAPI by the team.	

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	245529	A. BUILDING _____ B. WING _____	C 10/23/2024

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F 756	Continued From page 9 mg at noon. R9's Pharmacy Medication Review dated 11/16/23 at 12:15 p.m., identified staff spoke on the phone with family member (FM)-A regarding R9's Gradual Dose Reduction Request by Pharmacy and R9's medical provider: decrease lorazepam from 0.5mg three times a day to 0.5mg twice a day with 0.25mg at noon. The GDR request was rejected by FM-A. A fax sent to R9's provider with above text regarding GDR rejection by FM-A. R9's physician order dated 11/20/23, identified lorazepam 0.5 mg orally three times a day. R9's physician progress notes dated 11/20/23 to 10/23/24, identified R9 had major depression and anxiety with orders to continue to administer lorazepam. However, the physician progress notes failed to identify a justification of use for R9's lorazepam. During an interview on 10/23/24 at 10:33 a.m., registered nurse (RN)-B stated R9's lorazepam order was a "long standing" thing. R9 was in a bad accident years prior and family reported R9 had been taking it since then. Family refused the GDR. During interview on 10/23/24 at 10:35 a.m., the director of nursing (DON) stated the pharmacist sends all recommendations to the provider who then sends their response to us and I take care of them after I receive them. During a telephone interview on 10/23/24 at 12:54 p.m., consultant pharmacist (CP)-A stated a pharmacist did medication reviews for the facility	F 756		

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F 756	Continued From page 10 every month. Upon review of R9's 11/16/23, GDR request, CP-A stated R9's family didn't want R9's medications touched. If a family refused a resident's attempt at GDR, the pharmacist relied on the physician's response. As long as an order to continue the medication was received, the pharmacist would not request further review of the medication until the next GDR was recommended. CP-A stated she believed the family refusing GDR was a justifiable reason for continued lorazepam use. However, CP-A stated, after a perod of time, a physician documented justification of use and education would be warranted. During an interview on 10/23/24 at 1:21 p.m., the director of nursing (DON) stated she had never spoken with R9's family regarding R9's medication. The nurses call the family to get the psychotropic medication consent. The DON stated if the family refused the GDR, they would refuse to sign a consent for lorazepam and, without the consent, R9 would not receive her medication. The DON had not addressed a documented justified use with R9's physician. The facility policy Monitoring of Psychotropic Medications effective date 2/2024, identified the consultant pharmacist shall monitor the use of psychotropic medications at least once monthly during the monthly Medication Regimen Review (MRR) and upon request between MRRs. The monitoring hall include, but is not limited to, the review of Behavior and Side Effect Monthly Flow Sheets. - During the monthly MRR, the pharmacist will identify a list of residents receiving psychoactive medications. This list may be obtained from the electronic medical record system. Each of the	F 756		

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F 756	Continued From page 11 identified residents shall have Behavior and Side Effect Monthly Flow Sheets that are in PCC. - The Behavior and Side Effect Monthly Flow Sheets are located in the EMR in PCC under POC charting. The pharmacist must review the Flow Sheets, in addition to any other related documentation, and report any irregularities to the attending physician and Director of Nursing as outlined in the Consultant Pharmacist Services policy. Irregularities may include, but are not limited to, the following: - Lack of rationale identifying why a medication is required - Inappropriate diagnosis code(s) - Lack of care planning - Lack of resident specific monitoring - Inconsistent monitoring of side effects or behaviors - Lack of rationale identifying why a gradual dose reduction (GDR) is clinically contraindicated - Unnecessary drug, in which the drug is used: - in excessive dose - for excessive duration - without adequate monitoring or without adequate indications for use - in the presence of adverse consequences, which indicate the dosage should be reduced or discontinued without specific target symptoms.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		11/25/24

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F 758	Continued From page 12 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F 758		

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F 758	Continued From page 13 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure behavior monitoring and gradual dose reduction (GDR) or justification of continued use was identified for 1 of 5 (R9) residents reviewed for unnecessary medication who were on a psychotropic medication. Findings include: R9's quarterly Minimum Data Set (MDS) dated 8/13/24, identified R9 had a moderate cognitive impairment and had diagnoses that included Alzheimer's disease, anxiety and depression. R9's physician orders dated 11/20/23, lorazepam (an antianxiety medication) 0.5 milligram (mg). Give 0.5 mg orally three times a day related to anxiety disorder. R9's Consultant Pharmacist's Medication Review dated 11/8/23, identified R9 was due for a second request for lorazepam GDR. R9's last GDR was rejected by family earlier this year. R9 currently takes lorazepam 0.5 mg orally three times a day for anxiety. Would you like to attempt a lower dose at this time or continue as is? (Could try lorazepam 0.5 mg every morning and at bedtime with 0.25 mg at noon.) A physician response dated 11/8/23, identified to change to lorazepam 0.5 mg every morning and at bedtime with 0.25 mg at noon. R9's Pharmacy Medication Review dated 11/16/23 at 12:15 p.m., identified staff spoke on	F 758	1 Resident 9 has had a successful dose reduction of her lorazepam to 0.5mg po bid from lorazepam 0.5mg po tid. Family has been educated on effects of medication and why the need for a GDR. 2 All residents on psychotropic medications could be affected by this practice. Pharmacy has completed a review of all residents. All residents who are on psychotropic medications have had a nursing assessment completed. 3 Pharmacy review has been completed on all residents and GDR have been attempted on appropriate residents. Primary Physicians have been educated on documenting rationale related to GDR recommendations from pharmacy. 4.Policy related to GDR reviewed and revised as needed. New process for nurses when discussing with families related to GDR to ensure adequate education has been provided and documented. Education provided to staff related to importance of behavioral interventions and documentation to assist in efforts to discontinue psychotropic medications. New assessment has been implemented for nursing to review the following: Medical conditions Behaviors	

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F 758	Continued From page 14 the phone with family member (FM)-A regarding R9's Gradual Dose Reduction Request by Pharmacy and R9's medical provider: decrease lorazepam from 0.5mg three times a day to 0.5mg twice a day with 0.25mg at noon. The GDR request was rejected by FM-A. A fax sent to R9's provider with above text regarding GDR rejection by FM-A. R9's physician order dated 11/20/23, identified lorazepam 0.5 mg orally three times a day. R9's physician progress notes dated 11/20/23 to 10/23/24, identified R9 had major depression and anxiety with orders to continue to administer lorazepam. However, the physician progress notes failed to identify a justification of use for R9's lorazepam. R9's medical record failed to identify behavior monitoring and corresponding nursing assessment either supporting the continuation of the lorazepam does or recommending a dose reduction. During an interview on 10/23/24 at 10:33 a.m., registered nurse (RN)-B stated R9's lorazepam order was a "long standing" thing. R9 was in a bad accident years prior and family reported R9 had been taking it since then. Family refused the GDR. During an observation on 10/22/24 at 1:54 p.m., R9 was playing a bingo during a large group activity. R9 was relaxed, smiling and joking with the staff and other residents. During an observation on 10/23/24 at 7:13 a.m., R9 was awake and dressed for the day. R9 rang	F 758	Adverse reactions from medications GDR Behaviors Notification to MD, Pharmacy and families as applicable. Assessment to be completed quarterly, with any significant change and prn following the MDS schedule. This Assessment will be provided to the Primary Physician upon completion, will be reviewed at Care Conference and at the QAPI meeting. Team to review and give input. 5.DON and Pharmacist to do monthly and prn audits related to GDR to ensure no unnecessary medications are prescribed. Audits to be reviewed at monthly QAPI by the team and further audits determined by QAPI team.	

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F 758	Continued From page 15 a bell on her overbed table. Trained medication aide (TMA)-A entered R9's room R9 stated her floor needed to be swept. TMA-A had housekeeping go into R9's room and clean. R9 was calm. TMA-A stated R9 just needed reassurance that she was safe, that staff were always there to help and staff just needed to try to figure out what R9 needed/wanted. During an observation on 10/23/24 at 8:36 a.m., nursing assistant (NA)-D provided morning cares for R9. NA-D explained each step in a calm voice and short, simple cues. R9 chose her clothing after NA-D gave her choices and participated during cares. R9 remained calm and smiling throughout cares. During interview on 10/23/24 at 10:35 a.m., the director of nursing (DON) stated the pharmacist sends all recommendations to the provider who then sends their response to us and I take care of them after I receive them. During a telephone interview on 10/23/24 at 10:50 a.m., R9's physician had never spoken to R9's family regarding R9's lorazepam order nor had provided education regarding lorazepam. During a telephone interview on 10/23/24 at 12:54 p.m., consultant pharmacist (CP)-A stated a pharmacist did medication reviews for the facility every month. Upon review of R9's 11/16/23 GDR request, CP-A stated R9's family didn't want R9's medications touched. If a family refused a resident's attempt at GDR, the pharmacist relied on the physician's response. As long as an order to continue the medication was received, the pharmacist would not request further review of the medication until the next GDR was	F 758		

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F 758	Continued From page 16	F 758		

recommended. CP-A stated she believed the family refusing GDR was a justifiable reason for continued lorazepam use. However, CP-A stated, after a perod of time, a physician documented justification of use and education would be warranted.

During an interview on 10/23/24 at 1:04 p.m., NA-D stated R9 did not exhibit any behaviors. R9 could get a little confused but normally was not anxious, agitated, restless or anything like that. R9 was just "normal."

During an interview on 10/23/24 at 1:13 p.m., NA-C and NA-E stated R9 was pretty easy going. NA-E stated R9 had a lot of anxiety when she was first admitted to the facility but that had been a while. R9 did like to watch everything staff did during cares. If R9 didn't see you do it, it didn't happen. Staff just needed to let R9 do her thing. Staff needed to tell her or show her every step of the way and it usually went well. If R9 questioned anything, staff just did it again and it was all good.

During an interview on 10/23/24 at 1:18 p.m., registered nurse (RN)-C stated R9 was "pleasant", but forgetful. Other than that, R9 really didn't have any negative behaviors.

During an interview on 10/23/24 at 1:21 p.m., the director of nursing (DON) stated she had never spoken with R9's family regarding R9's medication. The nurses call the family to get the psychotropic medication consent. The DON stated if the family refused the GDR, they would refuse to sign a consent for lorazepam and, without the consent, R9 would not receive her medication. The DON had not addressed a documented justified use with R9's physician and

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F 758	Continued From page 17 felt the familiies refusals were enough. Staff were expected document R9's behavior and assess R9 for possible interventions. The facility policy Monitoring of Psychotropic Medications effective date 2/2024, identified the consultant pharmacist shall monitor the use of psychotropic medications at least once monthly during the monthly Medication Regimen Review (MRR) and upon request between MRRs. The monitoring hall include, but is not limited to, the review of Behavior and Side Effect Monthly Flow Sheets. - During the monthly MRR, the pharmacist will identify a list of residents receiving psychoactive medications. This list may be obtained from the electronic medical record system. Each of the identified residents shall have Behavior and Side Effect Monthly Flow Sheets that are in PCC. - The Behavior and Side Effect Monthly Flow Sheets are located in the EMR in PCC under POC charting. The pharmacist must review the Flow Sheets, in addition to any other related documentation, and report any irregularities to the attending physician and Director of Nursing as outlined in the Consultant Pharmacist Services policy. Irregularities may include, but are not limited to, the following: - Lack of rationale identifying why a medication is required - Inappropriate diagnosis code(s) - Lack of care planning - Lack of resident specific monitoring - Inconsistent monitoring of side effects or behaviors - Lack of rationale identifying why a gradual dose reduction (GDR) is clinically contraindicated - Unnecessary drug, in which the drug is used:	F 758		

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F 758	Continued From page 18 - in excessive dose - for excessive duration - without adequate monitoring or without adequate indications for use - in the presence of adverse consequences, which indicate the dosage should be reduced or discontinued without specific target symptoms.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		11/25/24

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F 880	Continued From page 19 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 880	1 Nurse (RN-A)reeducated on safe	

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F 880	Continued From page 20 review, the facility failed to use standard and enhanced barrier precautions (EBP); and failed to maintain proper infection control procedures for insulin administration for 1 of 3 (R17) residents reviewed for activities of daily living (ADL's). Findings include: R17's quarterly Minimum Data Set (MDS) dated 10/1/24, identified R17 was cognitively aware and had diagnoses that included malignant neoplasm of accessory sinus (sinus cavity cancer), type 2 diabetes, heart failure and hypertension. R17 required set up or clean up assistance with personal hygiene and R17 completed the activity. R17 had indwelling urinary catheter. R17's care plan dated 10/1/24, identified R17 required extensive assist of one staff for personal hygiene. R17 had a diagnosis of left-sided sinonasal squamous cell carcinoma with left orbital involvement (a rare tumor that affected the nasal and sinus cavity). R17 had his sinus's irrigated twice daily and contact precautions needed to be taken. R17 used an indwelling urinary catheter and staff were directed catheter every shift and as needed. The care plan did not address R17's need for EBP precautions due to an indwelling device. During an observation on 10/22/24 at 9:36 a.m., registered nurse (RN)-A did not clean the rubber stopper at the end of R17's Lantus (a long-acting insulin that helped manage blood sugars levels in certain people) pen, applied a needle and dialed R17's dose of medication. RN-A entered R17's room without donning a gown and/or gloves and approached R17. R17 was lying in bed on his left side and had dried dark red blood from his left	F 880	Insulin pen usage and EBP. 2 All residents could be affected by this practice. Conducted an audit of all residents who receive insulin to identify any similar deficiencies. Conducted an audit of all residents on EBP to ensure they are not affected by this practice. 3 Nurses educated on safe injection administration and all staff educated on EBP and usage of PPE and standard precautions. Insulin pen usage procedure was created. Policies and procedures to be reviewed and revised as necessary. Implemented a checklist for insulin administration to ensure compliance with infection control standards. 4 DON and designee to perform audits of insulin pen administration 2 times a week, results to be reviewed at monthly QAPI with the team to determine further audits. DON and designee to perform random audits daily to ensue EBP are being followed, proper PPE is utilized. Results to be reviewed at monthly QAPI and further audits to be determined by the team.	

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	245529	A. BUILDING _____ B. WING _____	C 10/23/2024

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F 880	Continued From page 21 nostril to the corner of his mouth and beard. R17 attempted to move his pillow under his head but his pillowcase was coming off exposing half of the pillow with an approximately 6-inch diameter circle of dried blood. RN-A stated, "let me help you with that" and, without putting on gloves, replaced the soiled bloody pillowcase on R17's pillow and put it under R17's head. R17 rolled onto his back using his trapeze bar and stated to use the right side of his abdomen because everyone always used the left side. RN-A failed to don gloves, then cleansed R17's injection site with an alcohol wipe and administered R17's Lantus injection. RN-A withdrew the needle and wiped the area again with an alcohol wipe. - At 9:45 a.m., RN-A stated she did not need to clean the rubber stopper of R17's Lantus pen because she "assumed" the person before her had cleaned the pen with an alcohol wipe before putting it back into the cart when they were done. "I guess you should never assume because they might not have done it." RN-A stated she did not wear gloves and never wore gloves with R17 because she thought it intimated him. RN-A stated if she had cleaned the blood from his face, she would have worn gloves then but not for this. RN-A then stated it didn't matter because she used hand sanitizer before going into R17's room. During an interview on 10/23/24 at 8:11 a.m., RN-C stated she cleaned the insulin pen rubber stopper before and after every use. "You don't know where it's been. Even when it's capped." Disinfecting of the rubber stopper was to prevent bacteria from entering the pen and causing an infection. R17 had EBP due to having an indwelling foley catheter. Staff needed to don a gown, gloves and/or a mask and eye protection when they did catheter care. RN-C wouldn't	F 880		

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F 880	Continued From page 22 necessarily put on a gown when she administered medications to R17 because you weren't coming into contact with R17. However, if RN-C needed to help R17 with changing his bedding or if you needed to get close to him and touch him, then RN-C would need to don a gown and gloves, especially with touching bodily fluids. "That's just what you do." During an interview on 10/23/24 at 8:24 a.m., RN-B stated staff needed to don a gown and gloves during catheter care. RN-B stated if he was only administering medications or insulin, RN-B would not don a gown because RN-B would not come into contact with R17. However, if providing any type of direct care to R17, staff would need to don gown, gloves, mask and "the whole works" because you were coming into direct contact with R17. "If it's bloody or wet and it's not yours, wear PPE to protect yourself and others." RN-B would clean the rubber stopper on the Lantus pen before applying the needle to prevent infection. During an interview on 10/23/24 at 10:39 a.m., the director of nursing (DON) stated R17 on EBP because R17 had a foley catheter. Staff were expected to clean the rubber stopper of an insulin pen prior to applying the needle to prevent bacteria from entering the pen. Staff were expected to don a gown and gloves during direct care and whenever in contact with bodily fluids to prevent infection. The facility policy Infection Control Practices: Standard Precautions Transmission Based Precautions dated 8/2024, identified EBP were an infection control intervention designed to reduce transmission of resistant organisms that	F 880		

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F 880	Continued From page 23 employed targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and/or infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/22/2024. At the time of this survey, Bigfork Valley Communities Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/14/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Bigfork Valley Communities Nursing Home was built in three stages. The original building was constructed in 1972 and is a 1-story building without a basement of Type II (111) construction. In 1985 a 1-story addition was constructed to the north of the original building and was determined to be Type II (111) construction. In 1999, a 1-story addition with a basement was constructed off the east wing of the original building and was determined to be type II (000) construction. In 2014 1 story addition was added that was	K 000		

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K 000	Continued From page 2 determined to be of Type II(000) construction. The building is divided into 4 smoke zones with 30 minute and 2-hour fire barriers. The original building has a common 2-hour fire barrier between the nursing home and the Bigfork Valley Hospital. The entire building has an automatic fire sprinkler system installed and also has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building Type II (000) construction. The facility has a capacity of 70 beds and had a census of 20 at the time of the survey.. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain emergency lighting system per NFPA 101 (2012 edition), Life Safety Code sections 19.2.9.1 and 7.9.1.3. This deficient practice could have a patterned impact on the residents within the facility.	K 291	1.Emergency Exit lighting has been purchased and will be installed as soon as it arrives. 2.A checklist has been created to ensure monthly and annual inspections are	1/1/25

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K 291	Continued From page 3 Findings include: On 10/22/2024 between 08:00am and 12:00pm, it was revealed by observation that the facility failed to conduct the annual 90 minute required Emergency Lighting test. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	completed. 3.Audits will be performed by Plant Operations Manager or designee. Audits will be reviewed at QAPI.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K 321		1/1/25

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K 321	Continued From page 4 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/22/2024 between 08:00am and 12:00pm, it was revealed by observation that the following storage rooms did not have a self-closing device. 1) Storage Room B-1 2) Storage Room B-2 Tamarack Lodge Hallway 4) Patient Room 19 5) Patient Room 17 6) Patient Room 15 7) Patient Room 14 8) Patient Room 11 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	1 Maintenance has addressed all the rooms listed in the tag. 2 Proper Spring closures are in place and function tested. 3 Plant Operations Manager or designee will conduct routine audits monthly. Results will be reviewed at QAPI to determine further audits. 4. Responsible person for corrective actions and monitoring compliance. Plant Operations Manager or designee.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		1/1/25

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K 353	Continued From page 5 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: 1) Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 10/22/2024 between 08:00am and 12:00pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads.	K 353	1 High storage was reorganized Unsecured sprinkler heads in the kitchen dry storage are now secured. Sprinkler system testing was completed on 11/14/24. 2 Education to be provided to departments utilizing the storage space. Indication line will be added to the walls 3. Audits monthly by Plant Operations manager or designee, will be reviewed at QAPI to determine further audits.	

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K 353	Continued From page 6 These obstructions were found in Cedar Kitchen Storage, Room B-1 and IT Storage room. 2) Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/22/2024 between 08:00am and 12:00pm, it was revealed by a review of available documentation the facility failed to perform the five (5) year sprinkler system testing. 3) Based on observation and staff interview, the facility failed to maintain the automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, section 5.4.1.4, and 5.4.1.4.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/22/2024 between 08:00am and 12:00pm, it was revealed by observation that there were 14 unsecured fire sprinkler heads that were not protected from being damaged, stored loosely within the spare sprinkler head boxes located by the fire sprinkler riser in the kitchen dry storage	K 353		

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K 353	Continued From page 7 room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/22/2024 between 08:00am and 12:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following areas:	K 372	1 Areas missing fire caulking were immediately addressed and corrected after survey. 2 Checklist created to monitor areas to ensure there is no missing fire caulking. 3.Plant Operations Manager or designee will do monthly audits; results will be reviewed at QAPI for further audits.	1/1/25

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K 372	Continued From page 8 1) Nursing home to Assisted Living / door by vending machine 2) Hospital to Nursing Home An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 372		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/22/2024 between 08:00am and 12:00pm, it was revealed by a review of available documentation that the facility could not provide a	K 521	1 Plant Operations Manager has contacted facility used contractor (Jamar) to schedule an inspection of fire dampers. 2 Audits will be completed by Plant Operations Manager or designee monthly. Results to be reviewed at QAPI to determine further audits.	1/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/22/2024**

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
K 521	Continued From page 9 fire damper inspection report. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/22/2024 between 08:00am and 12:00pm, it was revealed by a review of available documentation that the facility missing time for the March 2024 drill for the first quarter. An interview with the Maintenance Director	K 712	1 Facility Plant Operations Staff will review and readjust fire drills schedule. 2 Education will be provided to Plant Operations Staff. 3 Plant Operations Manager or designee will audit fire drill times monthly moving forward. Audits will be reviewed at QAPI for further audits.	1/1/25

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K 712	Continued From page 10 verified this deficient finding at the time of discovery.	K 712		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918		1/1/25

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K 918	Continued From page 11 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/22/2024 between 08:00am and 12:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the facility could not provide documentation that a 36 month four (4) hour load bank test had been performed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	1 Electrical System Maintenance and Testing has been completed on 11/11/24.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal	K 920		1/1/25

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K 920	Continued From page 12 electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/22/2024 between 08:00am and 12:00pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; Power-strip in maintenance employee break room An interview with the Maintenance Director verified this deficient finding at the time of	K 920	1 Conducted an immediate inspection of all electrical adaptive devices in use within the facility. Replaced any non-compliant devices with those meeting the required standards. 2 Established a schedule for quarterly audits of electrical adaptive devices to ensure ongoing compliance.	

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K 920	Continued From page 13 discovery.	K 920		