



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Bigfork Valley Communities
258 Pine Tree Drive PO box 258
Bigfork, MN 56628
Itasca County

Report #: H5529004

Date: February 4, 2015

Date of Visit: December 23, 2014
Time of Visit: 11:30 a.m. – 3:30 p.m.

By: Deborah Neuberger, R.N., Special Investigator

- Type of Facility:**
- Nursing Home
 - SLF
 - Hospital
 - HHA
 - ICF/IID
 - Other: _____
 - Home Care Provider/Assisted Living
 - Home Care

- Facility Self Report
- Complaint

Allegation(s): Neglect occurred when staff failed to ensure the resident's oxygen was removed before the resident lit his/her cigarette. The resident's oxygen started on fire burning the resident's cheeks and nose.

An unannounced visit was made at this facility and an investigation was conducted under:

- Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- Federal Regulations for EMTALA (42 CFR Part 489)
- State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

- State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- State Licensing Rules for Home Care (MN Rules Chapter 4668)
- State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

- Abuse Neglect Financial Exploitation was:
 Substantiated Not Substantiated Inconclusive based on the following information:

Based on a preponderance of evidence, neglect occurred when the facility staff failed to provide adequate supervision to a resident who was smoking. The staff did not remove the resident's oxygen prior to the resident lighting a cigarette. The oxygen/tubing ignited, resulting in first degree burns to the cheek and nose of the resident.

The resident's admission occurred a day before the fire. The resident had Chronic Obstructive Pulmonary Disorder and the resident used continuous oxygen per nasal cannula. The resident was a current smoker who smoked 2 - 5 times per day and required supervision during smoking. There was nothing further on the assessment to address the type of supervision the resident needed or what to do with the oxygen while the resident smoked.

The evening after admission the resident was outside smoking with a Nursing Assistant (NA), when the NA told the nurse that the resident required first aide due to injuries sustained when his/her oxygen ignited while the resident was smoking. Documentation indicated the resident smelled of burned hair and skin, and the resident had blackened skin on and under the nose, and bilaterally on both cheeks.

The resident was treated in the emergency department for first-degree burns to the nose and cheek. The resident was admitted for one night of observation and returned back to the facility.

The NA stated on the night of the fire the resident approached the NA about smoking outside. The NA took the resident outside to smoke in the courtyard, and asked the resident to take off his/her oxygen before s/he smoked. The NA did not watch to be sure that the resident took off the oxygen. The NA stated the oxygen started on fire, the NA pulled the tubing from the resident's nose, but it was still burning, threw the tubing on the ground, stepped on it, and unhooked it from the oxygen canister. The resident's face was black; the resident's upper lip burned, and there was bleeding from the outside of the resident's nostrils.

The registered nurse (RN) stated the resident requested to go outside to smoke. As soon as a NA was available to go with the resident, the RN gave the resident a cigarette and a lighter, and the resident went outside to smoke with the NA. The NA came back in and stated the resident needed first aide for burns.

Administrative nursing staff stated that although the resident's assessment indicated the resident required supervision with smoking, there was no direction to staff related the type of supervision required for the resident related to smoking and oxygen use prior to the fire.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the individual(s) and/or facility is responsible for the

Abuse Neglect Financial Exploitation. This determination was based on the following:

Although the facility had policies in place to assess and care-plan for resident needs, the facility failed to provide direction and supervision related to the resident's smoking and oxygen use.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: Yes No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: Yes No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:**Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated**

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

The Investigation included the following:**Document Review: The following records were reviewed during the investigation:**

Medical Records

Care Guide

Medication Administration Records

Treatment Sheets

Facility Incident Reports

Physician Progress Notes

ADL (Activities of Daily Living) Flow Sheets

Laboratory and X-ray Reports

Physician Orders

Social Service Notes

- Nurses Notes
- Meal Intake Records
- Activities Reports
- Weight Records
- Therapy and/or Ancillary Services Records
- Assessments
- Skin Assessments
- Care Plan Records

Other pertinent medical records:

- Hospital Records
- Ambulance/Paramedics
- Medical Examiner Records
- Death Certificate
- Police Report

Additional facility records:

- Resident/Family Council Minutes
- Personnel Records/Background Check, etc.
- Staff Time Sheets, Schedules, etc.
- Facility In-service Records
- Facility Internal Investigation Reports
- Facility Policies and Procedures
- Call Light Audits
- Other, specify: _____

Number of additional resident(s) reviewed: 1

Were residents selected based on the allegation(s)? Yes No N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

Yes No N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): Yes No N/A Specify: This was a facility self-report.

If unable to contact complainant, attempts were made on:

Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: Yes No N/A Specify: Unable to reach family listed due to no accurate phone number.

Did you interview the resident(s) identified in allegation: Yes No N/A Specify: _____

Did you interview additional residents: Yes No

Total number of resident interviews: 2

Interview with staff: Yes No N/A Specify: _____

Tennessee Warning given as required: Yes No

Total number of staff interviews: 6

Physician interviewed: Yes No

Nurse Practitioner interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: None identified.

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: Yes , date subpoena was issued _____ No

Were contacts made with any of the following:

Emergency personnel Police Officers Medical Examiner Other: Specify _____

Observations were conducted related to:

- | | | |
|---|--|---|
| <input type="checkbox"/> Wound Care | <input type="checkbox"/> Medication Pass | <input type="checkbox"/> Meals |
| <input type="checkbox"/> Personal Care | <input checked="" type="checkbox"/> Dignity/Privacy Issues | <input type="checkbox"/> Restorative Care |
| <input checked="" type="checkbox"/> Nursing Services | <input checked="" type="checkbox"/> Safety Issues | <input checked="" type="checkbox"/> Facility Tour |
| <input checked="" type="checkbox"/> Infection Control | <input checked="" type="checkbox"/> Cleanliness | <input checked="" type="checkbox"/> Injury |
| <input type="checkbox"/> Use of Equipment | <input type="checkbox"/> Transfers | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Call Light | <input checked="" type="checkbox"/> Other: Outdoor area where fire occurred. | |

Was any involved equipment inspected: Yes No N/A

Was equipment being operated in safe manner: Yes No N/A

Were photographs taken: Yes No Specify: _____

xc: Health Regulation Division - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing
Bigfork City Police Department
Itasca County Attorney
Bigfork City Attorney

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2014
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628		
(X4) ID PREFIX TAG	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 An abbreviated standard survey was conducted to investigate complaint #H5529004. As a result, the following deficiencies are issued.	F 000			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review that facility failed to develop the resident's temporary plan of care for 1 of 2 resident's reviewed, (R1), who smoked cigarettes while using oxygen. Findings include: Medical records review revealed R1 was admitted to the facility on 12/18/2014 with diagnoses that included Chronic Obstructive Pulmonary Disorder. Physician's orders dated 12/18/2014 revealed an order for continuous oxygen at 4L(liter) per nasal cannula to keep oxygen saturations between 88-94%. The resident's initial assessment, dated 12/18/2014, revealed the resident use oxygen by nasal cannula and was a current smoker. The resident's smoking assessment, dated 12/18/2014 revealed facility staff assessed the resident as smoking 2-5 times a day and required supervision during smoking. There was no further	F 281	F-281- Oxygen Safety class was held for all Long Term Care staff on 12/30/14. The Tobacco Use Policy was reviewed with all staff in attendance to the Oxygen Safety Meeting. On 01/01/2015, Administration updated the Tobacco Use Policy to include a smoking area for Elders in Long Term Care. The courtyard is now a smoking area during the month of October through April or when ice is present. This was changed due to the safety concerns of having the elders go off campus to smoke during winter months. The policy was emailed to all Long Term Care Staff to review, sign and return to the Director of Nursing by February 1, 2015. No smoking signs will be placed on all elders exterior doors where O2 is in use. The Director of Nursing Service will monitor compliance weekly and report at monthly quality assurance meeting. Date certain 2/3/2015		

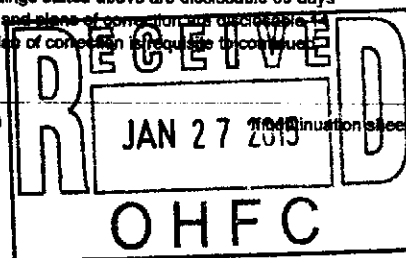
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] *[Title]* 1/23/15

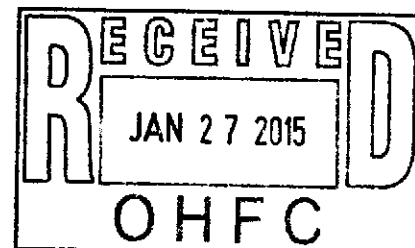
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 required to continue program participation.



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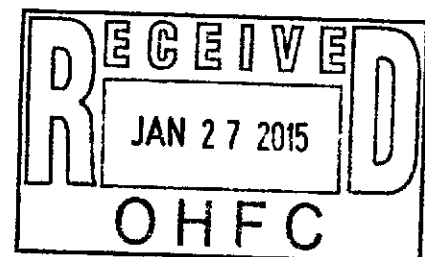
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F 281	Continued From page 1 instruction provided to staff of what type of supervision was needed. Nursing assistant (NA)-F was interviewed on 12/23/2014 at 2:07 p.m. and stated about 6:00 p.m. on 12/19/2014 the resident approached NA-F about smoking outside. NA-F stated he looked for a care-plan related to smoking for the resident and could not find one. NA-F stated he then asked his coworker if there was a care plan for smoking for the resident and there was none. NA-F stated he was not aware there was no smoking allowed in the courtyard, so he took the resident outside to the courtyard to smoke. NA-F stated he asked the resident to take off his oxygen before he smoked. NA-F stated he did not watch to be sure the resident took off the oxygen. NA-F stated the oxygen started on fire and NA-F pulled the tubing from the resident's nose, but it was still burning, so he then threw the tubing on the ground, stepped on it, and unhooked it from the oxygen canister. The resident's face was black, his mustache was burned, and he was bleeding from the outside of his nostrils. Registered Nurse-B (RN-B) was interviewed on 12/23/2014 at 12:45 p.m. and stated that although the resident was assessed as requiring supervision with smoking, there was no temporary care-plan initiated for the resident related to smoking prior to the fire. The policy titled Preliminary Care Plan, dated 8/15/11 revealed under the section titled POLICY: A preliminary plan of care to meet the elder's immediate needs shall be developed for each elder within twenty-four hours after admission.	F 281			
F 323	483.25(h) FREE OF ACCIDENT	F 323			



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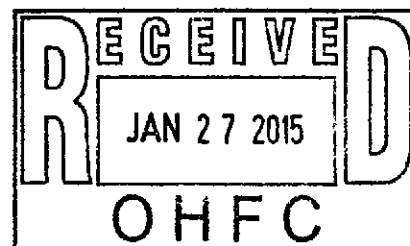
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F 323 SS=G	<p>Continued From page 2</p> <p>HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to prevent adequate supervision for 1 of 1 residents (R1) when R1 was allowed to smoke a cigarette while oxygen was on while in the presence of staff. R1 smoked with oxygen running per nasal cannula and ignited a fire that caused harm when R1's checks and nostrils were burned.</p> <p>Findings include:</p> <p>Medical records revealed R1 was admitted to the facility on 12/18/2014 with diagnoses that included Chronic Obstructive Pulmonary Disorder.</p> <p>Physician's orders dated 12/18/2014 revealed an order for continuous oxygen at 4L (liters) per nasal cannula to keep oxygen saturations between 88-94%.</p> <p>The resident's initial assessment, dated 12/18/2014, revealed the resident used oxygen by nasal cannula, and was a current smoker.</p> <p>The resident's smoking assessment, dated</p>	F 323	<p>F-323- A Temporary Safety Care plan will been implemented which address safety of Elders. Any form of O2 will be removed from Elder while smoking. Smoking aprons will be provided to any Elder who is chair bound. Compliance will be monitored by Director of Nursing weekly and report at monthly quality assurance meeting. Date certain 2/3/2015</p>



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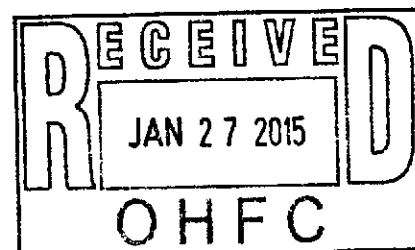
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F 323	<p>Continued From page 3</p> <p>12/18/2014 revealed facility staff assessed the resident as smoking 2-5 times per day and required supervision while he smoked. There was no further instruction provided to staff of what type of supervision was needed.</p> <p>Nursing notes dated 12/19/2014 at 11:38 p.m. and written by Registered Nurse (RN)-E, revealed the resident was outside smoking with Nursing Assistant (NA)-F, when NA-F stated the resident required first aide due to injuries experienced when his oxygen ignited while the resident was smoking. The RN-E's note revealed the resident smelled of burned hair and skin, and the resident had blackened skin on his nose, under his nose, and bilaterally on both cheeks. The resident was sent to the emergency room for assessment of burns experienced while smoking with oxygen on.</p> <p>Hospital records dated 12/19/2014 revealed the resident was seen in the emergency department for first degree burns. R1 was admitted to the hospital for observation and returned back to the nursing home on 12/20/14.</p> <p>NA-F was interviewed on 12/23/2014 at 2:07 p.m. and stated about 6:00 p.m. on 12/19/2014 the resident approached NA-F about smoking outside. NA-F stated he looked for a care-plan related to smoking for the resident, and could not find one. NA-F stated he then asked his coworker if there was a care plan for smoking for the resident, and there was none. NA-F stated he was not aware there was no smoking allowed in the courtyard, so he took the resident outside to the courtyard to smoke and asked the resident to take off his oxygen before he smoked. NA-F stated he did not watch to be sure the resident took off the oxygen. NA-F stated the oxygen</p>	F 323		



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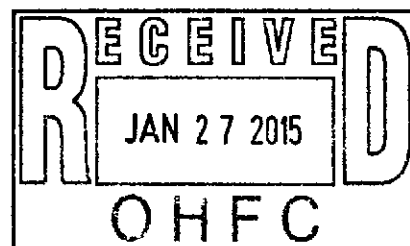
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F 323	<p>Continued From page 4</p> <p>started on fire and NA-F pulled the tubing from the resident's nose, but it was still burning, he then threw the tubing on the ground, stepped on it, and unhooked it from the oxygen canister. The resident's face was black, his mustache was burned, and he was bleeding from the outside of his nostrils.</p> <p>RN-E was interviewed on 12/29/2014 at 4:00 p.m. and stated R1 requested to go outside to smoke on 12/19/2014. As soon as an aide was available to go with him, RN-E gave R1 a cigarette and a lighter, and he went outside to smoke. NA-F came back in and stated R1 needed first aide for burns. When RN-E assessed R1, she observed burns to his nose, cheeks, and mustache, and open skin on his cheeks and nose. RN-E sent R1 to the emergency room for treatment of the burns.</p> <p>Director of Nursing-A was interviewed on 12/23/2014 at 12:00 p.m. and stated the resident was smoking on the facility property and the policy for the facility was that smoking was prohibited on the facility property. The DON indicated the no smoking policy on facility grounds was inconsistently enforced.</p> <p>The facility policy titled Tobacco-free Environment and dated Revised 12/14 was reviewed. Under the section titled Policy the following was noted: To establish and maintain the safest possible environment in which to deliver care, Bigfork Valley's buildings, parking lots and operated vehicles are tobacco-free. Under the section titled Patients: 1. Assessment of the patient's tobacco use will be part of the initial nursing assessment. Support programs will be offered for those desiring to use their hospitalization as an</p>	F 323	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 246529	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2014
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628	
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F 323	Continued From page 5 opportunity to quit smoking...4. The department managers or supervisors will speak with non-compliant patients reminding them of our policies, again offering to seek out alternatives...5. If the patient persists in using tobacco, support from the administration staff will be enlisted to determine, with the patient's physician, reasonable alternatives, which may include: transferring the patient, and/or confiscating the smoking materials, etc. Patient safety should also be a paramount concern.	F 323	





Where Skill Meets Compassion



P.O. Box 258
Bigfork, Minnesota 56628
(218) 743-3177
www.BigforkValley.org

February, 4 2015

Sarah Grebenc, MSW Unit Supervisor
Office of Health Facility Complaints
Health Regulations Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul Minnesota, 55164-0970

RE: Addendum to the plan of correction dated January 23, 2015.

F 281- R-1 was discharged to home on January 15, 2015. Education was given and documented with R-1 prior to discharge regarding O2 safety and smoking.

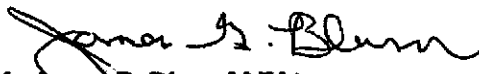
At this time, there are no elders who smoke and use Oxygen. If an elder is admitted into LTC in the future who smokes and uses Oxygen, a smoking assessment will be completed at admission. A temporary safety care plan will be implemented that addresses smoking and Oxygen use and reviewed with all staff working with the elder.

All admissions will be monitored and reviewed by the Director of Nursing.

Director of Nursing will look for and address medical records from transferring facilities regarding smoking. Director of Nursing will then monitor safety care plans with random audits with staff to ensure compliance with care plans. Director of Nursing will report to Quality Council monthly x 6 months.

F323- An Oxygen safety class was held on 12/30/14. All Long Term Care Staff attended. The facility policy for smoking was reviewed with staff. R-1 did not have any other incidents after the Oxygen safety class was held. No other elder in Bigfork Valley Communities smokes at this time. If an elder is admitted that smokes, a smoking assessment will be completed upon admission and a temporary safety care plan will be implemented. Staff will be educated on the care plan.

The Director of Nursing will audit weekly to ensure compliance with the No Smoking signs. A report will be given to the Quality Council monthly. Annual Oxygen safety training will continue to occur.


Mr. James G. Blum, LNHA
Bigfork Valley Communities
218-743-4330

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00834	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/30/2014
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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5529004. As a result the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of</p>	2 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.</p>	

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

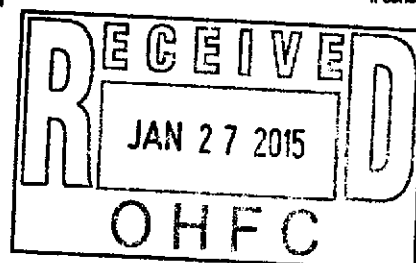
TITLE

(X6) DATE

STATE FORM

C6KD11

1/23/15
If continuation sheet 1 of 6

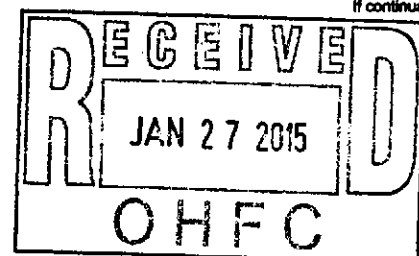


Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00834	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2014
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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota, 55164-0970.	2 000	<p>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830		

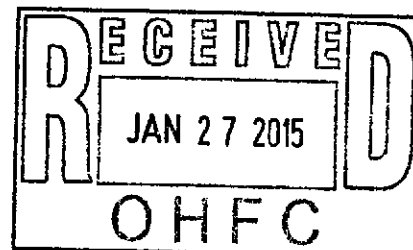


Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2014
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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628
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2 830	<p>Continued From page 2</p> <p>the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to prevent adequate supervision for 1 of 1 residents (R1) when R1 was allowed to smoke a cigarette while oxygen was on while in the presence of staff. R1 smoked with oxygen running per nasal cannula and ignited a fire that caused harm when R1's cheeks and nostrils were burned.</p> <p>Findings include:</p> <p>Medical records revealed R1 was admitted to the facility on 12/18/2014 with diagnoses that included Chronic Obstructive Pulmonary Disorder.</p> <p>Physician's orders dated 12/18/2014 revealed an order for continuous oxygen at 4L (liters) per nasal cannula to keep oxygen saturations between 88-94%.</p> <p>The resident's initial assessment, dated 12/18/2014, revealed the resident used oxygen by nasal cannula, and was a current smoker.</p> <p>The resident's smoking assessment, dated 12/18/2014 revealed facility staff assessed the</p>	2 830		

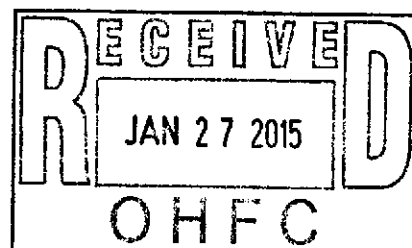


Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00834	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2014
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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628
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2 830	<p>Continued From page 3</p> <p>resident as smoking 2-5 times per day and required supervision while he smoked. There was no further instruction provided to staff of what type of supervision was needed.</p> <p>Nursing notes dated 12/19/2014 at 11:38 p.m. and written by Registered Nurse (RN)-E, revealed the resident was outside smoking with Nursing Assistant (NA)-F, when NA-F stated the resident required first aide due to injuries experienced when his oxygen ignited while the resident was smoking. The RN-E's note revealed the resident smelled of burned hair and skin, and the resident had blackened skin on his nose, under his nose, and bilaterally on both cheeks. The resident was sent to the emergency room for assessment of burns experienced while smoking with oxygen on.</p> <p>Hospital records dated 12/19/2014 revealed the resident was seen in the emergency department for first degree burns. R1 was admitted to the hospital for observation and returned back to the nursing home on 12/20/14.</p> <p>NA-F was interviewed on 12/23/2014 at 2:07 p.m. and stated about 6:00 p.m. on 12/19/2014 the resident approached NA-F about smoking outside. NA-F stated he looked for a care-plan related to smoking for the resident, and could not find one. NA-F stated he then asked his coworker if there was a care plan for smoking for the resident, and there was none. NA-F stated he was not aware there was no smoking allowed in the courtyard, so he took the resident outside to the courtyard to smoke and asked the resident to take off his oxygen before he smoked. NA-F stated he did not watch to be sure the resident took off the oxygen. NA-F stated the oxygen started on fire and NA-F pulled the tubing from the resident's nose, but it was still burning, he</p>	2 830		

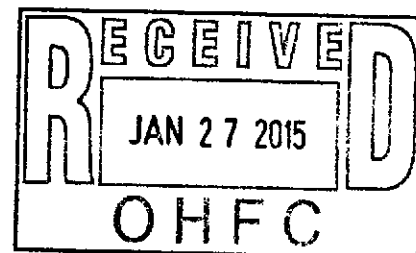


Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00834	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2014
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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 58628
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2 830	<p>Continued From page 4</p> <p>then threw the tubing on the ground, stepped on it, and unhooked it from the oxygen canister. The resident's face was black, his mustache was burned, and he was bleeding from the outside of his nostrils.</p> <p>RN-E was interviewed on 12/29/2014 at 4:00 p.m. and stated R1 requested to go outside to smoke on 12/19/2014. As soon as an aide was available to go with him, RN-E gave R1 a cigarette and a lighter, and he went outside to smoke. NA-F came back in and stated R1 needed first aide for burns. When RN-E assessed R1, she observed burns to his nose, cheeks, and mustache, and open skin on his cheeks and nose. RN-E sent R1 to the emergency room for treatment of the burns.</p> <p>Director of Nursing-A was interviewed on 12/23/2014 at 12:00 p.m. and stated the resident was smoking on the facility property and the policy for the facility was that smoking was prohibited on the facility property. The DON indicated the no smoking policy on facility grounds was inconsistently enforced.</p> <p>The facility policy titled Tobacco-free Environment and dated Revised 12/14 was reviewed. Under the section titled Policy the following was noted: To establish and maintain the safest possible environment in which to deliver care, Bigfork Valley's buildings, parking lots and operated vehicles are tobacco-free. Under the section titled Patients: 1. Assessment of the patient's tobacco use will be part of the initial nursing assessment. Support programs will be offered for those desiring to use their hospitalization as an opportunity to quit smoking...4. The department managers or supervisors will speak with non-compliant patients reminding them of our</p>	2 830		

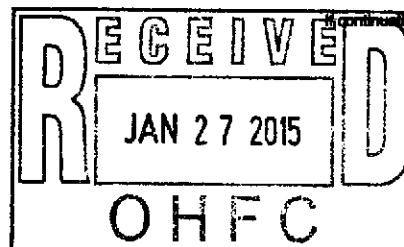


Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00834	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2014
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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY COMMUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628
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2 830	<p>Continued From page 5</p> <p>policies, again offering to seek out alternatives...5. If the patient persists in using tobacco, support from the administration staff will be enlisted to determine, with the patient's physician, reasonable alternatives, which may include: transferring the patient, and/or confiscating the smoking materials, etc. Patient safety should also be a paramount concern.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator or designee could update policy and procedures related to supervision and safety for smoking residents, train staff on the updated policies and monitor compliance with policies.</p> <p>TIME PERIOD FOR CORRECTION: Thirty (30) days.</p>	2 830		



Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245529	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 2/18/2015
Name of Facility BIGFORK VALLEY COMMUNITIES		Street Address, City, State, Zip Code 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC _____	Correction Completed 02/03/2015	ID Prefix F0323 Reg. # 483.25(h) LSC _____	Correction Completed 02/03/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By SG/mm	Date: 02/25/2015	Signature of Surveyor: 10567	Date: 02/18/2015
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 12/30/2014	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00834	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 2/18/2015
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Name of Facility BIGFORK VALLEY COMMUNITIES	Street Address, City, State, Zip Code 258 PINE TREE DRIVE, PO BOX 258 BIGFORK, MN 56628
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>20830</u>	Correction Completed 02/03/2015	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <u>MN Rule 4658.0520 Subp. 1</u>		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By <u>SG/mm</u>	Date: <u>02/25/2015</u>	Signature of Surveyor: <u>10567</u>	Date: <u>02/18/2015</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>12/30/2014</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		