

Electronically Delivered

March 16, 2020

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

RE: CCN: 245529  
Survey Cycle Start Date: March 10, 2020

Dear Administrator:

On March 10, 2020 a survey was completed at your facility by the Minnesota Department of Health to investigate complaints 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. At the time of survey, the complaints were substantiated but no deficiencies were issued, because corrective action was taken prior to the survey. A plan of correction is not required.

Also at the time of this survey, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute § 144.653 and/or Minnesota Statute § 144A.10.

The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to federal deficiencies only.

Electronically attached is your copy of the Federal CMS-2567 Form and State Form.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a long horizontal line extending to the right.

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

cc: Licensing and Certification File

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

PRINTED: 04/03/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245529</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/10/2020</b>
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

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

(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	<p><b>INITIAL COMMENTS</b></p> <p>On 3/10/20 - 3/11/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>The following complaints were found to be substantiated with no deficiency cited:</p> <p>H5529013C H5529014C</p> <p>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, it is required that the facility acknowledge receipt of the electronic documents.</p>	F 000		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/2020

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00834</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>03/10/2020</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------------------

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

(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	<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: On 3/10/20- 3/11/20, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found to be in compliance with the MN state licensure.</p> <p>The following complaints were found to be</p>	2 000		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00834</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/10/2020</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

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

(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  substantiated without licensing orders:  H5529013C H5529014C  The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		