



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 5, 2025

Licensee
Bigfork Valley Villa
258 Pine Tree Drive
Bigfork, MN 56628

RE: Project Number(s) SL20243016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20243016 On June 2, 2025, through June 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 31 residents; 12 residents received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the facility had sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the resident's assessments and service plans on a 24- hour per day basis. This had the potential to affect all residents, staff and visitors. In addition, the licensee failed to develop a staffing plan that included metrics to identify	0 470			

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0 470	Continued From page 2 staffing to meet scheduled and unscheduled needs of residents. Furthermore, the licensee failed to ensure the correct staffing plan was posted as required, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of 34 and had a current census of 31 residents, 12 residents received services. The assisted living facility was connected to a long-term care (LTC) facility, clinic, and hospital. On June 2, 2025, at 9:54 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated she was familiar with the current assisted living requirements. On June 2, 2025, at 9:57 a.m., CNS-C stated one licensed nurse worked the assisted living facility, herself (CNS-C). On June 2, 2025, at 10:17 a.m., CNS-C stated "our" (LTC) takes call (registered nurse/RN call) for the facility (assisted living) any time after hours, from 5:00 p.m. until 8:00 a.m. CNS-C stated LTC took call and was backup on weekends and holidays also.	0 470			

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0 470	Continued From page 3 On June 2, 2025, at 10:22 a.m., CNS-C stated the staffing schedule was as follows: - days: 6:30 a.m. until 3:00 p.m.; one ULP (unlicensed personnel) - Monday and Thursday, "just those two days" an additional ULP 8:00 a.m. until 4:30 pm., (vitals/baths/etc.) - evenings: 2:00 p.m. until 10:30 p.m.; one ULP - nights: 10:15 p.m., until 6:45 a.m.; one ULP CNS-C stated, if needed, ULPs would call LTC and staff from LTC would come to assist at the assisted living facility. CNS-C stated it (LTC called for assist) did not happen often, "possibly a year ago." On June 2, 2025, at 10:36 a.m., licensed assisted living director (LALD)-A stated the assisted living facility was to call the LTC facility when and if assistance was needed for extra staffing and nursing needs at the assisted living. On June 2, 2025, at 12:08 p.m., the surveyor reviewed the assisted living direct-care staffing plans dated October 21, 2024, and March 14, 2025, respectively which noted: Staffing Plan - when residents require the assistance of two-persons, there will be a minimum of two staff available at all times. During the daytime hours, the RN, LPN (licensed practical nurse) and Villa Coordinator may assist as the 2nd staff person. During the evening and nighttime hours, LTC staff was available to assist as needed and requested - during resident waking hours our facility shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents - during resident sleeping hours, with sixteen (16) to thirty-four (34) residents, our facility shall have at least one (1) direct care staff person on duty and awake at all times, and at least one (1)	0 470			

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0 470	Continued From page 4 additional person available on the premises: * day shift: = one CNA (ULP) (6:30 a.m. -3:00 p.m.) * afternoon shift = one ULP (2:00 p.m. - 10:30 p.m.) * night shift = one ULP (10:15 p.m. - 6:45 a.m.) * RN = one Monday thru Friday (8:00 a.m. - 4:30 p.m.), * weekends on-call* * Villa Coordinator = one Monday thru Friday (7:30 a.m. - 4:00 p.m.) * as needed: LPN or ULP= one (varying hours between 8:00 a.m. - 4:30 a.m.) * LTC RN, LTC ULP (based on staff and resident needs: = 2, daily after hours (4:30 p.m. - 8:00 a.m.), and on weekends: (phone number) (to be called when assist was needed). On June 2, 2025, at approximately 12:30 p.m., the surveyor reviewed an incident report dated March 28, 2025, at 11:50 (a.m. or p.m. not noted) completed by RN-D (LTC staff). On June 2, 2025, at 12:17 p.m., the surveyor and CNS-C observed a staffing board positioned on a wall in the common's area dated June 2, 2025. The Daily Staffing board noted: - Villa Office: phone nurse - Nurse(s): RN: Clinical Nurse Manager 8:00 a.m. - 4:30 p.m. Nurse's Aides (ULP) - ULP: 6:30 a.m. - 3:00 p.m. - ULP: 8:00 a.m. - 4:30 p.m. - ULP: 2:00 p.m. - 10:30 p.m. - ULP: 10:15 p.m. - 6:45 a.m. - After Hours & Weekends: Nurse-Additional CNAs (certified nursing assistance) - Villa Staff: 24/hours/day, phone number posted CNS-C explained to the surveyor how magnets were moved on the board to indicate the number of ULPs and hours ULPs worked each day.	0 470			

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0 470	Continued From page 5 On June 2, 2025, at 12:41 p.m., ULP-F stated she had called LTC in the past to speak to an RN. ULP-F added it had "been a while" since she (ULP-F) called LTC RN. ULP-F stated she had to report a resident fall. On June 2, 2025, at approximately 1:00 p.m., CNS-C stated she (CNS-C) had been out of the facility for "about four weeks" last July. CNS-C stated RN-E filled in and acted as the CNS for the facility for those four weeks when she (CNS-C) was not able to work. CNS-C stated the facility did not have a waiver to allow LTC staff to work at/cover at the assisted living facility. CNS-C stated she did not know a waiver was required. CNS-C stated LTC staff was used for on-call, backup needs, and for emergencies. STAFFING METRICS On June 2, 2025, at 12:08 p.m., CNS-C stated a metric was not used to determine staffing needs. CNS-C stated she was not aware a metric was required, but added it made sense to why one would be required. POSTED STAFFING On June 3, 2025, at 6:40 a.m., the surveyor observed the staffing board in the common's area dated June 3, 2025, which noted the same staffing as the prior day, which was in-correct (Monday and Thursdays were the only days the licensee had two ULPs on during daytime hours.) CNS-C later stated the staffing board was to be updated daily and was to indicate the correct daily staffing. The licensee's Assisted Living Staffing policy dated October 2024, noted: Staffing: 1. from the hours of 10:00 p.m. to 6:00 a.m.,	0 470			

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0 470	Continued From page 6 direct-care staff would respond to a resident request for assistance with health or safety needs within a reasonable amount of time 2. a minimum of two direct-care staff would be scheduled and available to assist at all times whenever a resident required the assistance of two 3. one or more person would be available 24 hours per day, seven days per week who were responsible of responding to the requests of the resident for assistance for health and safety needs. Person would be: a. awake b. located in : i. the Villa- OR- ii. (initials/ name of facility/ licensee) LTC (long term care)-OR- iii. (initials) hospital staff c. capable of communicating with residents d. capable of summoning appropriate assistance e. capable of following directions 4. a registered nurse would be available to staff working at all times. Availability may be in person, via phone, or via other electronic communication method. C. the CNS, or designee, would develop, write, and implement a staffing plan D. the staffing plan would provide qualified direct-care staff sufficient to meet the resident's needs 24 hours a day, seven-days a week and would be adequate to address: 1. each resident's needs as identified in the service plan and assisted living contract 2. each resident's acuity level as determined by the most recent assessment or individualized review 3. ability to meet the resident's scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises 4. the staffing plan would indicate if the assisted	0 470			

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0 470	Continued From page 7 living had a secured dementia care unit: the (name of licensee) does not have a secure dementia care unit 5. staff competency and training. E. the staffing plan would be evaluated for the appropriately of staffing levels in the facility and revised as needed at a minimum of two times per year The daily work schedule would be posted at the beginning of each day, on the mail floor near the dining room so it was accessible to staff, residents, volunteers, and the public. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs an according to an up-to-date service plan subject to accepted health care standards. Residents have the right to receive health care and other assisted living services in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must:	0 470			

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0 470	Continued From page 8 (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 470			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure individual abuse prevention plans (IAPP) with the required content was developed for one of three individuals residing in the assisted living facility (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 630			

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0 630	Continued From page 9 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7 was admitted to the facility on April 15, 2020, as a housing only resident. R7's record included a contract dated January 2, 2025. On June 3, 2025, at 7:32 a.m., the surveyor observed unlicensed personnel (ULP)-G ask R7 what he would like for breakfast. ULP-G stated R7 received no services, however R7 received breakfast. ULP-G asked R7 if he would like coffee, juice, hard boiled eggs, yogurt, lemon blueberry bread? R7's record did not include an abuse prevention plan. On June 3, 2025, at 12:23 p.m., assisted living coordinator/ULP (ALC/ULP)-N stated she completed abuse prevention plans and added she (ALC/ULP-N) may not have completed them (IAPP) for all residents. ALC/ULP-N stated R7's record did not include an IAPP. ALC/ULP-N stated it was possible R7 refused? ALD/ULP-N stated all residents were to have IAPPs completed. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to be free from physical, sexual, and emotional abuse: neglect; financial	0 630			

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0 630	Continued From page 10 exploitation; and all form of maltreatment covered under the Vulnerable Adults Act. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 630			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee	0 650			

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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY VILLA		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE BIGFORK, MN 56628			
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0 650	Continued From page 11 records contained required content for two of two employees (clinical nurse supervisor (CNS-C), unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS-C CNS-C was hired on August 28, 2023, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On June 2, 2025, at 9:57 a.m., during the entrance conference, CNS-C identified herself as the CNS for the facility. CNS-C's employee record did not include documentation of an annual performance review that identified areas of improvement needed and training needs. ULP-G ULP-G was hired on November 28, 2017, to provide direct care and services to the licensee's residents. On June 4, 2025, at 8:11 a.m., the surveyor observed ULP-G apply compression stockings (TEDs) and give R4 a nebulizer treatment (small machine that creates a mist out of liquid	0 650			

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0 650	Continued From page 12 medication, allowing for quicker and easier absorption of medication into the lungs). ULP-G's employee record did not include documentation of an annual performance review that identified areas of improvement needed and training needs. On June 3, 2025, at 10:38 a.m., CNS-C stated an annual performance review had not been completed on herself (CNS-C). In addition, CNS-C stated she was unable to locate a performance review in ULP-G's record. CNS-C stated she had not completed annual performance reviews that identified areas of improvements needed and training needs for any of the ULPs at the facility. CNS-C stated she "just learned the process" (annual performance reviews). The licensee's Personnel/Payroll Records policy dated July 2024, noted employee files would include work history, performance evaluation, disciplinary records, and commendations. In addition, information would be maintained for seven years after termination. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660			

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0 660	Continued From page 13 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) by not completing a TB risk assessment for the assisted living facility annually. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of 34 and had a current census of 31 residents, 12 residents received services. The assisted living facility was connected to a long-term care (LTC) facility,	0 660			

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0 660	Continued From page 14 clinic, and hospital. During the entrance conference on June 2, 2025, at 10:26 a.m., clinical nurse supervisor (CNS)-C stated human resources (HR) assisted with TB screenings. CNS-C stated she was not sure when the last TB risk assessment was completed, but CNS-C stated she thought the level was low. On June 2, 2025, at 3:11 p.m., the facility TB risk assessment was reviewed by the surveyor. The facility TB risk assessment worksheet was dated March 3, 2025, and titled: Bigfork Valley Hospital, 2025. On June 2, 2025, at 3:25 p.m., CNS-C stated there was not a "separate" TB risk assessment for the assisted living, rather one TB risk assessment for the "facility/building" (hospital, LTC, clinic). The TB risk assessment was reviewed with CNS-C. The TB risk assessment noted one ED (emergency department), one med/surg room (medical/surgical), 20 inpatient beds, air exchanges, lab hood, etc. CNS-C stated when you look at it "that way" there should be a separate TB risk assessment for the assisted living facility. CNS-C stated the completed TB assisted was very "comprehensive." The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated February 3, 2022, and based on CDC guidelines, indicated a TB risk assessment should be completed on an annual basis. The licensee's TB Infection Control Program dated December 2023, noted a risk assessment would be conducted to determine the risk of TB transmission at name of licensee/facility (hospital,	0 660			

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0 660	Continued From page 15 long term care (LTC), clinic, assisted living) and to develop appropriate infection control interventions based on actual risk. The risk assessment would be based on - community prevalence - number of infectious TB patients admitted, treated and reported by the facility - analysis of HCW Quantiferon-TB Gold screening data - evidence of transmission patient to patient, patient to HCW, or HCW to patient - review of TB patient medical records - observation of infection control practices - engineering evaluation - other risk factors by area and occupational group. Due to the small size and subsequent staffing patterns of (name of licensee/facility) the assessment would be conducted as a facility rather than department specific. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to	0 680			

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0 680	Continued From page 16 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 2, 2025, at 10:28 a.m., clinical nurse supervisor (CNS)-C stated there was an EPP binder in the housing	0 680			

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0 680	Continued From page 17 office, and one in the staff office, and one in the common's area. CNS-C added all EPPs were open and available. CNS-C stated executive coordinator/unlicensed personnel (EC/ULP)-B knew the facility's EPP the best. On June 2, 2025, at approximately 11:00 a.m., EC/ULP-B offered to review the facility's EPP with the surveyor. The surveyor observed a binder labeled Emergency and Disaster Plan in a holder positioned under the facilities posted licenses. The surveyor stated to EC/ULP-B, this must be the binder, and the surveyor removed the binder from the holder. EC/ULP-B stated there was another binder that should be gathered and would be needed. EC/ULP-B motioned to a binder labeled Disaster Plan Manual, located on a shelf, under a side table, near a chair in the commons area. On June 2, 2025, at 11:13 a.m. the surveyor and EC/ULP-B reviewed the EPP, to include, The Emergency and Disaster Plan binder, which contained the facilities policies: overview, bomb threat, announcements, chemical, biological, radiological nuclear & explosive events, emergency communications, facility evacuation, fire, hazardous materials incident, hazardous materials incident: decontamination, security alert-MOAB (management of aggressive behaviors) assistance requested, and site diagram. EC/ULP-B stated the Disaster Plan Manual binder had the information the surveyor requested, not the Emergency and Disaster Plan binder located in the holder. EC/ULP-B confirmed there was no signage of where the Disaster Plan Manual was located in the common's area. In addition, EC/ULP-B	0 680			

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0 680	Continued From page 18 confirmed the Emergency and Disaster Plan binder did not direct staff, residents, and visitors to the Disaster Plan Manual. EC/ULP-B confirmed the facility's EPP was not posted prominently. The licensee's EPP, dated November 19, 2024, lacked the following content and/or policies and procedures to address: - a missing resident plan that was reviewed quarterly - a description of the population served by the licensee. On June 2, 2025, at 11:15 a.m., EC/ULP-B stated the latest missing person policy review was completed in November 2024. EC/ULP-B stated she was not aware that a quarterly review of the missing person policy was required. In addition, EC/ULP-B confirmed the entry (see below) did not identify the description of the population served by the licensee (assisted living). - (name of facility/hospital, clinic, long-term care (LTC), assisted living) located in the city of (name) (north central Minnesota), serves northern Itasca and southern Koochiching counties. Our services include: a 20-bed critical access hospital (lab, imaging, physical and occupational therapy, chiropractic services and pharmacy), surgery center, specialty clinic, and senior services (30-unit senior apartments with assisted living services, and 40-bed LTC nursing facility) The licensee's Emergency Preparedness-Overview policy dated November 2024, noted the purpose of the establish guidelines were prepared to provide: ongoing care for LTC residents and assisted living tenants in the event of emergencies. The patient	0 680			

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0 680	Continued From page 19 population/services, noted: (name of licensee/hospital, LTC, assisted living) in the city of (name) (north central Minnesota), serves northern Itasca and southern Koochiching counties. Our services include: a 20-bed critical access hospital (lab, imaging, physical and occupation therapy, chiropractic services and pharmacy), surgery center, specially clinic, and senior services (30-unit senior apartments with assisted living services, and 40-bed LTC nursing facility). The licensee's Patient or resident Elopement policy noted, policy was last approved November 2024, effect date November 2024, and next review November 2025. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided.	0 680			

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0 680	Continued From page 20	0 680			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 3, 2025, from 10:30 a.m. to 12:30 p.m., with maintenance worker (MW)-H, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: FIRE RESISTANT RATED DOORS The fire-resistant rated door was observed propped in the open position with a block of	0 775			

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0 775	Continued From page 21 concrete at the laundry room near resident sleeping room 21. It was also observed that the same laundry room door did not automatically close and latch with normal operation of the door closer provided. The door or door closer needed adjustment in order to close automatically. It was observed the fire-resistant rated door leading into resident sleeping room 20 did not automatically close and latch. The fire-resistant rated door or closer needed adjustment in order to automatically close and latch. It was explained to MW-H, that all fire-resistant rated doors are required to automatically close and latch as designed and installed at the time of construction. FIRE SPRINKLER SYSTEM MAINTENANCE The provided fire sprinkler system documentation indicated the fire year system testing was required but not completed on the wet and dry sprinkler systems. It was explained to MW-H, that deficiencies indicated on the fire sprinkler test report are required to be completed. FIRE-RESISTANT RATED CEILING MAINTENANCE A hole two feet by one foot was observed through the fire-resistant rated drywall membrane on the ceiling in the mechanical room in the basement. It was explained to MW-H, that fire-resistant rated ceilings are required to be maintained to prevent the spread of smoke and fire outside the rated ceiling enclosure of the mechanical room.	0 775			

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0 775	Continued From page 22 FIRE ALARM SYSTEM SMOKE DETECTOR MAINTENANCE There was a smoke detector hanging from the wires out of the electrical mount box on the ceiling in the mechanical room basement. EXIT SIGN MAINTENANCE The exit sign above the marked exit door leading out of the dining room to the deck was not lit at the time of survey. It was explained to MW-H, that all exit lights are required to be lit at all times the building is occupied including during a power outage. ELECTRICAL LIGHT FIXTURE MAINTENANCE There was exposed electrical wires with no fixture exposed outside and above the marked exit door leading out of the dining room to the deck. It was explained all electrical fixtures are required to be maintained installed and operational as designed and installed at the time of construction approval. During the facility tour MW-H, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 800 SS=A	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

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0 800	Continued From page 23 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on June 3, 2025, from 10:30 a.m. to 12:30 p.m., with maintenance worker (MW)-H, the surveyor made the following observations of facility disrepair: DOOR MAINTENANCE The door leading into the shower room near the	0 800			

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0 800	Continued From page 24 salon was not secured at the top hinge and would not close all the way. The same door also had trim on the hinge side of the door jamb that was coming loose. During the facility tour MW-H, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810			

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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
0 810	Continued From page 25 least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 3, 2025, from 9:15 a.m., maintenance worker (MW)-H, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP updated November 2024, failed to include the following:	0 810			

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0 810	Continued From page 26 The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. The individual resident unique needs for evacuation are required to be readily available to all staff, at all times within the facility, for use in responding to a fire or similar emergency. During an interview on June 3, 2025, at 12:30 p.m., MW-H, stated documentation was not available for immediate reference indicating resident evacuation status and unique needs for evacuation. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by providing documentation the required employee training was completed upon hire and once per year thereafter. It was explained to MW-H, the employee FSEP training is required at hire and twice per year. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation residents were provided training as required.	0 810			

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0 810	Continued From page 27 During an interview on June 3, 2025, at 12:35 p.m., MW-H, stated documentation was not available indicating employees completed FSEP training twice per year and documentation was not available indicating residents were provided FSEP training once per year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding	0 950			

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0 950	Continued From page 28 subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident's (R7) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all residents who received services at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R7 was admitted to the facility on April 15, 2020, as a housing only resident. R7's record included an Assisted Living Resident Agreement dated January 2, 2025. On June 3, 2025, at 7:32 a.m., the surveyor observed unlicensed personnel (ULP)-G ask R7 what he would like for breakfast. ULP-G stated R7 received no services, but added R7 received breakfast. ULP-G asked R7 if he would like coffee, juice, hard boiled eggs, yogurt, lemon blueberry bread?	0 950			

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0 950	Continued From page 29 R7's Assisted Living Resident Agreement dated January 2, 2025, noted: - if resident declines to name a designated representative, resident please initial here: (box/blank) (page one) - resident's legal representative: noted/printed name, which was blank (page 15 of 36). R7's Assisted Living Resident Agreement lacked the required statutory verbiage for designated representative. On June 3, 2025, at 12:46 p.m., the surveyor reviewed the contracts used at the facility with assisted living coordinator/unlicensed personnel (ALC/ULP)-N. ALC/ULP-N stated she did not see the description of what a designated representative was in the licensee's contracts/agreements. ALC/ULP-N stated it was possible the verbiage might be in the handbook given to residents at the time of admission. On June 3, 2025, at 1:48 p.m., ALC/ULP-N stated all the contracts used at the facility were the same. On June 3, 2025, at 1:52 p.m., the surveyor reviewed the licensee's (name of facility/licensee) Assisted Living Handbook, dated March 18, 2024, with ALC/ULP-N, which noted: -you, as a resident of the Community, are primarily responsible for fulfilling your obligations under your agreement with us. However, you may find that assistance of others, such as family members, helpful from time to time, especially in times of emergency or ill health. You may designate a Designated Representative to assist you in your agreement -we encourage you to designate a representative, as both you and we will find it easier when need	0 950			

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0 950	Continued From page 30 arises. By making that designation in advance, we can be certain that we work with the person you have chosen to help you should the need arise. If you have designated a legal representative already (by example, by appointing a power of attorney), we would greatly appreciate receiving a copy of any legal papers you may have. ALD/ULP-N stated the contracts/agreements used by the licensee did not include the required designated representative verbiage. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290			

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01290	Continued From page 31 Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance was received in affiliation with the assisted living licensee's current health facility identification (HFID 20243) for two of seven employees (registered nurse (RN)-J, RN-K). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 2, 2025, at 9:50 a.m., the surveyor requested a NETStudy background report (online system used by the Minnesota Department of Human Services (DHS) to process background studies for individuals seeking to work in care-based settings) for all the employees providing care at the assisted living facility. On June 2, 2025, at 10:22 a.m., clinical nurse supervisor (CNS)-C stated, if needed, unlicensed personnel (ULP) would call long term care (LTC) facility (attached) and RNs (registered nurse) from LTC would answer calls or come to assisted living facility to assist as needed (PRN). RN-J RN-J was hired on July 1, 2024, to provide	01290			

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01290	Continued From page 32 supervision of staff and provide direct care services to the residents (take call and assist as needed: after hours, weekends, holidays) at the assisted living facility. RN-J's Minnesota RN license issue date was August 19, 1987. RN-J's employee record included a background study dated June 20, 2024, for HFID 834. RN-J's employee record lacked documentation of a cleared background study for HFID 20243 RN-K RN-K was hired on June 1, 2024, to provide supervision of staff and provide direct care services to the residents (take call and assist as needed: after hours, weekends, holidays) at the assisted living facility. RN-K's Minnesota RN license issue date was January 31, 2014. RN-K employee record included a background study dated June 12, 2024, for HFID 834. RN-K's employee record lacked documentation of a cleared background study for HFID 20243 On June 2, 2025, at 1:33 p.m., licensed assisted living director (LALD)-A stated the NETStudy report supplied to the surveyor would include some backgrounds that were dated as of this date (June 2, 2025). LALD-A stated once the report was ran it was brought to the licensee attention not all background studies were affiliated with HFID 20243. LALD-A stated the facility had corrected the issue this date.	01290			

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01290	Continued From page 33 The licensee's Vulnerable Adults Act Criminal Background Check policy dated February 2024, noted it was the policy of (name of licensee) to comply with the Minnesota law which required a Department of Human Services (DHS) criminal background check for employees, contractors and volunteers of DHS and Minnesota Department of Health (MDH) licensed programs per MN245C.13. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;	01500			

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01500	Continued From page 34 (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received all required content of annual training for each 12 months of employment for two of three	01500			

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01500	Continued From page 35 employees (clinical nurse supervisor (CNS)-C, registered nurse (RN)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-C CNS-C was hired on August 28, 2023, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On June 2, 2025, at 9:57 a.m., during the entrance conference, CNS-C identified herself as the CNS for the facility. CNS-C's employee record lacked evidence CNS-C successfully completed annual training as required to include: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On June 3, 2025, at 11:52 a.m., the surveyor reviewed CNS-C's employee file with CNS-C. CNS-C stated her record contained no evidence she completed person centered planning and	01500			

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01500	Continued From page 36 service delivery or how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. RN-E RN-E was hired on March 27, 2023, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On June 2, 2025, at approximately 1:00 p.m., CNS-C stated RN-E filled in and acted as the CNS for the facility for four weeks when she (CNS-C) was not able to work. CNS-C stated RN-E continues to take call and act as a backup RN for the assisted living facility. On June 4, 2025, at 8:45 a.m., CNS-C reviewed RN-E's employee record with the surveyor. CNS-C stated RN-E's employee record lacked required annual training to include person centered planning and service delivery and a review of the facility's policies and procedures. The licensee's Annual Training policy dated December 2024, noted all assisted living employees would complete annual education to include: - effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders - review of policies and procedures relating to the provision of assisted living services and how to implement them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			

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01530	Continued From page 37	01530			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on	01530			

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01530	Continued From page 38 topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (clinical nurse supervisor (CNS)-C), received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-C was hired on August 28, 2023, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On June 2, 2025, at 9:57 a.m., during the entrance conference, CNS-C identified herself as the CNS for the facility. CNS-C's employee record included: - dementia care: managing challenging behaviors, completed September 27, 2023; one hour - Alzheimer's disease and related disorders: the disease process, completed September 27, 2023;	01530			

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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE BIGFORK, MN 56628		
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01530	Continued From page 39 one hour - Alzheimer's disease and related disorders: the environment, completed September 27, 2023; one hour - Alzheimer's disease and related disorders: communication needs, completed September 27, 2023; one hour - Alzheimer's disease and related disorders: activities, completed September 27, 2023; one hour - dementia care: understanding Alzheimer's disease, completed September 27, 2023; one hour - Alzheimer's disease and related disorders: ADLs (activities of daily living) and behaviors, completed September 27, 2023; one hour. (Total of seven hours). CNS-C's employee record lacked evidence CNS-C successfully completed eight hours of initial dementia training as required. On June 3, 2025, at 11:52 a.m., CNS-C's record was reviewed with the surveyor. CNS-C stated she was not able to find "one more hour" of dementia training completed within the first 120 hours of employment. CNS-C confirmed she did not complete required initial dementia training within the required time period. The licensee's Dementia Training policy dated December 2024, noted supervisors of direct-care staff would complete a minimum of eight hours initial training on dementia care topics. The initial training would be completed within 120 working hours of the employment start date. Dementia care training would include: - an explanation of Alzheimer's disease and other dementia - assistance with activities of daily living	01530			

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01530	Continued From page 40 - problem solving with challenging behaviors - communication skills - person-centered planning and service delivery - understanding cognitive impairment - understanding behavioral and psychological symptoms of dementia - standards of dementia care including nonpharmacological dementia care practices that are person-centered and evidence-informed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a	01620			

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01620	Continued From page 41 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 2, 2025, at 9:50 a.m., clinical nurse supervisor (CNS)-C stated the licensee was familiar with current minimum assisted living requirements. R2's diagnoses included congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), hypertension (high blood pressure/HTN), and cataract of left eye. R2's service plan dated August 22, 2024, indicated R2 received the following services CHF therapy, medication management, skin care, and housekeeping services. On June 3, 2025, at 8:21 a.m., the surveyor	01620			

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01620	Continued From page 42 observed unlicensed personnel (ULP)-G use correct technique to weigh R2 to obtain a reading of 176.8 pounds. In addition, ULP-G administered R2's morning medication in apple sauce. R2's record included (name of licensee/facility) assessment-V3 (annual) dated August 22, 2024, which included: - cognition - medical diagnosis review - ER (emergency room)/hospitalizations/practitioner visits - psycho-social management - behaviors - medication and treatments - health monitoring (vital signs/blood glucose (sugar) - pain management - skin integrity - sleep - dietary and nutrition - ADL (activities of daily living, vision, hearing) - evacuation - safety and risk - smoking and alcohol use - activities, routines and habits - housekeeping - transportation - pet care - financial management. R2's record included (name of licensee/facility) Client (resident) monitor/reassessment visit notes forms dated October 14, 2024, January 7, 2025, and April 4, 2025, respectively, which included: - vital signs - review of service plans (housekeeping, personal hygiene, dressing, bathing, treatments, medications, medication administration, delegated task)	01620			

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01620	Continued From page 43 - any change in condition? - any new symptoms or vulnerabilities - care plan/service plan reviewed. On June 3, 2025, at 1:24 p.m., R2's assessment tool and a universal assessment tool were compared and reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated the monitoring/re-assessment tool used for R2 was regularly used by the licensee. CNS-C stated there were areas not addressed on the assessment tool used at the facility such as advance directives, spiritual and cultural preferences, sleep, smoking, alcohol, skin, and allergies. CNS-C stated she reviewed the resident's care plans at the same time she completed the resident's assessments. CNS-C stated the resident's care plans may include current issue/concerns, however CNS-C stated if there was an issue that had not been identified, it was possible that area could be missed. CNS-C stated the assessment tool in place did not include required assessments. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies;	01620			

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01620	Continued From page 44 (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency dated August 2024, noted a RN would complete the following comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required. A comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules. Current and historical records and information are reviewed to the extent they are made available to the RN and if the RN was aware of these records. Comprehensive assessments would include: - the resident's personal lifestyle preferences, including sleep schedule, dietary and social needs, leisure activities, and other customary routines that are important to the resident's quality of life - spiritual and cultural preferences, advanced health care directives and end-of-life preferences - ADLS (activities of daily living, toileting pattern, dressing, grooming, bathing, hygiene, mobility, eating - instrumental activities of daily living, housework, transportation, self-manage medications - physical health status: allergies, history and current health conditions, infections conditions - medication review - review medical, dental, and emergency room visits - primary care provider visits, hospitalizations, surgeries - review of physical therapist, occupational therapist, speech therapist or cognitive evaluation - weight, vital signs as indicated	01620			

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01620	Continued From page 45 - emotional and mental health condition, history and current diagnosis - cognition - communication and sensory capabilities - pain - skin conditions - nutritional and hydration status and preferences - treatments, type, frequency, level of assistance needed - risk indicators: falls, fall history, emergency evacuation ability, risk for dehydration, history of urinary tract infections, current fluid intake pattern, risk for emotional or psychological distress due to personal losses - unsuccessful prior placements, elopement risk, history of previous elopements - smoking - alcohol and drug use - decision-making authority. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and	01650			

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01650	Continued From page 46 (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4's diagnoses included Parkinson's (long-term degenerative disorder of the central nervous system that affects the motor system).	01650			

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01650	Continued From page 47 R4's service plan/care plan dated February 18, 2025, indicated R4 received assistance with compression stockings (TEDs) twice daily, wellness checks three times daily, nebulizer solution set-up for administration and device cleaning, laundry and housekeeping services. On June 4, 2025, at 8:11 a.m., the surveyor observed unlicensed personnel (ULP)-G apply TEDs and give R4 a nebulizer treatment (small machine that creates a mist out of liquid medication, allowing for quicker and easier absorption of medication into the lungs). R4's service plan noted: - staff will be monitored by RN (registered nurse) within 30 days of hire and periodically thereafter. R4's service plan lacked to include the method of monitoring of staff providing services. On June 3, 2025, at 1:35 p.m., R4's service plan was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated the facility's service plan template did not include the method that would be used for staff monitoring and that the required information would be lacking from all service plans. CNS-C stated monitoring would be done face to face. The licensee's Contents of Service Plans policy dated December 2024, noted service plans would include: -schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			

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01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for three of four residents (R8, R2, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). R8 R8's diagnoses included hypothyroidism, and Parkinson's (long-term degenerative disorder of the central nervous system that affects the motor	01750			

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01750	Continued From page 49 system). R8's service plan dated April 1, 2025, indicated R8 received medication management. R8's medication management plan dated April 1, 2025, noted R8 received medication administration. R8's June 1, 2025, through June 3, 2025, medication administration record (MAR) included: - levothyroxine sodium oral tablet 100 micrograms (mcg), give one tablet by mouth one time a day related to hypothyroidism. R8's prescriber order dated April 1, 2025, included the above order. On June 3, 2025, at 7:04 a.m., the surveyor observed unlicensed personnel (ULP)-G prepare R8's morning medication. ULP-G removed a bubble pack card of levothyroxine from a cabinet in R8's room. The surveyor observed, on the levothyroxine medication card, a pharmacy label that noted, "give with water, on empty stomach." ULP-G counted out six medications in total and administered them to R8. R8's MAR lacked specific information for R8's levothyroxine administration. On June 3, 2025, at 1:57 p.m., R8's record was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated R8 did not eat until about 8:00 a.m., so the medication was given correctly however, CNS-C stated the directions for R8's levothyroxine administration "got missed" on R8's MAR. CNS-C stated R8's record should have included specific administration directions for levothyroxine. CNS-C stated other residents who	01750			

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01750	Continued From page 50 received levothyroxine records included specific administration information. The manufacturers' instructions for levothyroxine dated February 15, 2019, noted take once a day on an empty stomach, 30 [minutes] to one hour before breakfast. Swallow capsules whole; do not chew or crush them. Do not remove the capsule from the package until you are ready to take it. Take tablets with a full glass of water as they may get stuck in throat and cause choking or gagging. R2 R2's diagnoses included age-related cataract of left eye (clouding of the lens inside the eye, which leads to low vision), and Parkinson's. R2's service plan dated August 22, 2024, indicated R2 received medication management. R2's medication management plan dated August 22, 2024, noted R2 received medication administration. On June 3, 2025, at 8:27 a.m., the surveyor observed ULP-G administered doxolamine eye solution (cataract) into R2's right eye. On June 3, 2025, at 8:40 a.m., the surveyor observed ULP-G administer Refresh eye solution into R2's eyes. R2's June 1, 2025, through June 3, 2025, MAR include: -Rhopressa solution 0.02%, instill one drop in left eye at bedtime, related to combined forms of age-related cataract. Wait five minutes in between administering different eye drop medication -Travatan Z solution 0.004% instill one drop in left	01750			

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01750	Continued From page 51 eye at bedtime, related to combined forms of age-related cataract wait five minutes in between administering different eye drop medication -dorzolamide HCl-timolol ophthalmic solution 22.3-6.8 milligrams (mg) instill one drop in left eye two times a day related to combined forms of age-related cataract -Refresh Plus ophthalmic solution, instill one drop in both eyes three times a day related to combined forms of age-related cataract, left eye. Wait five minutes before administering a different eye drop -Refresh Plus ophthalmic solution, instill one drop in both eyes every eight hours as needed (PRN) for dry eyes/watery eye. May have up to six times daily, upon request. R2's MAR, however, lacked instructions on which eye drop should be administered first and directions for which to give next, in order, along with directions of how long to wait between all drops. R2's prescriber order dated January 9, 2025, and April 22, 2025, included the above orders. The manufacturer's instructions for dorzolamide HCl dated October 2009 noted if you use other topically applied ophthalmic medications, they should be administered at least ten minutes before or after dorzolamide HCl-timolol ophthalmic solution. The manufacturer's instructions for Refresh Plus dated June 24, 2016, noted if you use Refresh with another eye medicine, leave at least 15 minutes between putting Refresh and the other medicine. On June 3, 2025, at 2:00 p.m., R2's record was reviewed with CNS-C. CNS-C confirmed R2's	01750			

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01750	Continued From page 52 MAR did not include wait time in-between all of the different eye solutions administrated to R2 (dorzolamide, and PRN Refresh). CNS-C stated all of R2's eye solutions should have included specific administration information. R6 R6's diagnoses included diabetes, gastro-esophageal reflux/GERD) R6's service plan dated May 9, 2025, indicated R6 received medication management. R6's medication management plan dated May 9, 2025, noted R6 received medication administration. On June 3, 2025, at 7:23 a.m., the surveyor observed ULP-G prepare and administer R6's morning medication using correct technique, to include metformin (diabetes). ULP-G then asked R6 what he would like for breakfast. ULP-G stated he would like a piece of lemon blueberry bread. R6 stated he did not need a hardboiled egg as he (R6) had one in the refrigerator. R6's June 1, 2025, through June 3, 2025, MAR include: -metformin HCl oral tablet 1000 mg give one tablet by mouth two times a day related to type 2 diabetes: 7:00 a.m., 6:00 p.m. -meloxicam 7.5 mg, give one tablet by mouth one time a day, related to osteoarthritis: 6:00 p.m. R6's prescriber's order dated May 9, 2025, included: -metformin 1000 mg, take one tablet twice a day with meals -meloxicam 7.5 mg (osteoarthritis), give one tablet by mouth one time a day. Take with food.	01750			

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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY VILLA		STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE BIGFORK, MN 56628			
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01750	Continued From page 53 On June 4, 2025, at 10:40 a.m., the surveyor reviewed R6's record with CNS-C. CNS-C stated some of R6's medications did not include specific instructions as required, to include metformin and meloxicam. CNS-C stated R6 ate meals at 7:00 a.m. and at 5:30 p.m., and additional instructions needed to be added to R6's MAR. CNS-C stated not all prescribers were as detailed as the prescriber that wrote R6's orders. The licensee's Medication Management Plan and Individualized Plan and Record Development policy dated February 2025, noted the resident's medication plan would include: - any client (resident) specific requirements relating to documentation of medication administration, verification that all medication were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions - identification of any specific client instructions regarding medication that staff would administer. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of	01760			

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01760	Continued From page 54 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per manufacturer's instruction, for one of three residents (R2). In addition, the licensee failed to ensure one of one ULP (ULP-G), followed registered nurse (RN) written instructions for one of two residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MANUFACTURER'S INSTRUCTION R2 R2's diagnoses included age-related cataract of left eye (clouding of the lens inside the eye, which leads to low vision), and Parkinson's (long-term degenerative disorder of the central nervous system that affects the motor system). R2's service plan dated August 22, 2024,	01760			

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01760	Continued From page 55 indicated R2 received medication management. R2's medication management plan dated August 22, 2024, noted R2 received medication administration. On June 3, 2025, at 8:27 a.m., the surveyor observed ULP-G administer doxolamine eye solution (cataract) into R2's right eye. On June 3, 2025, at 8:40 a.m., the surveyor observed ULP-G administer Refresh eye solution into R2's eyes. R2's June 1, 2025, through June 3, 2025, MAR include: - dorzolamide HCl-timolol ophthalmic solution 22.3-6.8 milligrams (mg) instill one drop in left eye two times a day related to combined forms of age-related cataract - Refresh Plus ophthalmic solution, instill one drop in both eyes three times a day related to combined forms of age-related cataract, left eye. wait five minutes before administering a different eye drop - Refresh Plus ophthalmic solution, instill one drop in both eyes every eight hours as needed (PRN) for dry eyes/watery eye. May have up to six times daily, upon request. R2's prescriber order dated January 9, 2025, and April 22, 2025, included the above orders. On June 3, 2025, at 2:00 p.m., manufacturer's instructions for R2's prescribed eye solutions were reviewed with CNS-C. CNS-C confirmed the wait time on R2's MAR were not the same as manufacturers' instructions. The manufacturer's instructions for dorzolamide	01760			

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01760	Continued From page 56 HCI dated October 2009, noted if you use other topically applied ophthalmic medications, they should be administered at least ten minutes before or after dorzolamide HCI-timolol ophthalmic solution. The manufacturer's instructions for Refresh Plus dated June 24, 2016, noted if you use Refresh with another eye medicine, leave at least 15 minutes between putting Refresh and the other medicine. WRITTEN INSTRUCTION R6 R6's diagnoses included diabetes, gastro-esophageal reflux/GERD), osteoarthritis, and anemia (not enough health blood cells to carry oxygen). R6's service plan dated May 9, 2025, indicated R6 received medication management. R6's medication management plan dated May 9, 2025, noted R2 received medication administration. On June 3, 2025, at 7:23 a.m., the surveyor observed ULP-G prepare and administer R6's morning medication using correct technique. ULP-G then asked R6 what he would like for breakfast. ULP-G stated he would like a piece of lemon blueberry bread. R6 stated he did not need a hardboiled egg as he (R6) had one in the refrigerator. R6's June 1, 2025, through June 3, 2025, MAR include: - ferrous sulfate oral tablet 325 mg, give one tablet by moth one time a day related to iron deficiency anemia secondary to blood loss, take	01760			

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01760	Continued From page 57 before breakfast: 7:00 a.m. - omeprazole 20 mg give one capsule by mouth one time a day, retailed to GERD, recommenced to take before meal: 6:00 p.m. R6's prescriber's order dated May 9, 2025, included: - ferrous sulfate 325 mg, take one tablet orally every morning before breakfast - omeprazole 20 mg delayed-release capsule, take one capsule once daily. Take before a meal. Do not crush. On June 4, 2025, at 10:31 a.m., the surveyor reviewed R6's record with CNS-C. CNS-C stated directions on MARs should be followed. CNS-C stated R6's ferrous sulfate was not given as prescribed should have been given prior to meal. In addition, after review of R6's MAR CNS-C stated R6's omeprazole was scheduled prior to a meal as prescribed. CNS-C stated R6 ate meals at 7:00 a.m. and at 5:30 p.m. CNS-C stated not all prescribers were as detailed as the prescriber that wrote R6's orders. CNS-C stated she looked through over prescriber's orders and felt the issue was isolated. The licensee's Medication Management Plan and Individualized Plan and Record Development policy dated February 2025, noted the resident's medication plan would include: - any client (resident) specific requirements relating to documentation of medication administration, verification that all medication were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions No further information was provided.	01760			

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01760	Continued From page 58	01760			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information, including the expiration date, for time sensitive medications for one of one resident, (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 2, 2025, at 10:06 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated medications were kept in resident's rooms.	01890			

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01890	Continued From page 59 R2's diagnoses included age-related cataract of left eye (clouding of the lens inside the eye, which leads to low vision), and Parkinson's. R2's service plan dated August 22, 2024, indicated R2 received medication management. R2's medication management plan dated August 22, 2024, noted R2 received medication administration. On June 2, 2025, at 10:41 a.m., during a tour of the facility CNS-C stated R2 was the only resident who currently used time sensitive medication, eye drops. CNS-C observed and confirmed the following TIME SENSITIVE MEDICATION -opened dorzolamide-timolol (high eye pressure) lack an open or expiration date for R2 PRESCRIPTION LABEL -one opened Rhopressa 0.2% (high eye pressure) eye solution had some writing on the label in black marker. The surveyor asked CNS-C if she could read the label? CNS-C stated she could read, four and "something." CNS-C stated "we" (licensee) should have put a new label on R2's Rhopressa eye solution. CNS-C confirmed the label on R2's Rhopressa was not legible. Directly after the above observation manufacturer's instructions were reviewed with CNS-C. CNS-C stated two of R2's eye medications were not dated as required. CNS-C stated the pharmacy did not send inserts with medications. CNS stated the pharmacy told her (CNS-C) one medication expired at six weeks and she (CNS-C) should have looked at the	01890			

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01890	Continued From page 60 manufacturer's instructions. On June 2, 2025, at 10:58 a.m., CNS-C stated she would consider this issue to be pattern issue. The manufacturer's instructions for dorzolamide-timolol dated August 3, 2023, noted dorzolamide/timolol should be sued within 28 days after the bottle was first opened. Therefore, you must throw away the bottle four weeks after you first opened it, even if some solution was left. To help you remember, write down the date that you opened it in the space on the carton and the bottle. The manufacturer's instructions Rhopressa dated December 2017, noted after opening the product may be kept at 36 degrees Fahrenheit (F) to 77 degrees for up to six weeks. The licensee's Medication Storage policy dated October 2024, noted until the medication was set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's (resident's) name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

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02310	Continued From page 61	02310			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care, medical, or nursing standards for one of one resident (R4) with an assistive device (consumer bedrail). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 2, 2025, at approximately 10:50 a.m., during a tour of the facility with clinical nurse supervisor (CNS)-C, the surveyor observed R4's door open and a consumer bedrail attached to the bed. R4 was seated in a recliner in the living area of his room. CNS-C stated there was only one resident (R4) who had an assistive device (bedrail) in use at the facility. On June 3, 2025, at 8:54 a.m., the surveyor	02310			

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02310	Continued From page 62 observed unlicensed personnel (ULP)-G knock on R4's door. ULP-G stated R4 went out with his family, and he (R4) may not have returned to the facility. ULP-G stated R4 had a bedrail on one side of his bed. On June 4, 2025, at 8:11 a.m., the surveyor observed ULP-G apply compression stockings (TEDs) and give R4 a nebulizer treatment (small machine that creates a mist out of liquid medication, allowing for quicker and easier absorption of medication into the lungs). R4 stated they (staff) removed the bedrail "last night." R4's diagnoses included Parkinson's (long-term degenerative disorder of the central nervous system that affects the motor system). R4's service plan/care plan dated February 18, 2025, indicated R4 received assistance with TEDs twice daily, wellness checks three times daily, nebulizer solution set-up for administration and device cleaning, laundry and housekeeping services. R4's Bed Rail Risk Data Collection Tool/assessment dated February 18, 2025, noted: - assist/grab bar, left - what is/are the symptom(s) or functional deficits that will be treated or managed with the use of bed rails(s)? Parkinson's, hypotension (low blood pressure) - what alternatives have been used? wedge, pillows, sides down, didn't help - when will the bed rail (s) be used? now - is the resident able to show you how they safety use the rail (s)? yes - how does the bed rail (s) benefit the resident? enable for mobility, positioning, helps position to sitting at side of bed and holds /helps to stand	02310			

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02310	Continued From page 63 - does the bed rail attach firmly to the bed? blank (noted options: yes, no, take rail out of service & contact maintenance to repair) - does the resident properly fit in the bed? yes - analysis: meets all guidelines/measurement, transfer handle -I give my approval with understanding of the risks vs. benefits as reviewed: authenticated by daughter. R4's record lacked a comprehensive assessment for the use of an assisted device (bedrail) including the installation and use of the device according to manufacturer's guidelines, lacked evidence of physical inspection of the bedrail and mattress for areas of entrapment, stability, correct installation of the device, and lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bedrail recall information. On June 3, 2025, at 2:10 p.m., the surveyor reviewed R4's record with CNS-C. CNS-C stated she had given the bedrail instructions to maintenance to use when they (maintenance) attached the bedrail to R4's bed. CNS-C stated maintenance did not return the instructions to her (CNS-C), for R4's record. CNS-C stated she was not aware of the need to check for recall of consumer type of bedrails. In addition, CNS-C stated she completed bedrail assessments yearly. CNS-C stated she was not aware that bedrail assessments were required more frequently. CNS-C stated R4 had had a "bed cane" on bed, with a black mesh covering. CNS-C stated R4 had been sleeping in his chair. CNS-C stated she completed an updated assessment last evening (June 2, 2025) and the assisted device was removed from R4's bed.	02310			

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02310	Continued From page 64 The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated February 17, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's	02310			

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NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
02310	Continued From page 65 guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Devices and Device Assessment policy dated February 2023, noted: - if the client (resident) expressed the desire to use a device or a device is in use/recommended, a nurse would complete a device assessment at the time of move in, upon hospital return, change in condition, or discovery of a rail. Nurse must check for device recalls at: https://www.cpsc.gov/Recalls and document on assessment - device would be installed as appropriate for the type of bed - for non-hospital beds: devices would be installed according to the devices manufacturer's instructions - staff will be educated to report to a licensed nurse immediately if the device was found to be loose or malfunctioning - physical devices would be assessed for safety during each re-assessment. If there were any safety issues identified, the director of health services or housing director would be notified immediately - staff will inspect bed and mattress for safety zones on a monthly basis - staff will inspect bed devices monthly	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY VILLA		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
02310	Continued From page 66 - two times per year the clinical nurse supervisor or designee, would check the FDA (food and drug administration) website for recalls on bed assistive devices No further information provided. TIME PERIOD OF CORRECTION: Two (2) days	02310			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by:	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE BIGFORK, MN 56628		
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02410	Continued From page 67 Based on observation and interview, the licensee failed to ensure privacy was maintained for one of four residents (R4) observed during personal cares and medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnosis included Parkinson's (long-term degenerative disorder of the central nervous system that affects the motor system). R4's service plan/care plan dated February 18, 2025, indicated R4 received assistance with TEDs (compression stockings) twice daily, wellness checks three times daily, nebulizer solution set-up for administration and device cleaning, laundry and housekeeping services. On June 4, 2025, from 8:11 a.m., until 8:35 a.m., the surveyor continuously observed unlicensed personnel (ULP)-G. On June 4, 2025, at 8:11 a.m., the surveyor observed ULP-G enter R4's room. R4's door had been open. ULP-G logged into an I-pad (computer system) and washed her hands at the sink. R4 was seated in a recliner in the living area of his room. ULP-G did not close R4's door after entering R4's room. ULP-G stated, I am going to start with your socks. R4 replied he did not like	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER BIGFORK VALLEY VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 258 PINE TREE DRIVE BIGFORK, MN 56628		
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02410	Continued From page 68 the socks but knew he needed to wear them. R4 lifted up his left leg. ULP-G applied the TED to R4's left leg and told R4 he could put his leg down. ULP-G applied to TED to R4's right leg. ULP-G asked R4 if he was in any pain. ULP-G stated R4 got nebulizer treatment (small machine that creates a mist out of liquid medication, allowing for quicker and easier absorption of medication into the lungs) up to four times daily. ULP-G picked up a mask, and the medication cup and went to the side table near R4 was seated. ULP-G stated she would wipe down the nebulizer and tubing prior to using the equipment. ULP-G applied gloves and cleaned R4's nebulizer equipment. On June 4, 2025, at 8:20 a.m., the surveyor observed an unidentified resident (UR) in R4's doorway. UR asked ULP-G if R4 was "here yet?" ULP-G joked with UR and replied she did not know (as ULP-G assisted R4.) UR visited with R4 briefly. ULP-G completed cleaning the equipment, handed R4 the nebulizer mask and ULP-G ensured R4 had the nebulizer mask on correctly. ULP-G turned on the nebulizer. On June 4, 2025, at 8:27 a.m., ULP-G turned off R4's nebulizer machine, removed R4's mask, and took the mask and medication cup to the sink. ULP-G washed the medication cup and nebulizer mask, and used hand sanitizer. ULP-G told R4 it was his (R4's) housekeeping day (scheduled). The surveyor observed UR outside of R4's door, looking in. On June 4, 2025, at 8:35 a.m., ULP-G stated she should have closed R4's door when she completed services "like that (TEDS and nebulizer). ULP-G stated R4 leaves the door open but added she (ULP-G) should have asked	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2025
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02410	Continued From page 69 R4 if she could close his door. UP-G added she did not even "think about asking him." On June 4, 2025, at 8:43 a.m., clinical nurse supervisor (CNS)-C stated ULPs should offer to close a resident's door, every single time. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			



Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
Bigfork Valley Villa 258 Pine Tree Drive Bigfork, MN 56628 Itasca County Parcel: Phone:	License: HFID 20243 Risk: License: Expires on: CFPM: NELLY BECKER CFPM #: CFPM239; Exp: 10-7-2027	Report Number: F7939251029 Inspection Type: Full - Single Date: 6/2/2025 Time: 11:38:59 AM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 0</u> <u>Delivery: Emailed</u>

No orders were issued for this inspection report.

Food & Beverage General Comment

DISCUSSION
ONLY SANITIZER IN RAG BUCKET, NO SOAP

RAW EGGS SHOULD BE ON THE BOTTOM SHELF BELOW THE READY TO EAT FOODS

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Bemidji District Office inspection report number F7939251029 from 6/2/2025

ALICE ROSIN
COOK


Ryan Trenberth,
Public Health Sanitarian 3
218-308-2133
ryan.trenberth@state.mn.us



Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Page: 1

Establishment Info

Bigfork Valley Villa
Bigfork
County/Group: Itasca County

Inspection Info

Report Number: F7939251029
Inspection Type: Full
Date: 6/2/2025
Time: 11:38:59 AM

Food Temperature: Product/Item/Unit: Rice; **Temperature Process:** Hot-Holding

Location: Steam Table at 174 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Cheese; **Temperature Process:** Cold-Holding

Location: Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No



Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Bigfork Valley Villa
Bigfork
County/Group: Itasca County

Inspection Info

Report Number: F7939251029
Inspection Type: Full
Date: 6/2/2025
Time: 11:38:59 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Kitchen **Equal To** 400 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** >160F Degrees F.

Comment:

Violation Issued?: No