STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bigfork Valley Communities	258 Pine Tree Drive Bigfork, MN 56628

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to follow up on grievances related to call light response times for 2 of 3 residents (R1, R4) reviewed for grievances.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 required substantial to maximal assistance for bed mobility, was dependent on staff for transfers and was always incontinent of bowel. R1's care plan identified limited physical mobility and directed staff to assist with positioning using two staff and indicated he was dependent on staff for transfers using a mechanical lift.R1's undated admission Record identified R1 admitted to the facility on [DATE]. Diagnosis included paraplegia, neuromuscular dysfunction of bladder and a stage IV pressure ulcer (a full-thickness tissue loss where exposed bone, tendon, or muscle is visible or directly palpable in the wound bed). R1's care plan dated 7/11/25, identified bowel incontinence, high risk for pressure injuries and a self-care deficit. The care plan indicated R1 required assistance from two staff for bed mobility, toileting and was dependent on staff for transfer using a mechanical lift.R4's care plan dated 7/11/25, indicated a potential for impaired skin integrity, risk for falls, self-care deficit and bowel and bladder incontinence. The care plan indicated R2 required assistance from two staff for toileting needs and was dependent on staff for transfers using a mechanical lift.R4's undated admission Record indicated R4 admitted to the facility 7/10/25. Diagnosis included multiple sclerosis, paraplegia. dependence on wheelchair and obesity.The facility concern/grievance forms indicated the following:9/29/25, care concern reported related to call light response times. Met with staff to ask about all light wait times. Nursing assistants (NA)'s on day shift stated morning were longer wait times due to answering previous lights and cares for other residents. Afternoon NA's reported they will answer the light but id another NA is not available they have to wait longer. Call light report showed longer wait times but did note other lights on prior to R1 and R2's with residents also requiring two staff assist. Staff to continue to check in with R1 and R2.10/6/25, Concern made by R1 about waiting a long time for call light to be answered. Met with R1 and R2 who reported waiting a long time for staff to answer light. Scheduler and health unit coordinator assisted with cares that day. Staff to continue to monitor call lights.On 11/14/25 at 10:32 a.m., R1 and R4 were interviewed. R1 stated staff had not been answering call lights for up to as long as two hours. R1 said the facility took action and completed audits but said the call lights were still on for a full hour, sometimes. R1 said staff were supposed to answer the light to see if there was an immediate need but indicated that had not been happening. R1 said he felt waiting thirty minutes for call lights to be answered was reasonable. R1 stated the social worker (SW) had spoken to him for the first time earlier in the day. R2 said staff did not come to assist her to get up this morning until after 9:00 a.m. Review of facility call light logs identified the following: 11/4/25, R4 placed the call light on at 7:47 a.m. Staff responded to the light at 9:11 a.m., one hour and 23 minutes later. 11/4/25, R1 placed his call light on at 7:57 a.m. Staff responded to the light at 9:07 a.m., one hour and 10 minutes later. 11/4/25, R4 placed the call light on at 12:31 p.m. Staff responded to the light at 2:01 p.m., one hour and thirty minutes later.11/5/25, R1 placed the call light on at 8:05 a.m. Staff responded to the light at 9:07 a.m., one hour and two minutes later.11/5/25, R4 placed the call light on at 12:26 p.m. Staff responded to the light at 1:41 p.m., one hour and 15 minutes later.11/7/25, R4 placed the call light on at 12:35 p.m. Staff responded to the light at 1:39 p.m., one hour and 4 minutes later.11/8/25, R1 and R4 both placed their call lights on at 8:11 a.m., the lights were answered by staff at 9:10 a.m., 58 minutes later.11/11/25, R4 placed the call light on at 8:17 p.m. Staff responded to the call light at 9:20 p.m., one hour and three minutes later.11/11/25, R4 placed the call light on at 12:43 p.m. Staff responded to the light at 1:42 p.m., 59 minutes later.11/12/25, R1 placed the call light on at 5:15 p.m., Staff responded to the call light at 6:54 p.m., one hour and 38 minutes later. 11/13/25, R1 placed the call light on at 8:09 a.m. Staff responded to the light at 9:45 a.m., one hour and 35 minutes later.11/13/25, R4 placed the call light on at 8:20 a.m. Staff responded to the light at 9:35 a.m., one hour and fourteen minutes later.11/13/25, R1 placed his call light on at 12:33 p.m., Staff responded to the light at 1:36 p.m., one hour and three minutes later.11/14/25, R4 placed her call light on at 8:06 a.m. The call light was answered by staff at 9:03 a.m., 57 minutes later.On 11/14/25 at 11:33 a.m., NA-A and NA-B were interviewed. NA-B stated they were able to monitor call lights on the unit outside the secured area and carried pagers and a monitor that showed up red when a call light was on. NA-B said because they were on a dementia unit they were told safety on that unit came first. NA-B said staff were not assigned to the three residents outside the secured unit. NA-A said sometimes they got over there on time and some days it took