

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bigfork Valley Communities		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to protect the residents' right to be free from mental and physical abuse from a resident (R4) for 5 of 6 residents (R5, R6, R7, R8, R9). This resulted in psychosocial harm for R5, R6, R7, R8, R9 who displayed and/or verbalized fear which included avoiding R4 and using garbage cans to barricade doors to prevent R4 from entering their rooms. Findings include: R4 R4's admission Record indicated she was admitted to the facility 5/21/26. R4's diagnoses included Alzheimer's disease, dementia with behavioral disturbance and aphasia (a communication disorder affecting speech, understanding, reading, and writing due to brain injury). R4's Comprehensive Behavioral assessment dated [DATE], indicated R4 had daily behaviors directed toward staff. R4's behaviors included screaming in the dining room and attempts to argue with other residents, taking other's belongings and food. The assessment indicated R4's behaviors were a safety concern. R4 had advanced dementia and was unable to communicate needs, had aphasia, jumbled words and phrases that did not make sense. R4 admitted from home where she displayed behaviors. Safety concerns related to impulsiveness and was not redirectable. R4's admission Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated she displayed physical, verbal and other behaviors directed toward others. R4's MDS indicated she was able to transfer and ambulate independently. Care Area Assessment (CAA) dated 6/1/26, indicated R4 yelled out at meals, approached other residents with the intention to take their food and would get angry and scream at other residents. It was unclear whether behaviors were provoked or not. R4's behaviors occurred in large crowds and during cares which could signal fear in a new environment. Family reported that R4 displayed the same behaviors in her previous living situation. R4's care plan identified severe dementia with behaviors. Care planned interventions with date initiated indicated: 5/29/26- Leave R4 in a safe place and return with new staff if agitated and/or aggressive. ^ 5/29/26- Started on Seroquel for aggression, physical behaviors of hitting, punching, taking other's belongings and behaviors toward other residents. 5/29/26- Family reported R4 had increased agitation from 11:00 a.m. to 12:00 p.m. She may be getting hungry. Give R4 small snack. 6/12/26- Approach in a calm manner, R4 did not like large groups of people and became agitated during mealtime. ^^ 6/12/26- R4 got anxious between 2:00 p.m. and 4:00 p.m., and family suggested having her fold towels. 6/12/26- R4 got anxious eating in common areas and did not like large groups of people, if upset move her to activity area for meal. 6/15/26 Allow R4 to wander or walk to help get rid of energy. Keep her safe and know her whereabouts. R4's Progress Notes identified the following: 5/21/26- R4 entered another resident's room and screamed when staff attempted to assist her out of the room. 5/22/26- R4 entered other resident rooms. Stop signs were placed across resident room doors and R4 would go under the banner. 5/23/26- During report, staff (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245529 If continuation sheet Page 1 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bigfork Valley Communities		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Some	heard a door slam. R4 was in another resident's room, standing against the door. R4 was pushing on the door trying to prevent staff from entering the room. The other resident was telling R4 to get out but denied any physical altercation. 5/25/26- R4 hit staff, kicked doors and ducked in and out of rooms under the stop sign. 5/27/26- R4 was yelling, aggressive and hit at staff and residents in dining area. 6/7/26- R4's aggressive, violent behaviors had increased over the weekend. Behaviors included R4 entering other resident rooms with terrorizing behaviors. 6/22/26- R4 started pushing another resident (R5) in her wheelchair and ran R5 into a post. After residents went into the dining room, R4 suddenly stood up and struck R5 on the arm. 6/22/26- R9 sat next to R4. R4 became angry and hit the other resident in the leg and chest. 6/25/26- R4 entered other residents' rooms all evening. Took bedding from a sleeping resident, threw another resident's belongings on the floor. R4 had altercation with R6, wandered into R6's room, became aggressive, grabbed R6's arm and broke R6's bracelets. 6/28/26- R4 was observed walking past R7 who was in the doorway of R7's room. R4 hit R7 in the face with an open hand. 7/2/26- R4 emerged from her room and unprovoked, walked over and hit R5 who was seated in the common area. 7/5/26- R4 was in R7's room and threw an object which hit R7. 7/6/26- R4 was hitting, kicking, spitting and yelling at other residents and visiting family. 7/7/26- R4 was hitting, kicking, spitting and yelling at other residents. 7/9/26/26- R4 was uncooperative and easily enraged with attempt at toileting or cares. Removed own incontinent brief and pants in common area. Another resident told R4 to stop screaming and be nice to staff. R4 later attempted to push another resident in their wheelchair which was unwanted by the other resident who pushed R4's hands away. R4 became upset, yelled loudly and tried to hit the other resident. R4 had socks in her hands and mostly hit the other resident with the socks. Staff had to stand between the two residents. Initial Incident Report dated 6/22/26, indicated R4 approached R9, appeared angry and struck R9 in the leg and chest. Facility investigation dated 6/23/26, indicated R4 was unable to be interviewed and more information from staff was requested. No redness, pain or discomfort noted for R9. E-mail from staff member to the administrator, licensed social worker (LSW) and interim director of nursing (DON) dated 6/22/26, indicated R4 hit R9 in the chest and the face. R5 R5's admission Record indicated she was admitted to the facility 9/5/23. R5's diagnoses included dementia without behaviors, anxiety and depression. R5's quarterly MDS dated [DATE], identified severe cognitive impairment and indicated she did not display behaviors. R5's MDS indicated she ambulated independently up to 50 feet and required assistance from staff for longer distances. R5's care plan dated 8/15/25, identified behaviors that included crying, wanting to call family and isolating herself in her room. The care plan identified R5 as a vulnerable adult and directed staff to allow her to make choices related to meals, activities and clothing. R6 R6's admission Record indicated she was admitted to the facility 7/24/24. R6's diagnoses included dementia, anxiety and depression. R6's quarterly MDS dated [DATE], identified moderate cognitive impairment and indicated she displayed verbal behaviors directed toward others. The MDS indicated R6 ambulated independently with the use of a walker. R6's care plan dated 6/2/25, identified short term memory loss and indicated she displayed verbal aggression toward other residents by making rude comments to them. Behaviors included crying, isolating herself in room and irritability. The care plan further identified R6 as a vulnerable adult due to placement in the facility. R7 R7's admission Record indicated she was admitted to the facility 2/6/25. R7's diagnoses included Alzheimer's disease, bipolar disorder and dementia without behaviors. R7's quarterly MDS dated [DATE], identified severe cognitive impairment and indicated she did not display behaviors. R7 ambulated independently with the use of a walker. R7's care plan dated 4/22/26, identified behaviors that included crying, feelings of loneliness, persistent worry and fear. The care plan identified impaired cognitive function and identified her as a (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bigfork Valley Communities		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Some	vulnerable adult due to medical diagnosis. R8 R8's admission Record indicated she was admitted to the facility 9/18/23. R8's diagnoses included Multiple Sclerosis and contractures. R8's quarterly MDS dated [DATE], identified intact cognition and indicated she did not display behaviors. R8 was dependent on staff for transfers, did not ambulate and was dependent on staff for wheelchair mobility. R8's care plan dated 4/22/26, identified her as a vulnerable adult related to placement in the facility. R9 R9's admission Record indicated she was admitted to the facility 7/2/25. R9's diagnosis included Alzheimer's disease. R9's quarterly MDS dated [DATE], identified severe cognitive impairment and indicated she displayed physical behaviors directed toward others. R9 was independent with transfers and ambulation. During interview on 7/9/26 at 2:02 p.m., R8 stated, It's been hell because of R4. R8 stated residents had to be locked in their rooms because R4 went on rampages and stated, The last one lasted a long time. R8 denied being hurt by R4 but stated, [R4] would crouch down and look at me under the stop sign banner. She's a sneaky old bird. Everyone is terrified of her. R8 confirmed she was also afraid of R4, Oh yes, very much so. I can't move or get out of bed without someone else helping me. [R4] has gone into other rooms and hit people while they were sleeping. Earlier this morning she [R4] was on a rampage again. During interview on 7/9/26 at 3:39 p.m., registered nurse (RN)-A stated a past weekend she worked R4 was on a rampage, screaming, hitting out, scratching, biting and kicking. You never know when it will happen. Staff tried to keep eyes on [R4] but they couldn't catch her every time or always get there in time. When R4 hit other residents, staff tried to step in between the residents. RN-A stated she had seen R4 hit R5, just the other day, R4 hit R5 in the chest with a baby doll. That same weekend, R4 had thrown an object at R7 and hit her but was unsure what was thrown or where it hit R7. RN-A stated R4 entered other resident rooms, and it upset the other residents. RN-A stated R7 was afraid of R4 and would go out of her way to ensure she did not cross paths with R4. R7 is not able to communicate her fear of R4. R6 gets upset about R4 and would get, worked up, R5 had been hit by R4 but RN-A did not think R5 would remember it. R5 was not able to verbalize her fear of R4. R8 was afraid of R4 and would not go within an inch of her. RN-A said R9 also would not remember it but had been close to fighting with R4. During interview on 7/9/26 at 3:59 p.m., with the licensed social worker (LSW) and interim director of nursing (DON), the LSW stated resident-to-resident altercations were documented in the progress notes and an incident report was completed. The LSW said staff were looking at variables to R4's behaviors and had tried different interventions which included a baby doll, one-to-one, music and folding towels. Neither the DON nor the LSW knew what had occurred earlier in the day when R4 was yelling at and became physically aggressive towards other residents. The LSW said staff had been doing a great job of keeping eyes on R4 and attempting to intervene when she was agitated. The LSW stated she had reached out to a behavioral unit to assist with R4's behaviors. During interview on 7/9/26 at 4:12 p.m., nursing assistant (NA)-A stated almost every time she worked, R4 got agitated, yelled, kicked, screamed and hit. Sometimes, [R4] would be walking and would go into a resident room and hit them. [R4] has hit [R5], [R7] and [R9]. [R4] has probably yelled at just about everyone on the unit. NA-A said she could tell other residents including R5, R6, R8 and R9 were afraid of R4. If these residents crossed paths with R4 they would turn around. During interview on 7/9/26 at 4:18 p.m., R6 stated, [R4] is a psycho. [R4] came into my room one time and grabbed my arm. I had to pull her hand off me. She knows I don't like her. She [R4] throws fits and gets wild. I told the nurses, if she [R4] gets after me, I'll smack her. R6 said she would shut her door and put her garbage can in front of it so it will make noise and wake her up if R4 tried to come into the room. During interview on 7/10/26 at 9:04 a.m., licensed practical nurse (LPN)-A stated when R4 did not take her medications she got out of hand and went into other resident rooms. The other day [R4] was sitting by the bird cage and was unprovoked, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bigfork Valley Communities		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Some	she hit [R5] on the leg. LPN-A said R4 has also been aggressive toward R6 and R7. LPN-A said stops signs were used on other residents' doors and LPN-A has needed to shut doors, its like putting them on lockdown when [R4] is out of control, until she calms down. LPN-A said it bothered the other residents to be stuck in their rooms. If [R4] went into other residents' rooms, staff tried to intervene and remove her. During interview on 7/10/26 at 9:14 a.m., NA-B stated R4 had hit R6 and said when R4 wandered into R6's room, R6 would scream and tell R4 to get out. NA-B had not heard other residents say they were afraid of R4 but a lot of residents made comments about R4. NA-B said R6 and R8 made comments about R4 and stated, I wouldn't be shocked if some of the residents are scared but haven't said anything. NA-B said they have not received training on how to deal with a violent resident, staff tried to remove R4 or give her space when she was agitated. During interview on 7/10/26 at 12:04 p.m., R7's family member (FM)-A stated he was not aware R7 had been hit by R4. FM-A said he did not think R7 would remember the incident other than immediately after. FM-A felt R7 would probably be more nervous than scared. During interview on 7/10/26 at approximately 1:00 p.m., RN-B stated she saw R4 strike R5 on more than one occasion. R5 was very even tempered and could not put two and two together. When R4 went into R7's room, R7 would scream and yell. RN-B said R7 told RN-B she was, scared to death, of R4. R7 closed her door and put a trash can in front of it at night because she was afraid of R4. During interview on 7/10/26 at 1:49 p.m., the LSW stated that after a resident-to-resident incident occurred, staff should put interventions in place to prevent it from happening again and to protect other residents. Facility policy Senior Services Abuse Prevention Plan dated 12/2024, indicated each individual had the right to be free from verbal, sexual, physical and mental abuse including mistreatment, neglect and involuntary seclusion. The policy indicated in the event of suspected mistreatment; the needs of the resident will be immediately addressed. Immediate steps should be taken to ensure that no resident remains in danger of mistreatment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bigfork Valley Communities		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to report to the state agency (SA) resident-to-resident abuse that resulted in mental anguish for 4 of 6 residents (R5, R6, R7, R8) reviewed for abuse. Findings include: R4R4's admission Record indicated she was admitted to the facility 5/21/26. R4's diagnoses included Alzheimer's disease, dementia with behavioral disturbance and aphasia (a communication disorder affecting speech, understanding, reading, and writing due to brain injury). R4's Comprehensive Behavioral assessment dated [DATE], indicated R4 had daily behaviors directed toward staff. R4's behaviors included screaming in the dining room and attempts to argue with other residents, taking other's belongings and food. The assessment indicated R4's behaviors were a safety concern. R4 had advanced dementia and was unable to communicate needs, had aphasia, jumbled words and phrases that did not make sense. R4 admitted from home where she displayed behaviors. Safety concerns related to impulsiveness and was not redirectable. R4's care plan dated 5/29/26, identified dementia, severe with behaviors. R4's Progress Notes identified the following: 5/21/26- R4 entered another resident's room and screamed when staff attempted to assist her out of the room. 5/22/26- R4 entered other resident rooms. Stop signs were placed across resident room doors and R4 would go under the banner. 5/23/26- During report, staff heard a door slam. R4 was in another resident's room, standing against the door. R4 was pushing on the door trying to prevent staff from entering the room. The other resident was telling R4 to get out but denied any physical altercation. 5/25/26- R4 hit staff, kicked doors and ducked in and out of rooms under the stop sign. 5/27/26- R4 was yelling, aggressive and hit at staff and residents in dining area. 6/7/26- R4's aggressive, violent behaviors had increased over the weekend. Behaviors included R4 entering other resident rooms with terrorizing behaviors. 6/22/26- R4 started pushing another resident (R5) in her wheelchair and ran R5 into a post. After residents went into the dining room, R4 suddenly stood up and struck R5 on the arm. 6/22/26- R9 sat next to R4. R4 became angry and hit the other resident in the leg and chest. 6/25/26- R4 entered other residents' rooms all evening. Took bedding from a sleeping resident, threw another resident's belongings on the floor. R4 had altercation with R6, wandered into R6's room, became aggressive, grabbed R6's arm and broke R6's bracelets. 6/28/26- R4 was observed walking past R7 who was in the doorway of R7's room. R4 hit R7 in the face with an open hand. 7/2/26- R4 emerged from her room and unprovoked, walked over and hit R5 who was seated in the common area. 7/5/26- R4 was in R7's room and threw an object which hit R7. 7/6/26- R4 was hitting, kicking, spitting and yelling at other residents and visiting family. 7/7/26- R4 was hitting, kicking, spitting and yelling at other residents. 7/9/26/26- R4 was uncooperative and easily enraged with attempt at toileting or cares. Removed own incontinent brief and pants in common area. Another resident told R4 to stop screaming and be nice to staff. R4 later attempted to push another resident in their wheelchair which was unwanted by the other resident who pushed R4's hands away. R4 became upset, yelled loudly and tried to hit the other resident. R4 had socks in her hands and mostly hit the other resident with the socks. Staff had to stand between the two residents. R5R5's admission Record indicated she was admitted to the facility 9/5/23. R5's diagnoses included dementia without behaviors, anxiety and depression. R5's quarterly MDS dated [DATE], identified severe cognitive impairment and indicated she did not display behaviors. R5's MDS indicated she ambulated independently up to 50 feet and required assistance from staff for longer distances. R5's care plan dated 8/15/25, identified behaviors that included crying, wanting to call family and isolating herself in (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bigfork Valley Communities		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her room. The care plan identified R5 as a vulnerable adult and directed staff to allow her to make choices related to meals, activities and clothing.R6R6's admission Record indicated she was admitted to the facility 7/24/24. R6's diagnoses included dementia, anxiety and depression.R6's quarterly MDS dated [DATE], identified moderate cognitive impairment and indicated she displayed verbal behaviors directed toward others. The MDS indicated R6 ambulated independently with the use of a walker.R6's care plan dated 6/2/25, identified short term memory loss and indicated she displayed verbal aggression toward other residents by making rude comments to them. Behaviors included crying, isolating herself in room and irritability. The care plan further identified R6 as a vulnerable adult due to placement in the facility.R7R7's admission Record indicated she was admitted to the facility 2/6/25. R7's diagnoses included Alzheimer's disease, bipolar disorder and dementia without behaviors.R7's quarterly MDS dated [DATE], identified severe cognitive impairment and indicated she did not display behaviors. R7 ambulated independently with the use of a walker.R7's care plan dated 4/22/26, identified behaviors that included crying, feelings of loneliness, persistent worry and fear. The care plan identified impaired cognitive function and identified her as a vulnerable adult due to medical diagnosis.R8R8's admission Record indicated she was admitted to the facility 9/18/23. R8's diagnoses included Multiple Sclerosis and contractures.R8's quarterly MDS dated [DATE], identified intact cognition and indicated she did not display behaviors. R8 was dependent on staff for transfers, did not ambulate and was dependent on staff for wheelchair mobility.R8's care plan dated 4/22/26, identified her as a vulnerable adult related to placement in the facility.During Interview on 7/9/26 at 2:02 p.m., R8 stated, It's been hell because of R4. R8 stated residents had to be locked in their rooms because R4 went on rampages and stated, The last one lasted a long time. R8 denied being hurt by R4 but stated, [R4] would crouch down and look at me under the stop sign banner. She's a sneaky old bird. Everyone is terrified of her. R8 confirmed she was also afraid of R4, Oh yes, very much so. I can't move or get out of bed without someone else helping me. [R4] has gone into other rooms and hit people while they were sleeping. Earlier this morning she [R4] was on a rampage again.During interview on 7/9/26 at 3:39 p.m., registered nurse (RN)-A stated a past weekend she worked R4 was on a rampage, screaming, hitting out, scratching, biting and kicking. You never know when it will happen. Staff tried to keep eyes on [R4] but they couldn't catch her every time or always get there in time. When R4 hit other residents, staff tried to step in between the residents. RN-A stated she had seen R4 hit R5, just the other day, R4 hit R5 in the chest with a baby doll. That same weekend, R4 had thrown an object at R7 and hit her but was unsure what was thrown or where it hit R7. RN-A stated R4 entered other resident rooms, and it upset the other residents. R7 was afraid of R4 and would go out of her way to ensure she did not cross paths with R4. R6 got upset about R4 and would get, worked up, R5 had been hit by R4 but RN-A did not think R5 would remember it. R8 was afraid of R4 and would not go within an inch of her. During interview on 7/9/26 at 4:12 p.m., Nursing assistant (NA)-A stated almost every time she worked, R4 got agitated, yelled, kicked, screamed and hit. NA-A said sometimes, R4 would be walking and would go into a resident room and hit them. NA-A said R4 had hit R5, R7 and R9 and had probably yelled at just about everyone on the unit. NA-A said she could tell other residents including R5, R6, and R8 were afraid of R4 and said if they crossed paths with R4 they would turn around.During interview on 7/9/26 at 4:18 p.m., R6 stated, [R4] is a psycho. [R4] came into my room one time and grabbed my arm. I had to pull her hand off me. She knows I don't like her. She [R4] throws fits and gets wild. I told the nurses, if she [R4] gets after me, I'll smack her. R6 said she would shut her door and put her garbage can in front of it so it will make noise and wake her up if R4 tried to come into the room.During interview on 7/10/26 at 9:04 a.m., licensed practical nurse (LPN)-A stated when R4 did not take her medications she got out of hand and went into other resident (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bigfork Valley Communities		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rooms. The other day [R4] was sitting by the bird cage and was unprovoked, she hit [R5] on the leg. LPN-A said R4 has also been aggressive toward R6 and R7. LPN-A said stops signs were used on other residents' doors and LPN-A has needed to shut doors, Its like putting them on lockdown when [R4] is out of control, until she calms down. LPN-A said it bothered the other residents to be stuck in their rooms. If [R4] went into other residents' rooms, staff tried to intervene and remove her. During interview on 7/10/26 at 9:22 a.m., the LSW stated she was only able to locate one incident report related to R4's resident-to-resident altercations dated 6/22/26. During interview on 7/10/26 at 9:14 a.m., NA-B stated R4 had hit R6 and said when R4 wandered into R6's room, R6 would scream and tell R4 to get out. NA-B had not heard other residents say they were afraid of R4 but a lot of residents made comments about R4. NA-B said R6 and R8 made comments about R4 and stated, I wouldn't be shocked if some of the residents are scared but haven't said anything. NA-B said they have not received training on how to deal with a violent resident, staff tried to remove R4 or give her space when she was agitated. During interview on 7/10/26 at 12:04 p.m., R7's family member (FM)-A stated he was not aware R7 had been hit by R4. FM-A said he did not think R7 would remember the incident other than immediately after. FM-A felt R7 would probably be more nervous than scared. During interview on 7/10/26 at approximately 1:00 p.m., RN-B stated she saw R4 strike R5 on more than one occasion. R5 was very even tempered and could not put two and two together. When R4 went into R7's room, R7 would scream and yell. RN-B said R7 told RN-B she was, scared to death, of R4. R7 closed her door and put a trash can in front of it at night because she was afraid of R4. During interview on 7/10/26 at 1:49 p.m., the interim director of nursing stated the resident-to-resident incidents for R4 towards other residents were not reported because R4 had dementia and no physical injuries had occurred. Facility policy Senior Services Abuse Prevention Plan dated 12/2024, indicated each individual had the right to be free from verbal, sexual, physical and mental abuse including mistreatment, neglect and involuntary seclusion. The policy indicated alleged abuse must be reported to the state agency no later than 24 hours if the events did not result in serious bodily injury.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bigfork Valley Communities		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to thoroughly investigate and failed to implement protection interventions resulting in ongoing incidents of physical abuse for 4 of 6 residents (R4, R5, R6, R7) reviewed for resident-to-resident abuse. Findings include: R4's admission Record indicated she was admitted to the facility 5/21/26. R4's diagnoses included Alzheimer's disease, dementia with behavioral disturbance and aphasia (a communication disorder affecting speech, understanding, reading, and writing due to brain injury). R4's Comprehensive Behavioral assessment dated [DATE], indicated R4 had daily behaviors directed toward staff. R4's behaviors included screaming in the dining room and attempts to argue with other residents, taking other's belongings and food. The assessment indicated R4's behaviors were a safety concern. R4 had advanced dementia and was unable to communicate needs, had aphasia, jumbled words and phrases that did not make sense. R4 admitted from home where she displayed behaviors. Safety concerns related to impulsiveness and was not redirectable. R4's admission Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated she displayed physical, verbal and other behaviors directed toward others. R4's MDS indicated she was able to transfer and ambulate independently. Care Area Assessment (CAA) dated 6/1/26, indicated R4 yelled out at meals, approached other residents with the intention to take their food and would get angry and scream at other residents. It was unclear whether behaviors were provoked or not. R4's behaviors occurred in large crowds and during cares which could signal fear in a new environment. Family reported that R4 displayed the same behaviors in her previous living situation. R4's care plan identified severe dementia with behaviors. Care planned interventions with date initiated indicated: 5/29/26- Leave R4 in a safe place and return with new staff if agitated and/or aggressive. 5/29/26- Started on Seroquel for aggression, physical behaviors of hitting, punching, taking other's belongings and behaviors toward other residents. 5/29/26- Family reported R4 had increased agitation from 11:00 a.m. to 12:00 p.m. She may be getting hungry. Give R4 small snack. 6/12/26- Approach in a calm manner, R4 did not like large groups of people and became agitated during mealtime. 6/12/26- R4 got anxious between 2:00 p.m. and 4:00 p.m., and family suggested having her fold towels. 6/12/26- R4 got anxious eating in common areas and did not like large groups of people, if upset move her to activity area for meal. 6/15/26 Allow R4 to wander or walk to help get rid of energy. Keep her safe and know her whereabouts. R4's care plan lacked evidence and/or interventions for abuse toward other residents. R4's Progress Notes identified the following: 5/21/26- R4 entered another resident's room and screamed when staff attempted to assist her out of the room. 5/22/26- R4 entered other resident rooms. Stop signs were placed across resident room doors and R4 would go under the banner. 5/23/26- During report, staff heard a door slam. R4 was in another resident's room, standing against the door. R4 was pushing on the door trying to prevent staff from entering the room. The other resident was telling R4 to get out but denied any physical altercation. 5/25/26- R4 hit staff, kicked doors and ducked in and out of rooms under the stop sign. 5/27/26- R4 was yelling, aggressive and hit at staff and residents in dining area. 6/7/26- R4's aggressive, violent behaviors had increased over the weekend. Behaviors included R4 entering other resident rooms with terrorizing behaviors. 6/22/26- R4 started pushing another resident (R5) in her wheelchair and ran R5 into a post. After residents went into the dining room, R4 suddenly stood up and struck R5 on the arm. 6/22/26- R9 sat next to R4. R4 became angry and hit the other resident in the leg and chest. 6/25/26- R4 entered other residents' rooms all evening. Took bedding from a sleeping resident, threw another resident's belongings on the floor. R4 had altercation with R6, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bigfork Valley Communities		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wandered into R6's room, became aggressive, grabbed R6's arm and broke R6's bracelets.6/28/26- R4 was observed walking past R7 who was in the doorway of R7's room. R4 hit R7 in the face with an open hand.7/2/26- R4 emerged from her room and unprovoked, walked over and hit R5 who was seated in the common area.7/5/26- R4 was in R7's room and threw an object which hit R7.7/6/26- R4 was hitting, kicking, spitting and yelling at other residents and visiting family.7/7/26- R4 was hitting, kicking, spitting and yelling at other residents.7/9/26/26- R4 was uncooperative and easily enraged with attempt at toileting or cares. Removed own incontinent brief and pants in common area. Another resident told R4 to stop screaming and be nice to staff. R4 later attempted to push another resident in their wheelchair which was unwanted by the other resident who pushed R4's hands away. R4 became upset, yelled loudly and tried to hit the other resident. R4 had socks in her hands and mostly hit the other resident with the socks. Staff had to stand between the two residents.R5R5's admission Record indicated she was admitted to the facility 9/5/23. R5's diagnoses included dementia without behaviors, anxiety and depression.R5's quarterly MDS dated [DATE], identified severe cognitive impairment and indicated she did not display behaviors. R5's MDS indicated she ambulated independently up to 50 feet and required assistance from staff for longer distances.R5's care plan dated 8/15/25, identified behaviors that included crying, wanting to call family and isolating herself in her room. The care plan identified R5 as a vulnerable adult and directed staff to allow her to make choices related to meals, activities and clothing.R6R6's admission Record indicated she was admitted to the facility 7/24/24. R6's diagnoses included dementia, anxiety and depression.R6's quarterly MDS dated [DATE], identified moderate cognitive impairment and indicated she displayed verbal behaviors directed toward others. The MDS indicated R6 ambulated independently with the use of a walker.R6's care plan dated 6/2/25, identified short term memory loss and indicated she displayed verbal aggression toward other residents by making rude comments to them. Behaviors included crying, isolating herself in room and irritability. The care plan further identified R6 as a vulnerable adult due to placement in the facility.R7R7's admission Record indicated she was admitted to the facility 2/6/25. R7's diagnoses included Alzheimer's disease, bipolar disorder and dementia without behaviors.R7's quarterly MDS dated [DATE], identified severe cognitive impairment and indicated she did not display behaviors. R7 ambulated independently with the use of a walker.R7's care plan dated 4/22/26, identified behaviors that included crying, feelings of loneliness, persistent worry and fear. The care plan identified impaired cognitive function and identified her as a vulnerable adult due to medical diagnosis.During interview on 7/9/26 at 3:39 p.m., registered nurse (RN)-A stated a past weekend she worked R4 was on a rampage, screaming, hitting out, scratching, biting and kicking. You never know when it will happen. Staff tried to keep eyes on [R4] but they couldn't catch her every time or always get there in time. When R4 hit other residents, staff tried to step in between the residents. RN-A stated she had seen R4 hit R5, just the other day, R4 hit R5 in the chest with a baby doll. That same weekend, R4 had thrown an object at R7 and hit her but was unsure what was thrown or where it hit R7. RN-A stated when a resident-to-resident incident occurred, a behavior note was placed in the progress note. RN-A said she was not aware if an incident report needed to be completed.During interview on 7/9/26 at 3:59 p.m., with the licensed social worker (LSW) and interim director of nursing (DON), the LSW stated resident-to-resident altercations were documented in the progress notes and an incident report was completed. The LSW said staff were looking at variables to R4's behaviors and had tried different interventions which included a baby doll, one-to-one, music and folding towels. Neither the DON nor the LSW knew what had occurred earlier in the day when R4 was yelling at and became physically aggressive towards other residents. The LSW said staff had been doing a great job of keeping eyes on R4 and attempting to intervene when she was agitated. The LSW (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bigfork Valley Communities		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she had reached out to a behavioral unit to assist with R4's behaviors. During interview on 7/10/26 at 9:04 a.m., licensed practical nurse (LPN)-A stated when R4 did not take her medications she got out of hand and went into other resident rooms. LPN-A said the other day R4 was sitting by the bird cage and unprovoked, hit R5 on the leg. LPN-A said R4 had also been aggressive toward R6 and R7. LPN-A said when R4 was out of control there were stop signs on other residents doors and said she had to shut resident doors, put them on lockdown until R4 calmed down. LPN-A said it bothered the other residents to be stuck in their rooms. LPN-A said if R4 went into other residents rooms, staff tried to intervene and remove R4. During interview on 7/10/26 at 9:22 a.m., the LSW stated she was only able to locate one incident report related to R4's resident-to-resident altercations dated 6/22/26. During interview on 7/10/26 at 12:04 p.m., R7's family member (FM)-A stated he had not been aware R7 had been hit by R4. During interview on 7/10/26 at approximately 1:00 p.m., RN-B stated she saw R4 strike R5 on more than one occasion. R5 was very even tempered and could not put two and two together. When R4 went into R7's room, R7 would scream and yell. RN-B said R7 told RN-B she was, scared to death, of R4. R7 closed her door and put a trash can in front of it at night because she was afraid of R4. RN-B said when a resident-to-resident altercation occurred staff documented in a progress note, no incident report form was completed. During interview on 7/10/26 at 1:49 p.m., the LSW stated after a resident-to-resident incident occurred, staff should have completed an incident report that included which residents were involved, staff who witnessed the incidents and the nature of the incident as well as interventions. The LSW stated staff should have followed-up following the incidents with both skin checks and emotional status of the residents. Facility policy Senior Services Abuse Prevention Plan dated 12/2024, indicated in the event of suspected mistreatment, the needs of the resident will be immediately addressed. Immediate steps should be taken to ensure that no resident remains in danger of mistreatment. Residents responsible party and physician should be notified as soon as possible. Follow up in the form of additional medical and psychological examination and treatment will be documented and implemented.		