DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
November 3, 2023

Administrator
Pioneer Care Center
1131 South Mabelle Avenue
Fergus Falls, MN  56537

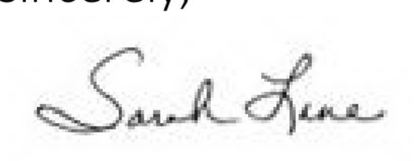
RE: CCN: 245463
Cycle Start Date: September 13, 2023

Dear Administrator:

On October 17, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance.  Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308  Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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November 3, 2023

Administrator
Pioneer Care Center
1131 South Mabelle Avenue
Fergus Falls, MN  56537

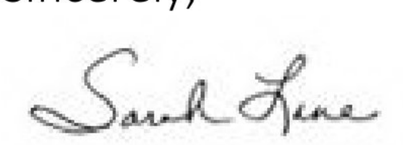
Re: Reinspection Results
Event ID:  4T2712

Dear Administrator:

On October 17, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 13, 2023.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
September 26, 2023

Administrator
Pioneer Care Center
1131 South Mabelle Avenue
Fergus Falls, MN  56537

RE: CCN: 245463
Cycle Start Date: September 13, 2023

Dear Administrator:

On September 13, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 13, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 13, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

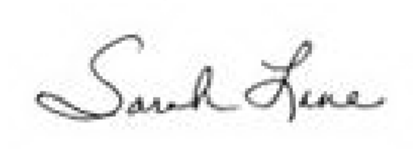
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308  Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered
September 26, 2023

Administrator
Pioneer Care Center
1131 South Mabelle Avenue
Fergus Falls, MN  56537

Re: State Nursing Home Licensing Orders
Event ID: 4T2711

Dear Administrator:

The above facility was surveyed on September 11, 2023 through September 13, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

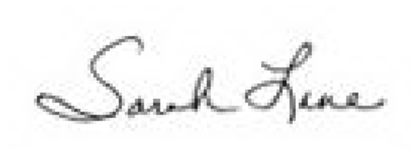
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245463 | A. BUILDING _____ B. WING _____ | C 09/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIONEER CARE CENTER | 1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>On 9/11/23, to 9/13/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 9/11/23, to 9/13/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>In addition to the recertification survey, the following complaints were reviewed:<br><br>The following complaints were reviewed with no deficiencies citted.<br>H54635310C (MN00092610).<br>H54635309C (MN00093435 and MN00093429).<br>H5463083C (MN00081966).<br>H5463082C (MN00082591).<br>H54635303C (MN00086671).<br>H54635306C (MN0088945).<br>H54635304C (MN00091393).<br>H54635305C (MN00093847.<br>H54635307C (MN00096311).<br><br>The following complaint was reviewed.<br>H54635308C (MN00096562) with a deficiency | F 000 | | |

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

Electronically Signed | 10/03/2023

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.

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| PIONEER CARE CENTER | 1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537 |

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| F 000 | Continued From page 1<br>cited at 677.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp<br>CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure residents were assessed for the ability to self administer medications for 2 of 2 residents (R57, R34) observed for medication administration.<br><br>Findings include:<br><br>R57<br><br>R57's Diagnosis Report dated 9/13/23, indicated R57 had diagnoses which included hemiplegia and hemiparesis (paralysis and/or weakness on one side of the body) following cerebral infarction (stroke) of right dominant side, low back pain, | F 554 | R57 and R 34 were reviewed and assessed for appropriateness of Self Administration of Medication orders.<br><br>All residents have the potential to be affected by this practice as all residents have medication orders.<br><br>All residents were assessed for the appropriateness of Self Administration of Medication process.<br><br>Resident Self Administration of Medication policy was reviewed. Licensed Nurses and TMA□s received education on | 10/5/23 |

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| F 554 | Continued From page 2<br>and depression.<br><br>R57's quarterly Minimum Data Set (MDS) assessment dated 7/25/23, indicated R57 was cognitively intact.<br><br>R57's Active Orders as of 9/13/23, included:<br><br>-acetaminophen 650 milligrams (mg) two times a day for pain.<br>-cyclobenzaprine five mg every eight hours as needed for pain related to muscle spasms.<br><br>R57's electronic health record (EHR) lacked a medication self-administration assessment.<br><br>During an observation on 9/11/23 at 6:40 p.m., registered nurse (RN)-A provided R57 with the two medications listed above and R57 stated she did not want to take the medication yet. RN-A stated R57 was approved for self-administration of medications and left the medications at R57's bedside in a paper medication cup for R57 to take at a later time independently.<br><br>-at 7:25 p.m., the medications remained at the resident's bedside in the medication cup.<br><br>During an interview on 9/12/23 at 11:51 a.m., clinical manager (CM)-A reviewed R57's EHR and was unable to find an assessment for self-administration of medications or a physician order for self-administration of medications. CM-A stated the medications should not have been left at R57's bedside.<br><br>R34<br><br>R34's Diagnosis Report dated 9/13/23, indicated | F 554 | Resident Self Administration of Medication Policy on 10/2/2023 and 10/3/2023.<br><br>Random audits will be conducted of appropriateness of Self Administration of Medications, and appropriate assessments/ documentation 4 residents weekly for 6 weeks. Audit results will be reviewed by the<br><br>Quality Assurance Committee, recommendations for follow up by the committee will be followed.<br><br>Date Of Substantial Compliance: 10/5/2023 | |

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| F 554 | Continued From page 3<br>R34 had diagnoses which included bilateral primary open-angle glaucoma (chronic, progressive, and irreversible optic neuropathy with progressive loss of peripheral vision), depression, anxiety, and dependence on supplemental oxygen.<br><br>R34's significant change MDS assessment dated 6/28/23, indicated R34 was cognitively intact.<br><br>R34's Active Orders as of 9/13/23, included:<br><br>-albuterol sulfate HFA aerosol solution 108 (90 Base) micrograms (mcg) per inhalation, one puff inhale every four hours as needed for shortness of breath, wheezing, or cough related to asthma<br>-artificial tears one percent instill two drops in both eyes two times a day for dry eyes and as needed<br>-Atrovent HFA aerosol solution 17 mcg per inhalation, two puffs inhale orally four times a day for shortness of breath related to asthma<br>-ProAir HFA aerosol solution 108 (90 Base) mcg per inhalation, one puff every four hours as needed for shortness of breath<br>-Symbicort aerosol 80-4.5 mcg per inhalation, two puffs two times a day for shortness of breath related to asthma.<br><br>R34's EHR lacked a medication self-administration assessment.<br><br>During an observation and interview on 9/11/23 at 2:24 p.m., in R34's room, her inhalers and eye drops were located in a box in her room. R34 said they were there so she could use them independently as needed.<br><br>During an interview on 9/12/23 at 3:51 p.m., the | F 554 | | |

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| F 554 | Continued From page 4<br>director of nursing (DON) stated residents were able to self administer medications after they had been assessed to safely self administer their medications and a physician's order had been obtained.<br><br>During an interview on 9/13/23 at 10:12 a.m., the consultant pharmacist stated the facility should follow their protocol/procedure to ensure the resident was safe to self-administer medications. When a resident was determined to be safe to administer medications, the facility should have obtained an order from the physician as well.<br><br>The facility policy titled Self-Administration of Medications dated 2/2021, indicated the interdisciplinary team (IDT)would assess each resident's cognitive and physical abilities to determine whether self-administering medications was safe and clinically appropriate for the resident. If the IDT determined it was safe and appropriate for the resident to self-administer their medications, it would be documented in the medical record and in the care plan. | F 554 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission. | F 655 | | 10/5/23 |

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| F 655 | Continued From page 5<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide a summary of the baseline care plan to the resident representative, for 1 of 1 (R3) resident reviewed for care planning. | F 655 | R23 Care Plan was reviewed, a Care Conference was held with resident and representative on 9/15/2023. Baseline Care Plan and current Care Plan were reviewed during Care Conference. | |

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| F 655 | Continued From page 6<br>Findings include:<br><br>R23's quarterly Minimum Data Set (MDS) dated 8/29/23, identified R23 had moderate cognitive impairment and had diagnosis which included anxiety disorder, depression, and seizure disorder. Indicated R23 required extensive assistance with bed mobility and toileting. Identified R23 required limited assistance from staff with transfers and personal hygiene.<br><br>R23's base line care plan dated 5/31/23, identified R23 required staff assistance with personal hygiene and ambulation and was independent with eating after setup. Identified R23 was at risk for falls and directed staff to ensure R23 was wearing proper footwear, and was signed by the clinical manager (CM)-B.<br><br>R 23's face sheet indicated he had been admitted to the facility on 5/31/23.<br><br>During an interview on 9/11/23 at 11:46 a.m., family member (FM)-A stated he had not received a summary of R23's baseline care plan.<br><br>During an interview on 9/13/23 at 11:50 a.m., clinical manager (CM)-B stated she completed R23's baseline care plan and was not able to recall providing R23's representative a summary of the baseline care plan.<br><br>During an interview on 9/13/23 at 12:06 p.m., director of nursing (DON) stated she was unsure why a summary of the baseline care plan was not provided to R23's representative. DON indicated her expectation was a summary of the baseline care plan would have been provided to R23's representative. | F 655 | All residents have the potential to be affected by this practice. Clinical Coordinators conducted a review of the most recent Care Conference dates.<br><br>Policy Care Plan  Baseline was reviewed and updated. Clinical Coordinators, MDS Nurse, Admission Nurse, Social Work Designee  received education on Policy Care Plans- Basic on 10/2/2023, and 10/3/2023.<br><br>The Director of Nursing or designee, will complete random weekly audits of baseline care plans for six (6) consecutive weeks. Random audits will be completed to ensure that baseline care plan summaries are being provided to residents, and that a copy has been placed in the medical record.<br><br>Audit results will be reviewed by the Quality Assurance Committee, recommendations for follow up by the committee will be followed.<br><br>Date Of Substantial Compliance: 10/5/2023 | |

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| F 655 | Continued From page 7<br><br>A facility policy titled Care Plan - Baseline dated 2001, revised 3/22, indicated the baseline care plan includes instructions needed to provide effective, person- centered care of the resident. Identified the resident and/ or representative were provided a written summary of the baseline care plan.<br><br>. | F 655 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary | F 657 | | 10/5/23 |

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| F 657 | Continued From page 8<br>team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to conduct a care planning meeting for 1 of 1 residents (R23) reviewed for care plan.<br><br>Findings include:<br><br>R23's quarterly Minimum Data Set (MDS) dated 8/29/23, identified R23 had moderate cognitive impairment and had diagnosis which included anxiety disorder, depression, and seizure disorder.<br><br>R 23's face sheet indicated he had been admitted to the facility on 5/31/23.<br><br>During an interview on 9/11/23 at 11:46 a.m., family member (FM)-A verified he was the representative for R23. FM-A stated he had not been invited to a care planning conference since R23 had been admitted to the facility. FM-A stated he would have considered attending if he had been invited.<br><br>R23's electronic health record (EHR) identified an admission MDS was completed on 6/6/23, and a quarterly MDS was completed on 8/29/23. The EHR lacked documentation a care conference occurred which included R23 or his responsible representative.<br><br>During an interview on 9/13/23 at 8:59 a.m., health information management (HIM) stated she was responsible for scheduling the care conferences. HIM confirmed R23's EHR lacked | F 657 | On 9/15/2023 the Interdisciplinary Team completed a Care Conference with R23 and Representative.<br><br>All residents of the facility have the potential to be affected by this practice. Clinical Coordinators conducted a review of the most recent Care Conference dates.<br><br>All interdisciplinary care plan team members responsible for coordinating care plan conferences (Social Services Designee, HIS Assistant, Clinical Coordinators, Admission Nurse, MDS Nurse) received education on the facility□s policy and procedure: Care Planning □ Resident Participation on 10/2/2023 and 10/3/2023.<br><br>The Social Services Director, or designee, will conduct a weekly random audit of ten (10) residents for a period of four (4) consecutive weeks to ensure that the resident/resident representative has been invited to a care conference on a regular basis (initial, quarterly etc.).<br><br>Audit results will be reviewed by the Quality Assurance Committee, recommendations for follow up by the committee will be followed.<br><br>Date of Substantial Compliance: | |

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| F 657 | Continued From page 9<br>documentation care conferences had been completed. HIM was unsure why a care conference had not been scheduled for R23.<br><br>During an interview on 9/13/23 at 9:17 a.m., social services designee (SSD) stated HIM scheduled the care conferences. SSD stated she could not recall having a care conference for R23. SSD confirmed R23's EHR lacked documentation of a care conference being held. SSD stated she was unsure why a care conference had not been completed for R23. SSD indicated care conferences were important to collaborate with R23 and his family in managing R23's care.<br><br>During an interview on 9/13/23 at 11:46 a.m., clinical manager (CM)-A stated she did not recall having a care conference for R23 and verified the record lacked documentation of a care conference being held for R23. CM-A stated she was unsure why a care conference had not been held. CM indicated it was important to have care conferences, to invite R23 and his family to collaborate on R23's care.<br><br>During an interview on 9/13/23 at 12:06 p.m., director of nursing (DON) confirmed R23's EHR lacked evidence of a care conference being held. DON stated she was unsure why a care conference had not been held. Indicated it was important to have care conferences to establish and to collaborate about resident's care. DON stated her expectation was all residents would have care conferences and all residents and family representatives would be invited to the care conferences.<br><br>A facility policy titled Care Planning-Resident Participation undated. Indicated the facility | F 657 | 10/5/2023 | |

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| F 657 | Continued From page 10<br>supported the resident's right to be informed of, and participate in, his or her care planning treatment. Indicated the facility would encourage and assist the resident and/ or resident representative to participate in choosing care and treatment options. | F 657 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 2 of 5 residents (R23 and R 63) reviewed for activities of daily living (ADL)'s.<br><br>Findings include:<br><br>R23<br><br>R23's quarterly Minimum Data Set (MDS) dated 8/29/23, identified R23 had moderate cognitive impairment and had diagnosis which included anxiety disorder, depression, and seizure disorder. Indicated R23 required extensive assistance with bed mobility and toileting. Identified R23 required limited assistance from staff with transfers and personal hygiene.<br><br>R23's current care plan dated 5/31/23, indicated R23 had deficits with ADL's related to activity intolerance. R23 required staff assistance with personal hygiene. | F 677 | Oral care was provided for R 64 on 9/13/2023, facial hair was shaved for R 23 on 9/12/2023.<br><br>All residents have the potential to be affected. The RN Clinical Coordinators assessed oral cares, and facial hair removal and interventions on Care Plans for each resident.<br><br>Review of the policy Activities of Daily Living Supporting was completed. Education was provided on this policy to all nursing staff on 10/2/2023 and 10/3/2023.<br><br>The Director of Nursing or designee, will conduct a random audit of at least five (5) residents per week for two (2) months to ensure proper shaving and oral care is being provided according to Care Plan.<br><br>Audit results will be reviewed by the | 10/5/23 |

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| F 677 | Continued From page 11<br><br>R23's comprehensive Care Area Assessment (CAA) dated 6/11/23, identified R23 required assistance with ADL's. Indicated R23 had an activity intolerance.<br><br>During an observation on 9/11/23 at 10:59 a.m., R23 was seated in a recliner in his room and had several dark long facial hair present on his chin, above his lips and on his cheeks which were approximately 1/4 inch or longer.<br><br>During an interview on 9/11/23, at 1:45 p.m., family member (FM)-A stated R23 preferred to be shaved daily.<br><br>During an observation on 9/11/23 at 6:06 p.m., R23 was seated on the edge of his bed and continued to have several long facial hair 1/4 inch or longer on his chin, above his lips and on his cheeks.<br><br>During an observation on 9/12/23 at 8:43 a.m., R23 was seated at the dining room table eating breakfast and continued to have several facial hair 1/4 inch or longer on his chin, above his lips and on his cheeks.<br><br>During an interview on 9/12/23 at 10:00 a.m., nursing assistant (NA)-A stated R23 required set up assistance from staff to shave. NA-A stated she had not assisted him with shaving recently. NA-A indicated she was unsure of when the last time R23 had been shaved and indicated the long dark facial hair on R23's face appeared to be more than a few days growth.<br><br>During an interview on 9/12/23 at 10:05 a.m., NA-B stated staff were required to assist with set | F 677 | Quality Assurance Committee, recommendations for follow up by the committee will be followed.<br><br>Date of Substantial Compliance: 10/5/2023 | |

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| F 677 | Continued From page 12<br>up for R23 to shave when facial hair became visible. NA-B stated he had not assisted NA-B with shaving recently. NA-B indicated the long facial hair on R23's face appeared to be more than a few days growth.<br><br>During an interview on 9/12/23 at 11:34 a.m., licensed practical nurse (LPN-A) stated R23 required set up assistance from staff to shave. LPN-A verified R23 had long facial hair and was uncertain when the last time R23 had been shaved. LPN-A stated her expectation was R23 would have been shaved daily.<br><br>During an interview on 9/12/23 at 3:55 p.m., director of nursing (DON) indicated R23 required staff assistance with shaving. DON stated her expectation was R23 would have been shaved daily or when facial hair was present. | F 677 | | |

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| F 677 | Continued From page 13 | F 677 | | |

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R63

R63's recent significant Minimum Data Set (MDS) dated 7/19/23, identified R63 had moderate cognitive impairment and had diagnosis which included cancer, dementia, and heart failure. Indicated R63 required total assistance of staff for all ADL's.

R63's care plan, revised 9/11/23, indicated R63 had deficits with ADL's and required total staff assistance with all cares.

R63's comprehensive Care Area Assessment

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| F 677 | Continued From page 14<br>(CAA) dated 7/20/23, identified R63 required total assistance from staff with all ADL's. Indicated R63 was on hospice and unable to perform ADL cares independently.<br><br>During an observation on 9/13/23, at 7:05 a.m.. R63 was laying in bed on her back with her head slightly elevated, glasses on and blanket pulled up to her chest. Room lights were shut off and television was shut off. Resident yelled out from her room.<br>- 9/13/23, 7:25 a.m. R63 was awake and looking around the room. R63 remained on her back with head slightly elevated. Glasses were on and call light was within reach.<br>- 9/13/23, 7:51 a.m. R63 continued the same as above.<br>- 9/13/23 8:03 a.m. NA-D and NA-E entered R63's room to provide daily ADL's for R63. NA-D asked R63 if her and NA-E could get her ready for the day. NA-D asked R63 to change her shirt and provided two shirt options. R63 chose a shirt, NA-D and NA-E removed R63's shirt and placed the new shirt on. NA-D placed gloves on and pulled R63's blankets down. NA-D provided directions to R63 to turn and roll and removed soiled brief. NA-D used contents from tube in drawer, placed on wipe and wiped R63's peri area and bottom. NA-D removed gloves and applied new brief under R63. NA-D applied new gloves and instructed R63 to roll to side to get brief pulled up and secured. NA-D removed gloves, pulled blankets up and applied hand sanitizer. NA-D applied gloves, obtained wet wash cloth from the bathroom sink, brought to R63's bedside and washed R63's face with the wet washcloth. NA-D removed gloves. NA-D asked if R63 would like her whiskers removed and R63 replied yes. NA-D stated she would find | F 677 | | |

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| F 677 | Continued From page 15<br>something to remove whiskers and then asked R63 what she would like for breakfast. NA-D then stated she would get R63 something to eat and drink, sanitized hands and left the room. NA-D or NA-E were not observed to provide oral cares.<br><br>During an interview on 9/13/23, at 9:48 a.m. NA-D stated R63 required full assistance from staff with ADL's. NA-D confirmed R63 had not received oral cares during am cares.<br><br>During an interview on 9/13/23, at 11:56 a.m. RN-B indicated R63 required full assistance from staff with ADL's. RN-B indicated his expectations were for staff to provide R63 with assistance of all ADL's which included oral cares.<br><br>During an interview on 9/13/23, at 1:05 p.m. director of nursing (DON) stated R63 required staff assistance from staff with ADL's and was incontinent of both bladder and bowel. DON indicated the expectations were each resident receive ADL cares daily including oral cares. DON stated if R63 refused her expectations would be staff would attempt to provide cares at a later time. If R63 continued to refuse, DON would expect staff to inform the RN and the refusal would be documented.<br><br>Review of a facility policy titled Activities of Daily Living (ADL's) Supporting dated 2001, revised 3/2018, revealed appropriate care and services would be provided for residents who were unable to carry out ADL's independently including: hygiene ( bathing, dressing, grooming, and oral care). | F 677 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3) | F 690 | | 10/5/23 |

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| F 690 | Continued From page 16<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure 1 of 1 | F 690 | Catheter Care was completed for R 78 on 9/12/2023. Catheter was removed | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 690 | Continued From page 17<br>residents(R78) received appropriate ongoing catheter cares reviewed for urinary catheter care.<br><br>Findings include:<br><br>R78's Diagnosis Report dated 9/13/23, indicated R78 had diagnoses which included malignant neoplasm of prostate.<br><br>R78's significant change Minimum Data Set (MDS) assessment dated 6/29/23, indicated R78 was cognitively intact and had an indwelling foley (urinary) catheter.<br><br>R78's significant change Care Area Assessment (CAA) dated 6/30/23, indicated R78 had a foley catheter in place related to a diagnosis of prostate cancer. The CAA identified proceed to care plan to avoid risk and complications related to the indwelling foley catheter.<br><br>R78's care plan dated 6/21/23, indicated R78 had a self-care deficit, had a foley catheter and had a goal to remain free from catheter-related trauma. Interventions included positioning the catheter bag and tubing below the level of the bladder and away from the entrance room door, monitor and document intake and output, monitor for pain and discomfort due to catheter, and monitor for signs and symptoms of infection (pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color and increased pulse and temperature). The care plan lacked information on how to care for the indwelling foley catheter.<br><br>R78's Order Summary Report current as of 9/13/23, directed staff to obtain urinary output (foley catheter) every shift. The report lacked information about catheter cares. | F 690 | 9/14/2023 per MD order.<br><br>Plans of Care were reviewed to determine residents with urinary Catheters.<br><br>Catheter Care, Urinary policy was reviewed. All Nursing staff received education on this policy on 10/2/2023 and 10/3/2023.<br><br>The Director of Nursing or designee will complete random weekly audits on 2 residents to ensure catheter cares are being completed for a total of 6 weeks.<br><br>Audit results will be reviewed by the Quality Assurance Committee, recommendations for follow up by the committee will be followed.<br><br>Date of Substantial Compliance: 10/5/2023 | |

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| | 245463 | A. BUILDING _____ B. WING _____ | C 09/13/2023 |

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| F 690 | Continued From page 18<br><br>During an observation on 9/12/23 at 10:47 a.m., nursing assistant (NA)-C entered R78's room to assist him out of bed and to get ready for the day. NA-C performed hand hygiene, donned gloves, placed a gait belt on R78 and walked with him into the bathroom. NA-C assisted R78 to sit on the toilet and removed his brief. NA-C reminded R78 to use the call light when he was done.<br><br>-at 10:56 a.m., R78 put on his call light, NA-C answered the call light, performed hand hygiene, put on gloves, threaded R78's foley catheter bag through his brief, assisted him to stand, pulled up his brief after wiping his rectal area, walked him to the sink and stood by while R78 washed his hands at the sink. NA-C assisted R78 to walk to his recliner, settled him into his chair, placed a blanket on his lap and exited the room with the garbage.<br><br>During an interview on 9/11/23 at 10:36 a.m., R78 said he believed he had the catheter in place for about two months. R78 stated staff did not cleanse around the catheter tube daily.<br><br>During an interview on 9/12/23 at 11:03 a.m., NA-C stated she did not complete catheter cares and believed the nurses performed R78's catheter cares. NA-C confirmed she had never completed any catheter cares for R78.<br><br>During an interview on 9/12/23 at 11:07 a.m., trained medication aide (TMA)-A stated R78 received catheter cares at bedtime and he would get a bath on Tuesdays and occasionally on Saturdays. TMA-A stated catheter cares had not been completed by her on 9/12/23. TMA-A reviewed R78's electronic health record (EHR) | F 690 | | |

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| F 690 | Continued From page 19<br>and was not able to locate where catheter cares had been documented as completed.<br><br>During a follow-up interview on 9/12/23 at 11:14 a.m., R78 stated staff had never washed around his catheter or his perineal area. R78 stated he received a tub bath twice a week.<br><br>During an interview on 9/12/23 at 11:45 a.m., clinical manager (CM)-A stated the standard of care for an indwelling foley catheter would be for staff to complete catheter and perineal cares at least once daily and to document the cares. CM-A stated catheter care was expected to be completed by the NAs. CM-A reviewed R78's care plan and verified the care plan lacked interventions for catheter cares.<br><br>During an interview on 9/13/23 at 11:38 a.m., the director on nursing (DON) stated the standard of care for residents who had catheters would be for staff to complete catheter care twice daily and as needed to prevent infections.<br><br>The policy Catheter Care, Urinary dated 8/2022, indicated the purpose of catheter care was to prevent urinary catheter-associated complications, including urinary tract infections. The policy indicated perineal care should have been completed daily. | F 690 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the | F 880 | | 10/5/23 |

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| F 880 | Continued From page 20<br>development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. | F 880 | | |

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| F 880 | Continued From page 21<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure oxygen tubing and nasal cannula ( a device that delivers extra oxygen through a tube and into the nose) were stored in a manner to prevent the potential contamination during the use of oxygen for 1 of 1 resident (R5) who utilized oxygen therapy.<br><br>Finding include:<br><br>R5's Diagnosis Report dated 9/13/23, indicated R5 had diagnoses which included heart failure (a disease in which the heart does not pump as well as it should), dementia, chronic respiratory failure with hypoxia (low oxygen levels in the blood stream), and cognitive communication deficit. | F 880 | R5□s Oxygen tubing/ nasal cannula was changed on 9/12/2023.<br><br>Residents Care Plans were reviewed to determine which residents used Oxygen Therapy.<br><br>Oxygen Administration policy was reviewed. All Nursing Staff received education on this policy on 10/2/2023 and 10/3/2023.<br><br>The Director of Nursing or designee will complete random weekly audits on 2 residents each week to ensure Oxygen Administration is being administered correctly. Monitoring of placement and | |

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| F 880 | Continued From page 22<br>R5's quarterly Minimum Data Set (MDS) assessment dated 8/17/23, indicated R5 was severely cognitively impaired and used oxygen. Identified R5 was dependent on staff for activities of daily living.<br><br>R5's care plan dated 8/16/23, indicated R5 had a potential for altered respiratory status related to heart failure with hypoxia. R5's interventions included to keep R5's oxygen saturations greater than 88% by applying oxygen.<br><br>R5's Order Summary current as of 9/13/23, indicated R5 had an order for oxygen at two liters per nasal cannula at all times three times a day for hypoxemia with chronic respiratory failure.<br><br>During an observation on 9/11/23 at 12:01 p.m., R5 was lying in bed and she did not have her oxygen on. R5's nasal cannula was on the floor under the bed, no date identified on the tubing and oxygen was running at two liters per minute.<br><br>During an observation on 9/12/23 at 2:03 p.m., R5 was observed lying in bed her and oxygen tubing was draped over the dresser in her room with the nasal cannula resting on the floor behind the dresser.<br><br>During an observation on 9/12/23 at 3:57 p.m., R5 rested in bed while receiving oxygen at two liters per nasal cannula.<br><br>During an interview on 9/12/23 at 3:59 p.m., registered nurse (RN)-A stated she had applied oxygen to R5 as she had checked R5's oxygen saturations and they were noted to be 87%. RN-A verified she used the nasal cannula that had been draped over the dresser. RN-A stated she had not | F 880 | changing of tubing/ cannula are being completed for a total of 6 weeks.<br><br>Audit results will be reviewed by the Quality Assurance Committee, recommendations for follow up by the committee will be followed.<br><br>Date Of Substantial Compliance: 10/5/2023 | |

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| F 880 | Continued From page 23<br>noticed the nasal cannula was on the floor however verified it should have been changed prior to applying it to R5.<br><br>During an interview on 9/13/23 at 11:46 a.m., the director of nursing (DON) stated she believed oxygen tubing was changed monthly and the tubing should have been dated. The DON verified she would expect staff to retrieve new oxygen tubing if the nasal cannula had been left on the floor to prevent the potential spread or development of infection.<br><br>The policy Oxygen Administration dated 2023, indicated oxygen tubing and mask/cannula should have been changed weekly and as needed when it had been soiled or contaminated. | F 880 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following: | F 883 | | 10/5/23 |

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| F 883 | Continued From page 24<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 3 of 5 residents (R7, R37, R41) were offered or received pneumococcal | F 883 | R7,R37,R41 pneumococcal vaccinations were offered and administered in accordance to CDC recommendations. | |

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| F 883 | Continued From page 25<br>vaccinations in accordance with the Center for Disease Control (CDC) recommendations.<br><br>Findings include:<br><br>Review of the Pneumococcal Vaccine Timing for Adults, dated 3/15/23, from the CDC identified adults 65 years of age or older who had previously received the Pneumococcal 13-valent Conjugate Vaccine (PCV13) and the Pneumococcal Polysaccharide Vaccine 23 (PPSV23) should receive one dose of the 20-valent Pneumococcal Conjugate Vaccine (PCV20).<br><br>Review of R7's Minnesota Immunization Information Connection (MIIC) identified R7 had received the PCV-13 vaccination on 4/23/15, and the PPSV23 vaccination on 10/04/07. R7's medical record lacked documentation R7 had been offered or received the PCV20 vaccination.<br><br>Review of R37's MIIC identified R37 had received the PCV-13 vaccination on 12/12/16, and the PPSV23 vaccination on 11/23/04. R37's medical record lacked documentation R37 had been offered or received the PCV20 vaccination.<br><br>Review of R41's MIIC identified R41 had received the PCV-13 vaccination on 5/9/16, and the PPSV23 vaccination on 11/06/00. R41's medical record lacked documentation R41 had been offered or received the PCV20 vaccination.<br><br>During an interview on 9/13/23 at 1:02 p.m., the director of nursing (DON confirmed the updated pneumococcal guidelines issued by the CDC on 3/15/23. DON reviewed residents' immunization records and confirmed the medical records | F 883 | All residents have the potential to be affected by this practice.<br><br>Pneumococcal Vaccine policy was reviewed. All Licensed Nurses received education on this policy on 10/2/2023 and 10/3/2023.<br><br>The Director of Nursing or designee will complete random weekly audits on 2 residents each week to ensure Pneumococcal Vaccines are being offered in accordance with CDC recommendations for a total of 6 weeks.<br><br>Audit results will be reviewed by the Quality Assurance Committee, recommendations for follow up by the committee will be followed.<br><br>Date Of Substantial Compliance: 10/5/2023 | |

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| F 883 | Continued From page 26<br>lacked documentation of the PVC20 vaccination. The DON stated her expectation were residents would be offered or receive pneumococcal vaccinations according to CDC guidelines upon admission and thereafter in accordance to the CDC recommendations.<br><br>Review of facility policy titled, Pneumococcal Vaccine updated 3/22, identified all residents would be offered pneumococcal vaccinations to aid in prevention of pneumococcal infections. Upon admission, residents would be provided information on the pneumococcal vaccinations and would be offered pneumococcal vaccinations after reviewing the residents pneumococcal vaccination history. Administration of pneumococcal vaccinations or revaccination would be made in accordance to CDC recommendations at the time of the vaccination. | F 883 | | |

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| | 245463 | A. BUILDING **02 - MAIN BLDG TWO** B. WING _____ | **09/12/2023** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/12/2023. At the time of this survey, Pioneer Care Center Building 02 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Electronically Signed | | 11/01/2023 |

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.

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| K 000 | Continued From page 1<br>HEALTH CARE FIRE INSPECTIONS<br>STATE FIRE MARSHAL DIVISION<br>445 MINNESOTA STREET, SUITE 145<br>ST. PAUL, MN 55101-5145, or<br><br>By e-mail to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>The facility was surveyed as two buildings. Pioneer Care Center is made up of two buildings. Building 02 is 2-stories without a basement and is built of Type II (111) construction. Building 03 is a 1-story building without a basement, built of Type V (111).<br><br>The building is fully sprinkler protected and has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor, and all common areas that is monitored for automatic fire department notification. In addition, the | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245463 | A. BUILDING **02 - MAIN BLDG TWO** B. WING _____ | **09/12/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PIONEER CARE CENTER** | **1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | Continued From page 2<br>sleeping rooms have smoke detection in them, and all hazardous areas have automatic fire detection.<br><br>The facility has a licensed capacity of 105 beds and had a census of 85 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 245463 | MULTIPLE CONSTRUCTION A. BUILDING: **02 - MAIN BLDG TWO** B. WING _____ | DATE SURVEY COMPLETE: **9/12/2023** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PIONEER CARE CENTER** | **1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| **K 753** | Combustible Decorations<br>CFR(s): NFPA 101<br><br>Combustible Decorations<br>Combustible decorations shall be prohibited unless one of the following is met:<br>o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.<br>o Decorations meet NFPA 701.<br>o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.<br>o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).<br>o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.<br>19.7.5.6<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to limit flammable decorations per NFPA 101 (2012 edition), Life Safety Code, section 19.7.5.6. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/12/2023 at 12:45 PM, it was revealed by observation that room D206 had 75-80 percent of the wall surface covered with pictures and other items. During the time of the survey a large quilt that covered at least 30-40 percent of the wall was removed by maintenance staff.<br><br>An interview with the Environmental Service Director verified this deficient finding at the time of discovery. |

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

**The above isolated deficiencies pose no actual harm to the residents**