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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6J2P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00443

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245463**

2.STATE VENDOR OR MEDICAID NO.
(L2) **707342900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PIONEER CARE CENTER**
(L4) **1131 SOUTH MABELLE AVENUE**
(L5) **FERGUS FALLS, MN** (L6) **56537**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/25/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
X Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEJI 08/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/11/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/11/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/24/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/12/2014
(L33)

DETERMINATION APPROVAL

CCN: 245463

On July 25, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 28, 2014, the Minnesota Department of Public Safety to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey (related to complaint number H5463019, completed on May 30, 2014 and a standard survey completed on June 12, 2014. We presumed, based on their plan of correction, that your facility had corrected these deficiencies as of July 17, 2014. Based on our PCR, we have determined that the facility has corrected the deficiencies issued pursuant to our abbreviated standard survey completed May 30, 2014 and standard survey, completed on June 12, 2014, as of July 9, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of June 26, 2014. The CMS Region V Office concurs and has authorized this Department to notify the facility these actions:

Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 30, 2014, be rescinded. (42 CFR 488.417 (b))

In our letter of June 26, 2014, we advised the facility that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), the facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 30, 2014, due to denial of payment for new admissions. Since the facility attained substantial compliance on July 9, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b forms for the standard survey, abbreviated standard survey and life safety code.

Effective July 9, 2014, the facility is certified for 105 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5463

August 8, 2014

Mr. Nathan Johnson, Administrator
Pioneer Care Center
1131 South Mabelle Avenue
Fergus Falls, Minnesota 56537

Dear Mr. Johnson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 9, 2014 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

August 5, 2014

Mr. Nathan Johnson, Administrator
Pioneer Care Center
1131 South Mabelle Avenue
Fergus Falls, Minnesota 56537

RE: Project Number S5392024, H5463019

Dear Mr. Johnson:

On July 2, 2014, CMS Region V Office informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 30, 2014. (42 CFR 488.417 (b))

Also, CMS Region V Office notified you their letter of June 26, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 30, 2014.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on May 30, 2014 and a standard survey completed on June 12, 2014. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On July 25, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 28, 2014, the Minnesota Department of Public Safety to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on May 30, 2014 and a standard survey completed on June 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey completed May 30, 2014 and standard survey, completed on June 12, 2014, as of July 9, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of June 26, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 30, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 30, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 30, 2014, is to be rescinded.

In our letter of June 26, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 30, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 9, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5463r14ohfc&lc

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245463	A. Building B. Wing	7/25/2014

Name of Facility	Street Address, City, State, Zip Code
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program , to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **07/06/2014**	ID Prefix **F0160** Reg. # **483.10(c)(6)** LSC	Correction Completed **07/06/2014**	ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **07/06/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **07/06/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/mm	08/08/2014	32603	07/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/12/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245463	A. Building B. Wing **02 - MAIN BLDG TWO**	7/28/2014

Name of Facility	Street Address, City, State, Zip Code
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0022	Correction Completed **07/02/2014**	ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **07/02/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 08/08/2014	**Signature of Surveyor:** 27200	**Date:** 07/28/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/10/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00443	A. Building B. Wing	7/25/2014

Name of Facility	Street Address, City, State, Zip Code
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20480** Reg. # **MN Rule 4658.0260 Subp. 4** LSC	Correction Completed **07/06/2014**	ID Prefix **20500** Reg. # **MN Rule 4658.0275 Subp. 2** LSC	Correction Completed **07/06/2014**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp. 7** LSC	Correction Completed **07/06/2014**
ID Prefix **21710** Reg. # **MN Rule 4658.1415 Subp. 7** LSC	Correction Completed **07/06/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/mm	08/08/2014	32603	07/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/12/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6J2P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00443

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245463**
2.STATE VENDOR OR MEDICAID NO.
(L2) **707342900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PIONEER CARE CENTER**
(L4) **1131 SOUTH MABELLE AVENUE**
(L5) **FERGUS FALLS, MN** (L6) **56537**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/12/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 07/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 08/06/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/11/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

June 26, 2014

Mr. Nathan Johnson, , Administrator
Pioneer Care Center
1131 South Mabelle Avenue
Fergus Falls, MN 56537

RE: Project Number H5463019, S5463024

Dear Mr. Johnson:

On June 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on May 30, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On June 12, 2014, the Minnesota Departments of Health and Public Safety completed a standard survey 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 to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:•

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 30, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 30, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 30, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Pioneer Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective August 30, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following
address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Gail Anderson, Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Phone: (218) 332-5140
Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 30, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	06/12/2014

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
F 000	INITIAL COMMENTS The facility's plan of correction (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 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal	F 159		7/6/14

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

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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F 159	Continued From page 1 funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide quarterly statements for residents or their legal representatives for 33 of 33 residents (R2, R4, R10, R12, R14, R20, R21, R27, R31, R33, R34, R36, R45, R66, R67, R68, R69, R74, R78, R84, R86, R90, R94, R98, R100, R102, R105, R116, R129, R133, R200, R201, and R202) with a balance in their personal fund accounts with the facility. Findings include: R33 had a personal funds account with the facility and the annual Minimum Data Set dated 5/23/14, identified R33 was cognitively intact.	F 159	On June 18, 2014, the business office sent out Resident Trust Statements to the responsible parties of R2, R4, R10, R14, R20, R21, R27, R31, R33, R34, R36, R45, R66, R67, R68, R69, R74, R78, R 84, R86, R90, R94, R98, R100, R102, R105, R 116, R 129, R133, R200, R201 and R202. A letter addressing the fact that statements had not been sent out previously was sent to these responsible parties from the CFO. On June 30th, 2014 an audit was completed to obtain a list of all residents with a Resident Trust Account.	

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F 159	Continued From page 2 During interview on 6/9/14, at 4:54 p.m. R33 stated she did not routinely receive a quarterly personal fund statement from the facility. R33 stated she would need to speak to the facility administrative assistant during business hours to inquire about the balance of money in her personal fund account. Review of the facility document, titled Trust Account Current Balance, dated 6/11/14, identified 46 resident personal funds accounts. Thirty three of the accounts were identified with balances. On 6/12/14, at 1:38 p.m., the facility chief financial officer (CFO) stated the required quarterly statements of activity in the remaining residents' personal funds accounts had not been provided for the past year. The CFO confirmed there had been one resident's family member who had requested, and been provided, a statement of their family member's personal funds account, but did not have information on the identity of the resident. The facility policy titled, Assisting Residents in Managing their Personal Funds, dated January, 2011, directed that the resident or the resident's legal representative would be provided with a quarterly accounting of the resident's funds on deposit with the community.	F 159	The policy Assisting Resident in Managing Their Person Funds was updated stating Resident Trust Statements will be provided at least quarterly to the resident or responsible party. The CFO completed education of the business office staff on July 2, 2014 regarding the updated policy. The CFO will audit monthly for three months that the statements for the Resident Trust Account have been sent out. The results of the audits will be reviewed by the Quarterly Quality Assurance Committee and further direction will be taken from this Committee.	
F 160 SS=C	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final	F 160		7/6/14

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F 160	Continued From page 3 accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to convey the balance of a personal funds account within 30 days after a resident's death, to the appropriate party, for 2 of 8 residents (R201, R202) reviewed for conveyance of funds upon death. Findings include: On 6/11/14, at 2:08 p.m., the facility chief financial officer (CFO) provided a list of residents that had personal funds accounts managed by the facility, who had passed away in the previous three months. Review of the records provided revealed the following: R201 had died on 9/12/13, and R201 had a remaining balance of $830.08 in a resident trust account that had not been conveyed to family, the resident's estate, or responsible party. R202 died on 11/9/13, and R202 had $90.51 in a resident trust account. The facility had sent a check from the resident trust account to R202's responsible party, however the check was dated 3/31/14, four months and 22 days after R202's death. During interview on 6/12/14, at 1:38 p.m., the CFO confirmed there were balances remaining in trust for residents who had died more than thirty days prior. CFO indicated she understood the	F 160	R 201 responsible party had received the remaining Resident Trust Fund balance on 11/9/13 and R 202 responsible party had received the remaining Resident Trust Fund balance on 3/31/2014. On June 30th, 2014 an audit was completed to obtain a list of all residents with a Resident Trust Account. The policy Assisting Resident in Managing Their Person Funds was updated stating upon death of a resident the funds will be distrusted to the resident□s responsible party within 30 days. The CFO completed education of the business office staff on July 2, 2014 regarding the updated policy. The CFO will audit monthly for three months to assure Resident Trust Account Funds are distributed within 30 days after death of a resident. The results of the audits will be reviewed by the Quarterly Quality Assurance Committee and further direction will be taken from this Committee.	

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F 160	Continued From page 4 facility was required to send the money to resident's responsible party within 90 days after death. Review of the facility policy titled, Assisting Residents in Managing their Personal Funds, approved 1/11, lacked instruction for conveyance of resident personal funds upon death.	F 160		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based observation, interview and document the facility failed to ensure the state survey results were readily accessible to review, this had the potential to affect all 100 residents residing in the facility and visitors. Findings include On 6/9/14, 12:00 p.m. during initial tour survey results were initially unable to be located, at 6:30 p.m. survey results were located on the second floor reception desk, left side top counter of desk behind a foliage plant. The survey results were in	F 167	This had the potential to affect all residents. The policy Providing Resident and Families with Information of Survey Results was reviewed. Postings were placed at the two main entrances of the building stating the location of the most recent survey results. The location of the survey results is in a three ring binder accessible to all visitors and residents on receptionist desk on second floor.	7/6/14

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F 167	Continued From page 5 a three ringed binder with 2013 survey results and plan of correction. However the binder was completely behind the plant which was 18 inches in height with full, broad shaped leaves. The foliages' diameter exceeded the binder thus blocking it from view. In addition, the binders title was against the wall, not visible without picking up binder. No notice of where the survey results could be found were observed in the facility. On 6/10/14 at 8:30 a.m., 6/11/14 at 7:00 a.m. and again on 6/12/14 at 8:00 a.m., the state survey results were observed in the same location, behind the foliage plant on the second floor reception desk of the facility. No notice of where the survey results could be found were observed. On 6/12/14, 9:20 a.m. during interview with R44, a resident council representative, she stated she didn't know where the survey results were located in the facility and indicated she would have to ask staff the location of the results. On 6/12/14, 2:15 p.m. during interview with R86 he stated he routinely was in the halls of the facility and did not know where the survey results were located. R86 also stated he understood the survey results should be on a bulletin board in the facility, but had not seen the results on the bulletin board. On 6/12/14, 2:45 p.m. the director of nursing (DON) verified placement of survey results from 2013 were located on the second floor reception desk behind a foliage plant. She confirmed the facility had not posted a notice for the location of the results. The DON confirmed that residents	F 167	Audits will be conducted monthly for three months by the Director of Nursing, to assure the postings are visible at the entrances, and the survey results are easily accessible on the receptionist desk. Results of Audits will be reviewed at Quarterly Quality Assurance Meeting, and recommendations for follow up by the team will be followed.	

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F 167	Continued From page 6 and visitors would not be able to see them behind the plant and would have to ask staff to view the survey results. Review of the facility policy titled Providing Residents and Families with Information of Survey Results and Advocacy Agencies, dated April 2011, directed a copy of the statement of deficiencies from the most recent survey and complaint survey would be available to residents, family members, and the public without asking a community representative. Further, the procedure directed staff that a notice of where the most recent survey results was to be posted at the two main entrances to the community.	F 167		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure sanitary storage of resident food related to opened and undated resident food containers in 2 of 6 neighborhoods. In addition, the facility failed to distribute food in a sanitary manner in 1 of 6 dining rooms in the facility.	F 371	The refrigerator/freezer on both Short Stay and Apple Blossom have been cleaned and all items are now labeled with the date the item was opened/prepared and product name. Also, all expiration items and unservable items such as moldy fruit have been discarded.	7/17/14

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F 371	Continued From page 7 Findings Include: During the initial tour of the facility on 6/9/14 at 1:33 p.m. a side by side refrigerator/freezer was observed in the kitchenette area on the short term stay unit, on the first floor. The following food items lacked a label to identify the date the item was opened or prepared. The refrigerator contained one carafe of cranberry juice, one carafe of apple juice, one plastic baggy that contained white shredded cheese, one carton of thickened cranberry juice half full, and one plastic carton of chocolate milk half full with an expiration date of 6/8/14, which was discarded by cook (C)-A who was present on tour. At 1:48 p.m. during the tour a side by side refrigerator/freezer was observed in the kitchenette area on apple blossom unit, located on the first floor. The following food items lacked a label to identify the date the item was opened or prepared. The refrigerator contained one plastic baggy that contained feta cheese, one plastic baggy of cherry tomatoes, one large plastic bag of shredded lettuce, and a plastic container of strawberries, half full with gray fuzzy mold growing on them, which was thrown away by dietary aid (DA)-A who was present on tour. During interview on 6/9/14 C-A confirmed the food items were not dated, and verified that they should have been dated. He indicated he was not aware when the food items had been placed in the refrigerator. During interview on 6/9/14 at 1:48 DA-A	F 371	To ensure this does not occur any where else in the facility all other household and main kitchen refrigerators have been cleaned and checked to ensure all items are labeled with date and item name, outdated items are discarded and no moldy or unservable food. A mandatory inservice will be held for all homemakers/cooks/chef on Thursday, July 17, 2014 to cover the above concerns and proper handwashing and glove use. QA audits of all household and main kitchen refrigerators will be completed weekly by neighborhood coordinators, dietitian, as well as peer review (homemakers and nursing staff) and reported to the QA committee quarterly. QA audits on handwashing and proper glove use will be completed weekly x 1 month then monthly on all households by neighborhood coordinators and dietitian. Results will be reported to the QA committee quarterly.	

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F 371	Continued From page 8 confirmed the food items were not dated, and stated "we normally do date stuff once it is opened." During interview on 6/12/14 at 12:41 p.m. dietary manager (DM) verified facility policy and stated "we date everything that is a hazardous food." She confirmed that she would expect staff to date, initial, and put the name of product on the package once it is opened. She also indicated dietary personnel were not responsible for routine inspections of the unit refrigerators and indicated nursing personnel were responsible for inspections. During interview on 6/12/14 at 1:55 p.m. unit coordinator (UC) verified that food items should have a label on them that requires the date and initials when opened. She also confirmed that this is what she would expect of the staff working in the kitchenettes. On 6/9/14 from 5:35 p.m. to 5:48 p.m. homemaker (HM)-H was observed serving the evening meal, which consisted of sloppy Joe sandwiches, to the residents in the Deerwood	F 371		

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F 371	Continued From page 9	F 371		

neighborhood. HM-H wore vinyl type gloves on both hands and stood near the steam table in the dining room. At 5:35 p.m., with both gloved hands HM-H picked up a clip board, turned the pages on the clip board, and placed the clipboard on the black colored counter on the right side of the steam table. HM-H immediately picked up a rectangular shaped white bun, placed a portion of meat mixture on the bun, and proceeded to place on bun on an individual resident plate. She then placed her gloved hand on the top of the bun and cut the bun in half with a knife. HM-H repeated this process, using dirty gloved hands to place the buns and meat mixture on individual resident places for the entire observation period.

On 6/9/14 at 6:15 p.m., HM-H verified she had handled the papers and clipboard, served resident food items and had not changed gloves or washed hands before serving the ready to eat items.

On 6/12/14 at 12:06 p.m. director of nursing (DON) confirmed the current facility policy and stated anytime staff touch food with gloves and touch something else they need to remove the gloves, wash hands and apply new gloves.

A facility procedure titled Hand Hygiene for Team Members who Prepare Food, revised 7/26/14, identified staff were to wash hands as often as necessary to remove soil and to prevent cross contamination when changing task.

Review of the facility policy titled Food Storage, revised on 2/11/10, indicated left over food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and

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F 371	Continued From page 10 dated before being refrigerated. Left over food is used within 3 days or discarded.	F 371		

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	245463	A. BUILDING **02 - MAIN BLDG TWO** B. WING _____	**06/10/2014**

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	INITIAL COMMENTS FIRE SAFETY Building 02 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. 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Care Center was not found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/02/2014

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.

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 _____	**06/10/2014**

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was surveyed as two buildings. Pioneer Care Center is made up of two buildings. Building 02 main building is a 2-story, without a basement and is Type II (111) construction. Building 03 is a 1-story building without a basement, Type V (000). The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 2007 edition. The facility has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 2007 edition. The fire alarm is monitored for automatic fire department notification. The sleeping rooms have smoke detection in them and all hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition.	K 000		

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	245463	A. BUILDING **02 - MAIN BLDG TWO** B. WING _____	**06/10/2014**

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K 000	Continued From page 2 The facility has a licensed capacity of 105 beds and had a census of 101 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify 2 of several non-required exit doors leading to the exterior that do not lead to the public way in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.1.7 and 7.10.8.1 These deficient practices could negatively affect 30 of 105 residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 11:30 AM and 3:30 PM on 06/10/2014, observations revealed that the doors leading to the enclosed courtyards from the dining room that are located in the Apple Blossom	K 022	Doors leading to the enclosed courtyards on Apple Blossom and Short Stay now have "NO EXIT" sign posted on them of required size. As per Environmental Director or Designee.	7/2/14

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K 022	Continued From page 3 and Short Stay Wings were not marked as "NO EXIT". These doors are not part of a required exits for the facility and need to display a sign that reads as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO". This deficient practice was confirmed by the Director of Maintenance.	K 022		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 18.3.2.1. The following deficient practice could negatively affect residents, staff, and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 11:30 AM and 3:30 PM	K 029	Penetration now has been sealed using materials having at least a two hour fire resistance rating. As per Environmental Director.	7/2/14

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K 029	Continued From page 4 on 06/10/2014, observation revealed, that there was a penetration in the wall around the sprinkler pipe located in the elevator equipment room that is located in the southwest corner of the Mechanical Wing. This deficient practice was confirmed by the Director of Maintenance.	K 029		

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	245463	A. BUILDING **03 - SOUTH BLDG 3** B. WING _____	**06/10/2014**

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

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K 000	INITIAL COMMENTS FIRE SAFETY Building 03 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Pioneer Care Center 02 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility was surveyed as two buildings. Pioneer Care Center is two buildings built in 2011. Building 02 main building is a 2-story, without a basement and is Type II (111) construction. Building 03 is a 1-story building without a basement and Type V (111) construction. Both buildings are fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 2007 edition. The facility has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 2007 edition. The fire alarm is monitored for automatic fire department notification. The sleeping rooms have smoke detection in them and all hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The facility has a licensed capacity of 105 beds	K 000	EPOC	

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

Electronically Signed | 07/02/2014

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K 000	Continued From page 1 and had a census of 101 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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	00443	A. BUILDING: _____ B. WING _____	06/12/2014

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On June 9, 10, 11, 12, 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

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2 000	Continued From page 1 Certification Program, 1505 Pebble Lake Road, Suite 300 Fergus Falls, MN 56537	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 480	MN Rule 4658.0260 Subp. 4 Personal Fund Accounting and Records Subp. 4. Financial record. The resident's financial record must be available through quarterly statements and on request to the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident. This MN Requirement is not met as evidenced	2 480		7/6/14

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2 480	Continued From page 2 by: Based on interview and document review, the facility failed to provide quarterly statements for residents or their legal representatives for 33 of 33 residents (R2, R4, R10, R12, R14, R20, R21, R27, R31, R33, R34, R36, R45, R66, R67, R68, R69, R74, R78, R84, R86, R90, R94, R98, R100, R102, R105, R116, R129, R133, R200, R201, and R202) with a balance in their personal fund accounts with the facility. Findings include: R33 had a personal funds account with the facility and the annual Minimum Data Set dated 5/23/14, identified R33 was cognitively intact. During interview on 6/9/14, at 4:54 p.m. R33 stated she did not routinely receive a quarterly personal fund statement from the facility. R33 stated she would need to speak to the facility administrative assistant during business hours to inquire about the balance of money in her personal fund account. Review of the facility document, titled Trust Account Current Balance, dated 6/11/14, identified 46 resident personal funds accounts. Thirty three of the accounts were identified with balances. On 6/12/14, at 1:38 p.m., the facility chief financial officer (CFO) stated the required quarterly statements of activity in the remaining residents' personal funds accounts had not been provided for the past year. The CFO confirmed there had been one resident's family member who had requested, and been provided, a statement of their family member's personal funds account, but did not have information on	2 480	Complete	

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2 480	Continued From page 3 the identity of the resident. The facility policy titled, Assisting Residents in Managing their Personal Funds, dated January, 2011, directed that the resident or the resident's legal representative would be provided with a quarterly accounting of the resident's funds on deposit with the community. SUGGESTED METHOD OF CORRECTION: The chief financial officer or designee could audit to ensure residents are receiving quarterly statements of their personal fund accounts. The quality assurance committee could design a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 480		
2 500	MN Rule 4658.0275 Subp. 2 Return of Funds After Discharge or Death Subp. 2. Death of a resident. Upon the death of a resident, a nursing home must convey the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to convey the balance of a personal funds account within 30 days after a resident's death, to the appropriate party, for 2 of 8 residents (R201, R202) reviewed for conveyance of funds upon death.	2 500	Complete	7/6/14

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2 500	Continued From page 4 Findings include: On 6/11/14, at 2:08 p.m., the facility chief financial officer (CFO) provided a list of residents that had personal funds accounts managed by the facility, who had passed away in the previous three months. Review of the records provided revealed the following: R201 had died on 9/12/13, and R201 had a remaining balance of $830.08 in a resident trust account that had not been conveyed to family, the resident's estate, or responsible party. R202 died on 11/9/13, and R202 had $90.51 in a resident trust account. The facility had sent a check from the resident trust account to R202's responsible party, however the check was dated 3/31/14, four months and 22 days after R202's death. During interview on 6/12/14, at 1:38 p.m., the CFO confirmed there were balances remaining in trust for residents who had died more than thirty days prior. CFO indicated she understood the facility was required to send the money to resident's responsible party within 90 days after death. Review of the facility policy titled, Assisting Residents in Managing their Personal Funds, approved 1/11, lacked instruction for conveyance of resident personal funds upon death. SUGGESTED METHOD OF CORRECTION: The chief financial officer or designee could audit to ensure all balances of personal funds are conveyed after a resident death. The quality	2 500		

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2 500	Continued From page 5 assurance committee could design a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 500		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure sanitary storage of resident food related to opened and undated resident food containers in 2 of 6 neighborhoods. In addition, the facility failed to distribute food in a sanitary manner in 1 of 6 dining rooms in the facility. Findings Include: During the initial tour of the facility on 6/9/14 at 1:33 p.m. a side by side refrigerator/freezer was observed in the kitchenette area on the short term stay unit, on the first floor. The following food items lacked a label to identify the date the item was opened or prepared. The refrigerator contained one carafe of cranberry juice, one carafe of apple juice, one plastic baggy that contained white shredded cheese, one carton of thickened cranberry juice half full, and one plastic carton of chocolate milk half full with an expiration	21015	Complete	7/17/14

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21015	Continued From page 6 date of 6/8/14, which was discarded by cook (C)-A who was present on tour. At 1:48 p.m. during the tour a side by side refrigerator/freezer was observed in the kitchenette area on apple blossom unit, located on the first floor. The following food items lacked a label to identify the date the item was opened or prepared. The refrigerator contained one plastic baggy that contained feta cheese, one plastic baggy of cherry tomatoes, one large plastic bag of shredded lettuce, and a plastic container of strawberries, half full with gray fuzzy mold growing on them, which was thrown away by dietary aid (DA)-A who was present on tour. During interview on 6/9/14 C-A confirmed the food items were not dated, and verified that they should have been dated. He indicated he was not aware when the food items had been placed in the refrigerator. During interview on 6/9/14 at 1:48 DA-A confirmed the food items were not dated, and stated "we normally do date stuff once it is opened." During interview on 6/12/14 at 12:41 p.m. dietary manager (DM) verified facility policy and stated "we date everything that is a hazardous food." She confirmed that she would expect staff to date, initial, and put the name of product on the package once it is opened. She also indicated dietary personnel were not responsible for routine inspections of the unit refrigerators and indicated nursing personnel were responsible for inspections. During interview on 6/12/14 at 1:55 p.m. unit coordinator (UC) verified that food items should	21015		

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21015	Continued From page 7 have a label on them that requires the date and initials when opened. She also confirmed that this is what she would expect of the staff working in the kitchenettes. On 6/9/14 from 5:35 p.m. to 5:48 p.m. homemaker (HM)-H was observed serving the evening meal, which consisted of sloppy Joe sandwiches, to the residents in the Deerwood neighborhood. HM-H wore vinyl type gloves on both hands and stood near the steam table in the dining room. At 5:35 p.m., with both gloved hands HM-H picked up a clip board, turned the pages on the clip board, and placed the clipboard on the black colored counter on the right side of the steam table. HM-H immediately picked up a rectangular shaped white bun, placed a portion of meat mixture on the bun, and proceeded to place on bun on an individual resident plate. She then placed her gloved hand on the top of the bun and cut the bun in half with a knife. HM-H repeated this process, using dirty gloved hands to place the buns and meat mixture on individual resident places for the entire observation period. On 6/9/14 at 6:15 p.m., HM-H verified she had handled the papers and clipboard, served resident food items and had not changed gloves or washed hands before serving the ready to eat items. On 6/12/14 at 12:06 p.m. director of nursing (DON) confirmed the current facility policy and stated anytime staff touch food with gloves and touch something else they need to remove the gloves, wash hands and apply new gloves. A facility procedure titled Hand Hygiene for Team	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00443	A. BUILDING: _____ B. WING _____	06/12/2014

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21015	Continued From page 8 Members who Prepare Food, revised 7/26/14, identified staff were to wash hands as often as necessary to remove soil and to prevent cross contamination when changing task. Review of the facility policy titled Food Storage, revised on 2/11/10, indicated left over food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Left over food is used within 3 days or discarded. SUGGESTED METHOD OF CORRECTION: The Director Of Nursing and the Dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner, and is stored in a sanitary condition. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis to ensure staff are following safe food handling practices, and food items are labeled and dated on all units. The quality assurance committee could design a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance	21710		7/6/14

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21710	Continued From page 9 Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an environment that was free of accident hazards, related to hot water temperatures in 10 of 10 resident bathrooms (R17, R23, R24, R25, R28, R44, R84, R129, R134 and R166) tested for safe water temperatures. Findings include: During the environmental tour on 6/12/14, at 12:15 p.m. the director of maintenance (DM) checked the water temperatures with the facility monitor. The following water temperatures were observed: -R17's resident bathroom was 120 degrees Fahrenheit (F), -R23's resident bathroom was 117 degrees F, -R24's resident bathroom was 118 degrees F, -R25's resident bathroom was 118 degrees F, -R28's resident bathroom was 120 degrees F, -R44's resident bathroom was 120 degrees F, -R84's resident bathroom was 120 degrees F, -R129's resident bathroom was 116 degrees F, -R134's resident bathroom was 118 degrees F, -R166's resident bathroom was 118 degrees F. During interview on 6/12/14, at 12:30 p.m. the DM	21710	complete	

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21710	Continued From page 10 confirmed the water temperatures were above the acceptable temperature of 115 degrees F. He indicated he felt the facility water thermometer wasn't the best as it had curved glass on the top and was difficult to read, and stated the facility would be getting a digital thermometer in the future. The DM confirmed that all maintenance staff were aware of the maximum acceptable temperature of 115 degrees F, and stated he had not heard of any complaints of the water being too hot. During interview on 6/12/14, at 1:51 p.m. the director of nursing and the administrator both confirmed they had not received any complaints from residents or staff of the water being too hot. Review of the facility's monthly water temperature audit form, revealed that audits were completed 3 out of the 4 past months, with the latest audit completed on 4/28/14. The audits lacked a documented temperature for resident rooms for 6 of 6 units identified on the facility audit tracking log. Review of the facility's Safety of Water Temperatures policy dated April 2010, directed that water temperatures are to be no more than 105-115 degrees F. Water temperatures are to be tested periodically and temperatures to be documented on a safety log. SUGGESTED METHOD FOR CORRECTION: The Environmental Director, Director of Nursing and/or designee could monitor and develop a system to review water temperatures at the resident level on a weekly basis to ensure they	21710		

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21710	Continued From page 11 are between 105 and 115 degrees Fahrenheit. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21710		