	nin op neomi	N SERVICES		CENTERS FOR ME	DICARE & MEDICAID SERVICES
	-			ON AND TRANSMITTAL	ID: 9Q5I
	PART I -	TO BE COMPI	LETED BY THE	STATE SURVEY AGENCY	Facility ID: 00443
1. MEDICARE/MEDICAID PROVID (L1) 245463	ER NO.	3. NAME AND AI (L3) PIONEER (DRESS OF FACILITY		4. TYPE OF ACTION: 7 (L8)
2.STATE VENDOR OR MEDICAID I	NO		H MABELLE AVEN	UE	1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 707342900		(L5) FERGUS FA		(L6) 56537	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	 PROVIDER/SU 01 Hospital 	JPPLIER CATEGORY 05 HHA 09 H	<u>02</u> (L7) SRD 13 PTIP 22 CLIA	8. Full Survey After Complaint
	8/2016 (L34)	02 SNF/NF/Dual	06 PRTF 10 N		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct		CF/IID 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP 12 H	HC 16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED AS:		
From (a):		A. In Complia	ance With	And/Or Approved Waivers Of	f The Following Requirements:
To (b) :		0	equirements	2. Technical Personne	6. Scope of Services Limit
			e Based On:	3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	105 (L18)	1. A	cceptable POC	4. 7-Day RN (Rural S	
13.Total Certified Beds	105 (L17)	B. Not in Comp	liance with Program	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied Waiver	8: * Code: A *	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1):	(L15)
105					
(L37) (L38)	(L39)	(L42)	(L43)		
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION DATE	:	
	× ·				
17. SURVEYOR SIGNATURE		Date :		18. STATE SURVEY AGENC	
Denis Erickson, HFE NEII		C	3/24/2016	Enforcement	
				19)	
			(I		(L20)
РА	RT II - TO BE	COMPLETED		NAL OFFICE OR SINGLE S	
PA 19. DETERMINATION OF ELIGIBID		20. COM	BY HCFA REGIO	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina	STATE AGENCY ancial Solvency (HCFA-2572)
	LITY	20. COM	BY HCFA REGIO	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513)
19. DETERMINATION OF ELIGIBII	LITY Participate e	20. COM	BY HCFA REGIO	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Contr	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513)
 DETERMINATION OF ELIGIBII _X_ 1. Facility is Eligible to 1 	LITY Participate	20. COM	BY HCFA REGIO	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Contr	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513)
 DETERMINATION OF ELIGIBII _X_ 1. Facility is Eligible to 1 	LITY Participate e	20. COM RIGI	BY HCFA REGIO	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Contr	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 2. Facility is not Eligible 	LITY Participate e (L21)	20. COM RIGI MENT 2.	BY HCFA REGIC IPLIANCE WITH CIV HTS ACT:	NAL OFFICE OR SINGLE S L 21. 21. 1. Statement of Final 2. Ownership/Contra 3. Both of the Abox 26. TERMINATION ACTION	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID 1. Facility is Eligible to 1 2. Facility is not Eligible 22. ORIGINAL DATE 	LITY Participate e (L21) 23. LTC AGREE	20. COM RIGI MENT 2.	BY HCFA REGIC IPLIANCE WITH CIV HTS ACT: 4. LTC AGREEMENT	NAL OFFICE OR SINGLE \$ L 21. 1. Statement of Final 2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 	LITY Participate e (L21) 23. LTC AGREE	20. COM RIGI MENT 2.	BY HCFA REGIC IPLIANCE WITH CIV HTS ACT: 4. LTC AGREEMENT	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Conti 3. Both of the Above 26. TERMINATION ACTION VOLUNTARY 0	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 _2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 	LITY Participate e (L21) 23. LTC AGREEI BEGINNINC	20. COM RIGI MENT 2. ; DATE	BY HCFA REGIC IPLIANCE WITH CIV HTS ACT: 4. LTC AGREEMENT ENDING DATE	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Contract 3. Both of the Above 26. TERMINATION ACTION VOLUNTARY 0 01-Merger, Closure	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) /e :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 _2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 	LITY Participate e (L21) 23. LTC AGREEI BEGINNINC (L41) 27. ALTERNATI	20. COM RIGI MENT 2. ; DATE	BY HCFA REGIC IPLIANCE WITH CIV HTS ACT: 4. LTC AGREEMENT ENDING DATE	NAL OFFICE OR SINGLE S L 21. 2. Ownership/Contr 3. Both of the Abov 26. TERMINATION ACTION VOLUNTARY 0 01-Merger, Closure 02-Dissatisfaction W/ Reimburg	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re : W: (L30) D INVOLUNTARY 05-Fail to Meet Health/Safety sement 06-Fail to Meet Agreement ion OTHER
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 _2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE: 	LITY Participate e (L21) 23. LTC AGREEI BEGINNING (L41) 27. ALTERNATI A. Suspension	20. COM RIGH MENT 2- B DATE VE SANCTIONS of Admissions:	BY HCFA REGIC IPLIANCE WITH CIV HTS ACT: 4. LTC AGREEMENT ENDING DATE	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Contra 3. Both of the Abovent 3. Both of the Abovent 3. Both of the Abovent 26. TERMINATION ACTION VOLUNTARY 0 01-Merger, Closure 0 0 02-Dissatisfaction W/ Reimburg 0 0 03-Risk of Involuntary Termination 0	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 _2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 	LITY Participate e (L21) 23. LTC AGREEI BEGINNING (L41) 27. ALTERNATI A. Suspension	20. COM RIGI MENT 2. 5 DATE VE SANCTIONS	BY HCFA REGIC IPLIANCE WITH CIV HTS ACT: 4. LTC AGREEMENT ENDING DATE (L25) (L44)	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Contra 3. Both of the Abovent 3. Both of the Abovent 3. Both of the Abovent 26. TERMINATION ACTION VOLUNTARY 0 01-Merger, Closure 0 0 02-Dissatisfaction W/ Reimburg 0 0 03-Risk of Involuntary Termination 0	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 _2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE: 	LITY Participate e (L21) 23. LTC AGREEI BEGINNINC (L41) 27. ALTERNATI A. Suspension B. Rescind St	20. COM RIGI MENT 2- 3 DATE VE SANCTIONS n of Admissions: Ispension Date:	BY HCFA REGIC IPLIANCE WITH CIV ITS ACT: 4. LTC AGREEMENT ENDING DATE (L25) (L44) (L45)	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Contract 3. Both of the Above 26. TERMINATION ACTION VOLUNTARY 0 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 _2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE: 	LITY Participate e (L21) 23. LTC AGREEI BEGINNINC (L41) 27. ALTERNATI A. Suspension B. Rescind St	20. COM RIGI MENT 2. 5 DATE VE SANCTIONS n of Admissions: Ispension Date:	BY HCFA REGIC IPLIANCE WITH CIV ITS ACT: 4. LTC AGREEMENT ENDING DATE (L25) (L44) (L45)	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Contra 3. Both of the Abovent 3. Both of the Abovent 3. Both of the Abovent 26. TERMINATION ACTION VOLUNTARY 0 01-Merger, Closure 0 0 02-Dissatisfaction W/ Reimburg 0 0 03-Risk of Involuntary Termination 0	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 _2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE: 	LITY Participate e (L21) 23. LTC AGREEI BEGINNINC (L41) 27. ALTERNATI A. Suspension B. Rescind St	20. COM RIGI MENT 2- 3 DATE VE SANCTIONS n of Admissions: Ispension Date:	BY HCFA REGIC IPLIANCE WITH CIV ITS ACT: 4. LTC AGREEMENT ENDING DATE (L25) (L44) (L45) /CARRIER NO.	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Contract 3. Both of the Above 26. TERMINATION ACTION VOLUNTARY 0 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal 30. REMARKS	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 _2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE: 	LITY Participate e (L21) 23. LTC AGREEI BEGINNINC (L41) 27. ALTERNATI A. Suspension B. Rescind St	20. COM RIGI MENT 2. 5 DATE VE SANCTIONS n of Admissions: Ispension Date:	BY HCFA REGIC IPLIANCE WITH CIV ITS ACT: 4. LTC AGREEMENT ENDING DATE (L25) (L44) (L45)	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fina 2. Ownership/Contract 3. Both of the Above 26. TERMINATION ACTION VOLUNTARY 0 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal 30. REMARKS	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 _2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE: (L27) 28. TERMINATION DATE: 	LITY Participate e (L21) 23. LTC AGREEI BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind St 25 (L28)	20. COM RIGI MENT 2. DATE VE SANCTIONS to of Admissions: Ispension Date: . INTERMEDIARY, 03001	BY HCFA REGIC IPLIANCE WITH CIV HTS ACT: 4. LTC AGREEMENT ENDING DATE (L25) (L44) (L45) /CARRIER NO. (L	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fin: 2. Ownership/Contract 3. Both of the Abovential Statement of the Abovent of the Abovential Statement of the Abovent	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :
 19. DETERMINATION OF ELIGIBID _X_ 1. Facility is Eligible to 1 _2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE: 	LITY Participate e (L21) 23. LTC AGREEI BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind St 25 (L28)	20. COM RIGI MENT 2. DATE VE SANCTIONS to of Admissions: Ispension Date: . INTERMEDIARY, 03001	BY HCFA REGIC IPLIANCE WITH CIV ITS ACT: 4. LTC AGREEMENT ENDING DATE (L25) (L44) (L45) /CARRIER NO.	NAL OFFICE OR SINGLE S L 21. 1. Statement of Fin: 2. Ownership/Contract 3. Both of the Abovential Statement of the Abovent of the Abovential Statement of the Abovent	STATE AGENCY ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re :



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245463

May 3, 2016

Ms. Sara Watkins, Administrator Pioneer Care Center 1131 South Mabelle Avenue Fergus Falls, Minnesota 56537

Dear Ms. Watkins:

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 March 1, 2016 the above facility is certified for:

105 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 skilled 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 Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 24, 2016

Ms. Sara Watkins, Administrator Pioneer Care Center 1131 South Mabelle Avenue Fergus Falls, Minnesota 56537

RE: Project Number S5463026

Dear Ms. Watkins:

On February 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 28, 2016. 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 March 18, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 25, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 28, 2016, effective March 1, 2016 and therefore remedies outlined in our letter to you dated February 15, 2016, will not be imposed.

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.

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

An equal opportunity employer

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		[DATE OF REVIS	IT
	B. Wing	Y2	2 3	3/18/2016	Y3
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).

ITEI	Μ	DATE	ITEM		DATE	ITEM		DAT	E
Y4		Y5	Y4		Y5	Y4		Y5	
ID Prefix	F0225	Correctio	n ID Prefix FC)226	Correction	ID Prefix	F0279	Corre	ection
Reg. #	483.13(c)(1)(ii)-(i - (4)	i), (c)(2) Complete	d Reg. # 483	3.13(c)	Completed	Reg. #	483.20(d), 483.20(^{k)(1)} Comp	oleted
LSC		03/01/2016	LSC		03/01/2016	LSC		03/01/	2016
ID Prefix	F0282	Correctio	ID Prefix FC)314	Correction	ID Prefix	F0323	Corre	ection
Reg. #	483.20(k)(3)(ii)	Complete	d Reg. # ⁴⁸³	3.25(c)	Completed	Reg. #	483.25(h)	Comp	oleted
LSC		03/01/2016	LSC		03/01/2016	LSC		03/01/	2016
ID Prefix		Correction	n ID Prefix		Correction	ID Prefix		Corre	ection
Reg. #		Complete	d Reg. #		Completed	Reg. #		Comp	oleted
LSC			LSC			LSC			
ID Prefix		Correctio	ID Prefix		Correction	ID Prefix		Corre	ection
Reg. #		Complete	d Reg. #		Completed	Reg. #		Comp	oleted
LSC			LSC			LSC			
ID Prefix		Correctio	ID Prefix		Correction	ID Prefix		Corre	ection
Reg. #		Complete	d Reg. #		Completed	Reg. #		Comp	oleted
LSC			LSC			LSC			
REVIEWE			DATE	SIGNATU	RE OF SURVEYOR		[DATE	
STATE AG		(INITIALS) GA/m	m 03/24/201	.6	31256		(03/18/201	6
REVIEWE CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			C	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/28/2016		COMPLETED ON		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					NO

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	IT
IDENTIFICATION NUMBER	A. Building 03 - SOUTH BLDG 3				
245463 _{Y1}	B. Wing	Y2	2	2/25/2016	Y3
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).

ITEM	DATE	ITEM	DATE	ITEM		DATE
Y4	Y5	Y4	Y5	Y4		Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
NFPA 101 Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC K0025	02/18/2016	LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	•	DATE	
	TL/mm	03/24/2016	36536			5/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY	COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICAT PART I - TO BE COMPLETED BY THI					ID: 9Q5I Facility ID: 00443
1. MEDICARE/MEDICAID PROVIDER N (L1) 245463 2.STATE VENDOR OR MEDICAID NO. (L2) 707342900		3. NAME AND ADE (L3) PIONEER C4 (L4) 1131 SOUTH (L5) FERGUS FAI	ARE CENTER MABELLE AVE LLS, MN	NUE	(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
5. EFFECTIVE DATE CHANGE OF OWN (L9)	VERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
 6. DATE OF SURVEY 01/28 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	2016 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 105 (L37) (L38)	105 (L18) 105 (L17) 19 SNF (L39)	X B. Not in Comp	ce With uirements Based On: cceptable POC		And/Or Approved Waivers Of TH 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	e Following Requirements:
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):			
17. SURVEYOR SIGNATURE	Ell	Date :	3/08/2016	(L19)	18. STATE SURVEY AGENCY A Mark Mean Enforcement Spec	ialist 03/10/2016
	PART II - TO	BE COMPLETEI) BY HCFA RE		OFFICE OR SINGLE STA	(L20) TE AGENCY
 DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Part <u>2</u>. Facility is not Eligible 			PLIANCE WITH C TS ACT:	IVIL	 Statement of Finan Ownership/Control Both of the Above 	Interest Disclosure Stmt (HCFA-1513)
_X 1. Facility is Eligible to Part	icipate	RIGH			2. Ownership/Control	Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to Part 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987	(L21) 23. LTC AGREEM BEGINNING	RIGH ENT 24	TS ACT: 4. LTC AGREEME ENDING DATE	NT	 Ownership/Control Both of the Above 26. TERMINATION ACTION: 	Interest Disclosure Stmt (HCFA-1513) (L30) 0 INVOLUNTARY 05-Fail to Meet Health/Safety
1. Facility is Eligible to Part 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION	icipate (L21) 23. LTC AGREEM	RIGH ENT 2: DATE E SANCTIONS of Admissions:	TS ACT: 4. LTC AGREEME	NT	2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY</u> 01-Merger, Closure	Interest Disclosure Stmt (HCFA-1513)
L Facility is Eligible to Part 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE: (L27)	icipate (L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	RIGH ENT 2. DATE E SANCTIONS of Admissions: pension Date:	TS ACT: 4. LTC AGREEME ENDING DATE (L25) (L44) (L45)	NT	2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	Interest Disclosure Stmt (HCFA-1513) (L30) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement OTHER 07-Provider Status Change
L. Facility is Eligible to Part 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE:	icipate (L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	RIGH ENT 2- DATE E SANCTIONS of Admissions: pension Date: . INTERMEDIARY/C/	TS ACT: 4. LTC AGREEME ENDING DATE (L25) (L44) (L45)	NT	2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination	Interest Disclosure Stmt (HCFA-1513) (L30) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement OTHER 07-Provider Status Change
L Facility is Eligible to Part 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE: (L27)	icipate (L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	RIGH ENT 2. DATE E SANCTIONS of Admissions: pension Date:	TS ACT: 4. LTC AGREEME ENDING DATE (L25) (L44) (L45)	NT	2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	Interest Disclosure Stmt (HCFA-1513) (L30) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement OTHER 07-Provider Status Change
L Facility is Eligible to Part 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/11/1987 (L24) 25. LTC EXTENSION DATE: (L27)	icipate (L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus 29 (L28)	RIGH ENT 2- DATE E SANCTIONS of Admissions: pension Date: . INTERMEDIARY/C/	TS ACT: 4. LTC AGREEME ENDING DATE (L25) (L44) (L45) ARRIER NO.	NT ; (L31)	2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	Interest Disclosure Stmt (HCFA-1513) (L30) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement OTHER 07-Provider Status Change



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 15, 2016

Ms. Sara Watkins, Administrator Pioneer Care Center 1131 South Mabelle Avenue Fergus Falls, Minnesota 56537

RE: Project Number S5463026

Dear Ms. Watkins:

On January 28, 2016, a standard 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 constitute actual harm that is not immediate jeopardy (Level G).

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

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, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: gail.anderson@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 8, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 8, 2016 the following remedy will be imposed:

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

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 remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- 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 the respective deficiencies (if any) is acceptable.

Pioneer Care Center February 15, 2016 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite 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 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 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 April 28, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

Pioneer Care Center February 15, 2016 Page 5 issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 July 28, 2016 (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 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525 Pioneer Care Center February 15, 2016 Page 6

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 Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

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

		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245463	B. WING _			01/	28/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				31 SOUTH MABELLE AVENUE		
				FE	ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	0			
F 225 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substa regulations has beet your verification. 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INE The facility must no been found guilty of mistreating residen had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must en involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with (c)(2) - (4) PORT DIVIDUALS at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ties. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law I procedures (including to the	F 22	25			3/1/16
							(X6) DATE
	ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		02/19/2016
	iouny olyneu						02/10/2010

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.

PRINTED: 03/08/2016

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM /	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245463	B. WING _		01/2	28/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 1	F 22	25		
	The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.					
	by: Based on interview facility failed to imm administrator, imme Agency (SA), and fa investigation for 1 o alleged abuse in the Findings include: R55's quarterly Min 1/5/16, identified R8 required assistance	NT is not met as evidenced y and document review, the hediately report to the ediately report to the State ailed to conduct a thorough of 1 residents (R55) who e facility. imum Data Set (MDS) dated 55 was cognitively intact and e with activities of daily living dentified R55 had diagnoses		 R 55 and R 64 a thorough inves has been completed by the Adminis Director of Nursing, and Social Sen Director according to facility policy a procedure regarding the 12/6/15 an 1/26/16 allegations. All residents were reviewed; all residents residing at Pioneer Care a Vulnerable Adults, all residents hav potential to be affected by this. All violations involving mistreatment ar misappropriation of resident prope 	strator, vices and id are e the alleged id	
	which included Parl	kinson's disease, anxiety and r, the MDS identified R55 had		administrator and investigated follor facility Abuse Prevention Plan.	-	
	needed a safe envir identified R55 had i	ised 1/11/16, identified R55 ronment. The care plan also mpaired cognitive or impaired thought processes		3) Facility s Abuse Prevention Plar reviewed which included, 1) Screen potential hires; 2) Training of emplo (both for new employees and ongoi	ning Nyees	

Facility ID: 00443

If continuation sheet Page 2 of 54

PRINTED: 03/08/2016

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · /	E SURVEY PLETED
		245463	B. WING			01/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 225	Continued From pa	age 2	F 2	225			
	related to disease p disease and R55 has and anti-anxiety me for side effects. On 1/25/16, at 10:3 to the facility by fam the facility social wo (DON) and clinical of received a report vi member on 12/6/15 had reported allega regarding a male vi some staff member facility investigate th On 1/25/16, at 2:05 aware of the 12/6/1 made by R55 a little remember anything She stated she did had been complete regarding R55's alle if the allegations has the administrator. In investigated the allegations first administrator and S have reported the a then investigated at She stated if staff w allegations they wo staff member. DON what their policy dir	A contract of the second secon			 training for all employees); 3) Prevere policies and procedures 4) Identified of possible incidents or allegations need investigation; 5)Investigation 7 incidents and allegations 6)Protectine residents during an investigation 7) Reporting of incidents and investigations and to state agency, and facility responsible results of the investigations and Timely reporting to the Administrator state agencies of incidents and allegations. The Accidents and Incidents Policy reviewed and updated, stating the I Accident form will be submitted to the Director of Nursing or her designee. The Abuse Prevention Plan, and Ada and Incident Policy will be reviewed all staff on Feb 26th and 29th,2016 Additional training will be conducted all licensed nursing staff, social word and Administrator, thorough investig of incidents and allegations, and prevention of further abuse while the investigation is in process. 4) The Director of Nursing and or designee will conduct audits, of incidents and allegations are thoroughly investigated, and the facility prevention and allegations are thoroughly investigated, and the facility prevention of success. 	cation which of on of ations se to 1 8) or and was ncident he scident l with ccident l with ccident l with ccident l with ccident l with ccident l with ccident l with ccident l with ccident l with ccident l with ccident co the idents ts	
	On 1/25/16, at 2:10	p.m. administrator stated she ne sexual abuse allegations				n is in	

Facility ID: 00443

If continuation sheet Page 3 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245463	B. WING			01/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PIONEEI	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	reported by R55. SI any allegations of s immediately to the s confirmed they sho allegations first and On 1/25/16, at 2:27 aware of the allega She stated she did the SA because she investigated, staff a decided there was need was not an incident but there should ha stated they typically best judgement and an incident or allega On 1/26/16, at 1:32 the presence of her (POA). POA stated abuse allegations to friends they reporte allegations to R55's contacted the SW, report the allegatior had observed staff resident and with ea period of time. She after she was admit stated the most rec the night before las and a female reside reply to R55's daug mom doesn't want i not much we can de On 1/26/16, at 5:00	he stated she would expect exual abuse to be reported SA and the administrator. She uld have reported the then investigated. p.m. SW stated she was tions made by R55 on 12/6/15. not report the allegations to e just didn't, and after she and R64 denied the abuse she no abuse. She confirmed there report for R55's allegations we been progress notes. SW instruct staff to make their d decide if they should report ation or not. p.m. R55 was interviewed in healthcare power of attorney after R55 reported the sexual o her and 2 other family d R55's sexual abuse a daughter. R55's daughter DON and CC-A via email to ns on 12/6/15. R55 stated she having sexual relations with a ach other many nights over a stated it started immediately tted to the nursing home. She ent sexual relations happened t between a male staff person ent. The POA stated the SW's hter in December was, "Your to give us names, so there is	F2	225	documentation to identify any unrep incidents, as well as staff interviews Random audits will occur weekly for month, then monthly for three mont Results of audits will be reported to Quality Assurance Committee and further recommendations. 5) Corrective Action Completed by 1st , 2016.	s. or one ths. o the follow	

CENTEI STATEMENT AND PLAN C	RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER R CARE CENTER SUMMARY STA (EACH DEFICIENCY	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245463 TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	 S 1 F		FORM <u>MB NO.</u> (X3) DATE COM 01/2	03/08/2016 APPROVED 0938-0391 E SURVEY PLETED 28/2016 (X5) COMPLETION DATE
F 225	majority of the sexu between a male sta resident. R55 state any staff or residen afraid of retaliation. in her and 2 other fa November-early De her room most nigh relations with her ro also reported staff among each other of the most recent sex night before last be a female resident. S reporting this most the facility and indic misconduct betwee female resident the Deerwood unit at 1 ⁻¹ On 1/26/16, at 5:15 notified of sexual m member and a reside evening at 11:30 p. On 1/27/16, at 2:57 an email in Decemb indicating R55 had stated they talked to really feel like there He stated the inves talking with R55 and know what we woul and indicated the S the allegations to th didn't have anything reporting was some a team. He stated a	ail relations she reported was aff person and a female d she was unwilling to identify t by name because she was POA stated R55 had confided amily friends in late ecember that a man came into nts and would engage in sexual commate. She stated R55 had were engaging in sexual acts during the night. She stated kual relations happened the tween a male staff person and She agreed to surveyor to recent allegation of abuse to cated the incident of sexual en a male staff person and a e night before last on the	225	DEFICIENCY)		

Facility ID: 00443

If continuation sheet Page 5 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245463	B. WING _			01/:	28/2016
NAME OF !	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				31 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	stated he never dis R55 again and it ha stated he didn't kno again, but she was services for R55 an On 1/27/16, at 3:33 the team who inves allegations reported 1/26/16. She stated for the 1/26/16, alle majority of the inves R64 and nursing as in the allegations. S practical nurse (LPI last night. She state for contacting NA-E last night. She state talked to them last she revised R55's of entries in both R55' from the 12/6/15, all the abuse allegation after she responded 12/11/15, the invest confirmed printed e She stated nothing R64's medical reco were not substantia On 1/27/16, at 5:06 worked in the facilit the Deerwwod unit had not gotten a ho his shift because he stated NA-B worked R55 or R64 becaus morning. She said s	cussed the allegations with ad never come up again. He ow if the SW talked to R55 responsible for the social ad R64. B.p.m. SW stated she was on stigated the sexual abuse d to her 12/6/15 and on d they filed a report with the SA egations and completed the stigation last night. She stated She stated NA-B and licensed N)-B were assigned to that unit ed the DON was responsible and LPN-B prior to their shift ed she wasn't sure if the DON night or not. She confirmed care plan today and made late 's and R64's medical records llegations. She stated when ns were made 12/6/15, she felt d to R55's daughter's email on tigation was completed. She emails and provided copies. was documented in R55 and ord because the allegations		25			

If continuation sheet Page 6 of 54

		AND HUMAN SERVICES			FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245463	B. WING		01/	28/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	R64 denied the abu	JSE.	F 22	5		
	officer (CEO) stated identified NA)-B as abuse allegations. If completed their inve- completely comforts that night even thou in the abuse allegat interviewed regardin he felt confident that because R64 denie was aware of the se December. He stated December allegation allegations to the S credible staff perso He stated he felt the interview any other	 p.m. the chief executive d he was aware R55 had the alleged perpetrator in the He stated the facility estigation last night and he felt able allowing NA-B to work ugh NA-B had been identified tion and had not been ng the allegations. He stated at the allegations were not true ed the abuse. CEO stated he exual abuse allegations in ed the SW investigated the ons and they didn't report the A because the SW was a n and R64 denied the abuse. e facility did not need to residents because this was CEO stated he felt the facility 				
	because the allegat stated he was confi complete investigat delusions. He state people were engag home. The adminis the interview, stated interviewed R55 or facility because the the abuse and he d administrator stated thorough investigat night.	view NA-B or other staff tion was just not true. He ident the facility conducted a tion and that R55 was having ed R55 also told him groups of ing in sex within the nursing strator, who was present during d the policeman never R64 after being called to the facility told them R64 denied lidn't need to. The d she too felt they completed a ion and it was completed last				

If continuation sheet Page 7 of 54

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	ING		FORM MB NO. (X3) DATE	03/08/2016 APPROVED 0938-0391 E SURVEY PLETED
		245463	B. WING			01/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	because they inves allegations were no allegations were rep were too many unki allegations they had felt confident with the stated she felt they She stated SW tool was a team decisio of sexual abuse. SS received the approp services support from regarding the allegat handled everything facility would invest report to SA after the allegations were rep Review of the Accid revised 2/2014, rev incidents involving representation. The nurse/and/or the dir compete a Report of submit the original to the incident or accid ensure that the admit the report for each Review of the Abus revised 8/1/05, reve- suspected incident neglect or injury of a notified immediately a resident incident/a	o the SA in December tigated and determined the treportable. She stated the ported now because there nown variables in the d to rule out. SSD stated she he facility's investigation and did a complete investigation. K the lead in December and it n not to report the allegations SD stated she felt R55 priate amount of social om December until now ations. She stated she felt they correctly. She stated the igate the allegations and then hey determined if the portable or not. dents and Incidents policy, ealed all accidents or residents occurring on our nvestigated and reported to 'he nurse supervisor shall of Incident/Accident form and to the DON within 24 hours of dent, and the DON shall ninistrator receives a copy of	F	225			

If continuation sheet Page 8 of 54

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO (X3) DAT	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		IPLETED	
		245463	B. WING _		01/	28/2016	
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
PIONEEI	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 225	to include the inves identified residents during an investigat	ige 8 tigation and results. The policy shall be protected from harm tion and alleged perpetrators during an investigation.	F 22	25			
F 226 SS=D	483.13(c) DEVELO	P/IMPLMENT	F 22	26		3/1/16	
	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.						
	by: Based on interview failed to follow their related to the imme Agency (SA), and t	NT is not met as evidenced y and record review, the facility Vulnerable Adult Policy ediate reporting to the State to conduct a thorough of 1 residents (R55) who e facility.		1) R55 and R 64 a thorough inv has been completed by the Adm Director of Nursing, and Social S Director according to facility poli procedure regarding the 12/6/15 1/26/16 allegations.	inistrator, Services cy and		
	revised 2/2014 reversions involving residents shall be investigate administrator. The investigate administrator is a compete a Report of submit the original the incident or accircles.	dents and Incidents policy, ealed all accidents or incidents occurring on our premises d and reported to the nurse supervisor/charge rector or supervisor shall of Incident/Accident form and to the DON within 24 hours of dent, and the DON shall ninistrator receives a copy of occurrence.		 2) All residents were reviewed, a residents residing at Pioneer Ca Vulnerable Adults, all residents I potential of being affected by thi alleged violations involving mistin neglect, or abuse, including injurunknown source and misappropresident property are reported to agency and administrator and infollowing facility Abuse Prevention I reviewed which included, 1) Scr potential hires; 2) Training of em (both for new employees and or 	re are have the s. All eatment, ries of riation of state vestigated on Plan. Plan was eening ployees		

Event ID:9Q5I11

Facility ID: 00443

If continuation sheet Page 9 of 54

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES			E CONSTRUCTION (X3	(3) DATE	0938-039 SURVEY
NU PLAN (F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMP	LETED
		245463	B. WING _			01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				31 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIC DATE
F 226	Continued From pa Review of the Abus	-	F 22	26	training for all employees); 3) Prevent	tion	
	Review of the Abuse Prevention Plan policy, revised 8/1/05 revealed if an incident or suspected incident of abuse, mistreatment, neglect or injury of unknown source be reported immediately to the SA and the administrator notified immediately. The policy further identified a resident incident/accident report must be completed for all accidents or incidents and was to include the investigation and results. The policy identified residents shall be protected from harm during an investigation and alleged perpetrators will be suspended during an investigation.				policies and procedures 4) Identificat of possible incidents or allegations wh need investigation; 5)Investigation of incidents and allegations 6)Protection residents during an investigation 7) Reporting of incidents and investigation	tion hich n of ons	
					to state agency, and facility response the results of the investigations and 8 Timely reporting to the Administrator a state agencies of incidents and allegations.	3)	
	1/5/16 identified R5 required assistance (ADLs). The MDS in which included Park	imum Data Set (MDS) dated 5 was cognitively intact and e with activities of daily living dentified R55 had diagnoses kinson's disease, anxiety and c the MDS identified R55 had			The Accidents and Incidents Policy wa reviewed and updated stating the Incid Accident form will be submitted to the Director of Nursing or her designee. The Abuse Prevention Plan and the	ident	
	no behaviors or sign R55's care plan rev	vised 1/11/16 identified R55			Accidents and Incidents Policy will be reviewed with all staff on Feb 26th and 29th, 2016. Additional training will be conducted with all licensed nursing sta	nd e	
	identified R55 had i function/dementia c related to disease p disease and R55 ha	ronment. The care plan also mpaired cognitive or impaired thought processes processes of Parkinson's ad received anti-depressant edication and was monitored			social workers, and Administrator on F 26th and 29th, 2016 regarding reportin State agency and Administrator, Thore Investigations, and prevention of furth abuse while the investigation is in process.	Feb ing to rough	
	to the facility by fam the facility social wo (DON) and clinical of received a report vi member on 12/6/15 had reported allega regarding a male vi	0 a.m. review of an email sent hily member (FM)-A revealed orker (SW), director of nurses coordinator (CC-A) had a email by R55's family 5. The report identified R55 tions of sexual abuse sitor and R64, and between rs. FM-A had requested the			4) The Director of Nursing and or designee will conduct audits, of incide reports, to ensure all incidents of pote resident abuse are being reported to t state agency and administrator, incide and allegations are thoroughly investigated, and the facility prevents further abuse while the investigation is process. Audits will also be conducte	ential the ents is in	

Facility ID: 00443

If continuation sheet Page 10 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		245463	B. WING			01/;	28/2016	
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 226	facility investigate the one of the 12/6/1 made by R55 a little remember anything She stated she did had been complete regarding R55's alle if the allegations had the administrator. It investigated the allegations first administrator and Shave reported the at then investigated at She stated if staff we allegations they work their policy dir On 1/25/16, at 2:10 was not aware of the reported by R55. Shany allegations first and they sho allegations first and On 1/25/16, at 2:27 aware of the allegations firs	he allegation made by R55. p.m. DON stated she was 5, allegations of sexual abuse e bit, but stated she could not specific about the allegations. not know if an incident report d, or if the was documentation egations. She also didn't know d been reported to the SA or DON stated the SW egations but was unsure of e. DON indicated with these the facility would investigate and then report to the SA. DON stated they should illegations first to the SA, and fter the report had been done. vere identified in the uld sometimes suspend the I stated she was unsure of ected them to do. p.m. administrator stated she he sexual abuse allegations he stated she would expect exual abuse to be reported SA and the administrator. She uld have reported the	F 2	226	documentation to identify any unrep incidents, as well as staff interviews Random audits will occur weekly for month, then monthly for three mont Results of audits will be reported to Quality Assurance Committee and further recommendations. 5) Corrective Action Completed by 1st, 2016.	s. or one ths. o the follow		

If continuation sheet Page 11 of 54

		AND HUMAN SERVICES				FORM	: 03/08/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245463	B. WING			01/28/2016	
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	best judgement and an incident or allega On 1/26/16, at 1:32 the presence of her (POA). POA stated abuse allegations to friends they reporte allegations to R55's contacted the SW, report the allegation had observed staff resident and with ea period of time. She after she was admin stated the most rec the night before las and a female reside reply to R55's daug mom doesn't want to not much we can de On 1/26/16, at 5:00 interview of R55 with majority of the sexu between a male star resident. R55 stated any staff or residen afraid of retaliation. in her and 2 other fa November-early De her room most night relations with her ro among each other of the most recent sex night before last be	v instruct staff to make their d decide if they should report ation or not. p.m. R55 was interviewed in r healthcare power of attorney after R55 reported the sexual o her and 2 other family ed R55's sexual abuse s daughter. R55's daughter DON and CC-A via email to ns on 12/6/15. R55 stated she having sexual relations with a ach other many nights over a stated it started immediately tted to the nursing home. She sent sexual relations happened t between a male staff person ent. The POA stated the SW's hter in December was, "Your to give us names, so there is o." p.m. during follow up th her POA, R55 stated the ual relations she reported was aff person and a female d she was unwilling to identify t by name because she was POA stated R55 had confided	F	226			

If continuation sheet Page 12 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245463	B. WING			01/28/2016		
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 226	reporting this most the facility and indic misconduct betwee female resident the Deerwood unit at 1 On 1/26/16, at 5:15 notified of sexual m member and a resid evening at 11:30 p. On 1/27/16, at 2:57 an email in Decemb indicating R55 had stated they talked to really feel like there He stated the invest talking with R55 an know what we woul and indicated the S the allegations to the didn't have anything reporting was some a team. He stated a comes up there has stated he never dis R55 again and it has stated he didn't know again, but she was services for R55 an On 1/27/16, at 3:33 the team who invest allegations reported 1/26/16. She stated for the 1/26/16, alle majority of the invest R64 and nursing as	recent allegation of abuse to cated the incident of sexual in a male staff person and a night before last on the 1:30 p.m. p.m. the administrator was isconduct between a staff dent which occurred Sunday m. on the Deerwood unit. p.m. CC-A stated he received ber from R55's daughter made sexual allegations. He o R55 and R64 and they didn't was anything to investigate. tigation was closed after d R64. He stated, "I don't d have reported to the SA" W and himself didn't report the SA because they felt they g to report. He stated VA ething the facility discussed as anytime anything like this is to be an investigation. He cussed the allegations with ad never come up again. He ow if the SW talked to R55 responsible for the social	F2	226				

If continuation sheet Page 13 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245463	B. WING _			01/28/2016	
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				31 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	practical nurse (LPI last night. She state for contacting NA-E last night. She state talked to them last she revised R55's of entries in both R55' from the 12/6/15, at the abuse allegation after she responded 12/11/15, the invest confirmed printed e She stated nothing R64's medical reco were not substantia On 1/27/16, at 5:06 worked in the facilit the Deerwwod unit had not gotten a ho his shift because he stated NA-B worked R55 or R64 becaus morning. She said s during the investiga R64 denied the abu On 1/27/16, at 7:00 officer (CEO) stated identified NA)-B as abuse allegations. I completely comfort that night even thou in the abuse allegat interviewed regardii he felt confident tha because R64 denied	N)-B were assigned to that unit ed the DON was responsible B and LPN-B prior to their shift ed she wasn't sure if the DON night or not. She confirmed care plan today and made late 's and R64's medical records llegations. She stated when ns were made 12/6/15, she felt d to R55's daughter's email on tigation was completed. She emails and provided copies. was documented in R55 and rd because the allegations ated. a p.m. DON confirmed NA-B y the previous night shift on with LPN-B. She stated she old of NA-B before he started e didn't answer his phone. She d on Deerwood but not with se NA-B told her he didn't this she allowed NA-B to work ation of the allegation because	F 22	26			

If continuation sheet Page 14 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245463	B. WING	i		01/28/2016	
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	December. He state December allegation allegations to the S credible staff perso He stated he felt the interview any other about R55 and R64 didn't need to intervi- because the allegat stated he was confit complete investigat delusions. He state people were engag home. The adminis- the interview, stated interviewed R55 or facility because the the abuse and he d administrator stated thorough investigat night. On 1/28/16, at 8:45 director (SSD) state were not reported to because they inves allegations were re were too many unk allegations they had felt confident with th stated she felt they She stated SW tool was a team decisio of sexual abuse. So received the approp services support fro	ed the SW investigated the ons and they didn't report the A because the SW was a on and R64 denied the abuse. e facility did not need to residents because this was 4. CEO stated he felt the facility view NA-B or other staff tion was just not true. He ident the facility conducted a tion and that R55 was having ed R55 also told him groups of ing in sex within the nursing strator, who was present during d the policeman never R64 after being called to the facility told them R64 denied	F	226			

Facility ID: 00443

If continuation sheet Page 15 of 54

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245463	B. WING			01/28/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER	R CARE CENTER				31 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226 F 279 SS=D	handled everything facility would invest report to SA after th allegations were rep 483.20(d), 483.20(k	correctly. She stated the igate the allegations and then ney determined if the portable or not. (1) DEVELOP	F 2 F 2	226			3/1/16
		he results of the assessment and revise the resident's n of care.					
	plan for each reside objectives and time medical, nursing, ar	evelop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any so be required under § due to the resident's	describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under the right to refuse treatment).					
	by: Based on observat review the facility fa comprehensive card	e plan which included hing needs for 1 of 3 residents			 R 96 expired 2/5/16. All residents Braden scores wereviewed and those who are at risk (Braden score of 15-18 or lower) cat affected by this. 		

Facility ID: 00443

B. WING ID PREF TAG	1131 SOUTH MA FERGUS FALL PROV (EACH C	S, CITY, STATE, ZIP CODE	01/2 CTION DULD BE	28/2016 (x5) COMPLETIO DATE
ID PREF TAG	1131 SOUTH MA FERGUS FALL PROV (EACH C	ABELLE AVENUE _S, MN 56537 VIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO EFERENCED TO THE APPF	TION DULD BE	(X5) COMPLETIO
PREF TAG	1131 SOUTH MA FERGUS FALL PROV (EACH C	ABELLE AVENUE _S, MN 56537 VIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO EFERENCED TO THE APPF	TION DULD BE	COMPLETIC
PREF TAG	FERGUS FALL	LS, MN 56537 VIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO EFERENCED TO THE APPP	ULD BE	COMPLETIC
PREF TAG	(EACH (CORRECTIVE ACTION SHO EFERENCED TO THE APPE	ULD BE	COMPLETIC
				DATE
F 2	' 9			
t vere h aily o n of ng a a or er ure aing R96 (s, I s. e nd	 3) Those rehave tissue Each residischedule dischedule direviewed acurrent rep Pressure Libeen updativill be developing appropriate pressure uivill be reviet changes and Repositioniinclude the admission, resident signee. repositioniir Care Plan. household include new the audits. audits will be audits of guality Assisted 	ted to include that a d eloped for a resident a pressure ulcer with e interventions to pre- lcer from developing, ewed with any condit nd quarterly. Also, the ing Policy has been u a Tissue tolerance tes and with any change is status. staff will be educated ates Feb 26th and 29 be completed by the Audits include obser ng, and information for Will complete 4 aud per week x 4 weeks, ra- be completed by the ignee. the audits will be take surance committee for dations.	apleted. positioning hs will be ed with Policy in has care plan at risk of h vent . Care Plan ion e updated to st upon e in d on the th, 2016. DON or vation of pund on lits per . Will also v occur into andom DON en to the or further	
r t sdtinnutinn liker h	laily vo on of ng t s a d, s or n ner sure	lailyPressure bwobeen updabon ofwill be devdevelopingappropriatengpressure uwill be revittchanges aRepositions ainclude thed,admission,tresident sher4) Nursingpolicy updaa.Audits willningdesignee.repositioniCare Plan.householdinclude newtrs.and/or desResults ofQuality Assherecomment5) Comple	Haily wo on ofPressure Ulcer Risk Assessme been updated to include that a developing a pressure ulcer wit appropriate interventions to pre pressure ulcer from developing will be reviewed with any condit changes and quarterly. Also, the Repositioning Policy has been updated to include the Tissue tolerance test admission, and with any change resident s status.14) Nursing staff will be educated policy updates Feb 26th and 29 Audits will be completed by the designee. Audits include obser repositioning, and information for Care Plan. Will complete 4 audits household per week x 4 weeks, ra audits will be completed by the and/or designee.1R96 end and/or designee.1Results of the audits will be take Quality Assurance committee for recommendations.15) Completion date: March 1st,	Iaily wo on ofPressure Ulcer Risk Assessment has been updated to include that a care plan will be developed for a resident at risk of developing a pressure ulcer with appropriate interventions to prevent pressure ulcer from developing. Care Plan will be reviewed with any condition thanges and quarterly. Also, the Repositioning Policy has been updated to include the Tissue tolerance test upon admission, and with any change in resident s status.14) Nursing staff will be educated on the policy updates Feb 26th and 29th, 2016. Audits will be completed by the DON or designee. Audits include observation of repositioning, and information found on Care Plan. Will complete 4 audits per household per week x 4 weeks. Will also include new admissions as they occur into the audits will be completed by the DON rs.1 R96 eland/or designee. Results of the audits will be taken to the Quality Assurance committee for further recommendations.15) Completion date: March 1st, 2016

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245463	B. WING _		01/:	01/28/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER	R CARE CENTER				31 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	Continued From pa admission.	ıge 17	F 27	79			
	identified R96 had a heels and buttocks. R96 required assist reposition in bed. H to identify a turn an R96's care plan list checking and chang reducing mattress,	arrent care plan dated 12/8/15, an actual skin impairment to . R96's care plan identified tance of 2 staff to turn and lowever, R96's care plan failed d repositioning schedule. ed various interventions of ging every 2 hours, pressure apply booties to both feet keep R96's skin clean and					
	7:59 a.m. to 10:58 a in bed on her back	continuous observations from a.m., R96 was observed lying without being offered, or ion during the entire					
	her back, eyes clos to her neck. R96's l	was observed lying in bed on sed, with a blanket covering up bilateral bottom of both feet nd black padded boots were eet.					
	same position, on h	remained lying in bed in the her back with a blanket neck. No staff had been R96's room.					
	same position, on h covering. A housek briefly enter R96's r closet and drawers	remained lying in bed in the ner back with a blanket eeping staff was observed to room, to place clothing into the . The housekeeping's staff the room, R96 remained in the her eyes closed.					

If continuation sheet Page 18 of 54

	-	AND HUMAN SERVICES				FORM	: 03/08/2016 APPROVED . 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,		E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245463	B. WING			01	/28/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
PIONEER CARE CENTER					I31 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 279	Continued From pa	ige 18	F 2	79				
	position, on her bac and a blanket cover make no changes in No staff had been of - At 10:17 a.m. R96 back, eyes open, a chin. Nursing assist walking down the h NA-A looked at R96 however did not sto was not observed to - At 10:19 a.m. the (CNP) entered R96 R96's bed. The CN immediately exited same position, lying - At 10:46 a.m. R96 position, on her bac blanket was coverin - At 10:58 a.m. R96 NA-A and NA-E ent assistance with per observed to have p inch (in) by 8 in abs R96's sacral area.	remained lying in the same ck, in bed with her eyes open ring her. R96 was observed to n her position independently. observed to enter R96's room. 6 continued to lay in bed on her blanket covering up to her tant (NA)-A was observed all outside of R96's room. 6's room as she walked past, op or enter R96's room. NA-A o offer R96 assistance. certified nurse practitioner t's room and approached P briefly spoke with R96 and the room. R96 remained in the g on her back in bed. 6 remained lying in the same ck, in bed, eyes open, a ng up to her chin. 6 remained on her back in bed. tered R96's room to provide sonal cares. R96 was ressure ulcer covered with a 4 sorbent dressing covered The dressing had a moderate oungent, foul smelling drainage through R96's dressing and						
	assisted R96 to get	1 a.m. NA-E stated she had dressed that morning at 6:45 she had not repositioned R96						

If continuation sheet Page 19 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245463		B. WING	i		01/28/2016		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER CARE CENTER					131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	reposition herself a for repositioning even On 1/28/16, at 11:0 aware R96 had blac 1/24/16 and a slight time. LPN-A stated treatment of applyin buttocks had not im LPN-A stated she w care plan directed f should be reposition relieve pressure on On 1/28/16, at 11:0 not repositioned R9 shift (7:00 a.m.,) an was last repositioned R96 had not been r 10:58 a.m. a total o On 1/28/16, at 11:2 (RN)-A identified R9 the sacrum had wo ulcer and R96's sta heel had worsened RN-A confirmed R9 repositioning plan fe was not on a currer On 1/28/16, at 11:3 (DON) confirmed sl pressure ulcer had stage 4 and stated	-E stated R96 was unable to nd required staff assistance ery 2-3 hours. 3 a.m. LPN- A stated she was ck eschar on R96's sacrum on t odor was also present at that she felt the previous ng Udder Balm to R96's proved R96's pressure ulcers. vas unaware of what R96's for repositioning, but felt R96 ned at least every 2 hours to	F 2	279			
	1 .						

If continuation sheet Page 20 of 54

		AND HUMAN SERVICES			FORM	03/08/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,		(X3) DATE SURVEY COMPLETED		
		245463	B. WING		01/2	28/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 279	Continued From pa	.ge 20	F 279			
F 282 SS=D			F 282	1) R99 expired 2/11/2016		3/1/16

Facility ID: 00443

If continuation sheet Page 21 of 54

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO.		
				IG	· · · ·	(X3) DATE SURVEY COMPLETED	
		245463	B. WING _		01/2	01/28/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE		
PIONEEF	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIOI DATE	
F 282	Continued From pa	ige 21	F 28	2			
	plan for 1 of 3 resident (R99) reviewed for accidents, and for 1 of 1 residents (R99) at risk for development of pressure ulcers. Findings include:			 All residents and their of reviewed by the fall team. a potential for falls were in can be affected by this. All Braden scores were reviewho are at risk can be affected 	Those that have lentified, and I residents wed and those		
	indicated R99 was de-conditioning, an R99's care plan list included chair alarr wheelchair, Wande and indicated R99 was not safe and si	plan revised on 9/25/15, at risk for falls related to d gait/balance problems. ed various interventions which n on the seat of the rguard, use of a baby monitor may self transfer at times, but taff should assist R99 to sit ver lift as needed to get R99 to		3)The policy Falls and Fal Managing was reviewed. states, staff will identify an relevant interventions to tr serious consequences of policy was also updated to individualized fall intervent on the residents care plan on the Care Card located resident s closet.	This policy ad implement by to minimize falling. The o state, tions are located and as needed		
	R99's current nursi provided by the fac which included R99 may use a tilt and s may self transfer at On 1/27/15, from 1 was observed in a and no chair alarm At 1:17 p.m. a staff	ng assistant care plan ility listed various interventions 0 utilized a chair alarm, and space wheelchair if really tired, 1 times but is not safe. 1:50 a.m. to 1:17 p.m. R99 red tilt and space wheelchair was observed on R99's chair. member wheeled R99 back to		Those residents who Brack indicated at risk of pressur have tissue tolerance test Each resident will have the schedule determined. Car reviewed and updated as current repositioning sche Repositioning worksheets completed by the nursing shift, and communicated t shift the last reposition tim resident.	re ulcers will s completed. eir repositioning re plans will be needed with dule. will be assistants each o the oncoming		
	into his bed utilizing was observed in the no alarm sounded wheelchair to the b On 1/27/16, at 1:22	Jining room and transferred g a mechanical lift. No alarm e seat of the wheelchair and when R99 was lifted from the ed. c p.m. nursing assistant (NA)-H d R99 had not had an alarm in		Staff education will be hele 29th, 2016. This education policy Falls and Fall Risk, also the Repositioning pol implementation of repositi worksheets.	n will review the Managing and icy with		

Facility ID: 00443

If continuation sheet Page 22 of 54

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE	0938-039 SURVEY PLETED
		245463	B. WING			01/:	28/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, O	CITY, STATE, ZIP CODE		2010
PIONEE	R CARE CENTER		1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH COF	ER'S PLAN OF CORRECTIC RRECTIVE ACTION SHOULI ERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 282	wheelchair. NA-H i chair alarm in a reg unsure if he was su and space wheelch On 1/27/16, during NA-H and NA-J at was at risk for falls alarm on the seat of NA-H indicated the transferred from th and space wheelch NA-H confirmed R9 of a chair alarm an On 1/27/16, at 1:35 (LPN)-C confirmed on his tilt and spac facility was "trialing for R99. LPN-C col chair alarm in place confirmed R99 was "staff should be usi On 1/28/16, at 5:07 (DON) confirmed F was at risk for furth chair alarm in the w she would expect s R99's current care R99 had impairment cyst to buttocks, of	lizing the tilt and space ndicated R99 had utilized a gular wheelchair but was upposed to have one in the tilt nair. a follow up interview with 1:54 p.m., they verified R99, , and was to have a chair of his tilt and space wheelchair. chair alarm had not been e regular wheelchair to the tilt nair and it should of been. 99's care plan directed the use d indicated it was an oversight. 5 p.m. licensed practical nurse I R99 did not had a chair alarm e wheelchair and indicated the " a different type of wheelchair nfirmed R99 had not had the e for the entire morning. She s at risk for falls and stated, ing the alarm." 7 p.m. director of nursing R99's care plan indicated R99 her falls and R99 utilized a wheelchair. The DON stated staff to have the alarm on and would expect the staff to	F 2	will conduct a interventions, measures for implemented Audits will als compliance o plan for timely observation of will be conduct then monthly reported to th Committee, a by that team of	audits by observation , to ensure fall interver individual residents a according to care pla so be completed to er of following the reside y repositioning by of repositioning logs. A cted weekly for one n for 3 months. Result and recommendations will be followed. Action Completed by	ention are an. hsure nts care hudits honth, s will be s given	

If continuation sheet Page 23 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
245463		B. WING			01/28/2016		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER CARE CENTER					131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	Continued From pa to keep skin clean a various intervention area with each inco able to tolerate repo no alterations in ski Review of R99's cu plan, provided by th monitor, document skin breakdown, as reposition in bed, to change as needed, incontinent episode On 1/27/16, at 1:17 seated in a red tilt a dining room table, v R99 back to his roo R99 from the wheel mechanical lift. NA- was incontinent of to stated he was dry. would like to lay" ar NA-H and NA-J pro his back laying on a him, then placed a of his body and upp slightly elevated ap in low position, call functioning, covered up to his mid chest and at 1:23 p.m. NA- At 4:14 p.m. NA-K and proceeded to a care. NA-K and NA product was wet wit	age 23 and dry. The care plan listed as which included to clean peri- portinent episode and R99 was positioning every two hours with in. rrent nursing assistant care he facility, directed staff to and report any changes in asist with one staff to turn and buse disposable briefs, clean peri area after each and space wheelchair at the when NA-H and NA-J wheeled of and proceeded to assist lchair to his bed via total H checked R99 to see if he powel and bladder and NA-H NA-H asked R99 "how he and he did not respond to her. Deceded by positioning R99 on a white cloth pad underneath pillow on his upper right side per left side, head of bed proximately 30 degrees, bed light placed, bed alarm d with a blanket which came area, video monitor in place, A-H and NA-J exited the room.	1	282	DEFICIENCY)		
	and proceeded to c	hange his incontinent product. provided peri cares to R99's					
		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
---	--	--	-------------------	-----	--	-----------	-------------------------------------
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	<u>, ,, ,, ,</u>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245463	B. WING	i		01/:	28/2016
NAME OF PROVIDER OR SUPP	LIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER CARE CENTER	ł				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
PREFIX (EACH DEFIC	IENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282 Continued From scrotal area wh color. At 4:20 p.m. Ma side and NA-1 p rectal/buttocks it which extend that he had on During the obs to be slightly re extended to the with no open at R99 had not be until 4:20 p.m., R99 was unable independently a repositioned ex- plan and had n incontinence as On 1/27/16, at care plan direct every two hour when R99 had or changed and here and I wen On 1/27/16, at needed to be ro indicated day s last been reposi- verified R99 wa hours due to pa from his cyst at was getting ant monitor, so we also stated, "I d	m pa hich f A-K : voroci which led u his r erva ed ar erva a to le to and very bo s dir 7:33 last d stav f s to last d stav s to poss hift i s to b s to poss hift i s to b s to s to b s to s to s to s to s to s to s to s to	age 24 was bright red and shiny in and NA-I rolled R99 to his left eeded by cleaning up R99's ch had soft brown stool all over up underneath R99's dressing right upper buttocks area. tion R99's buttocks was noted ound the rectal area which ter edges of his buttock crease	F2	282	DEFICIENCY)		

Facility ID: 00443

If continuation sheet Page 25 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245463	B. WING			01/:	28/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	repo him prior to us On 1/28/16, at 8:32 confirmed R99 was and bladder and ne and repositioned ev verified R99's care expect staff to follow sure the resident is hours." On 1/28/16, at 9:26 was routinely incont and needed to be c repositioned every to that she did not rep not reposition him w alarm." NA-H stated reposition, we try no 1/28/16 at 5:07 p.m R99's care plan and repositioned every 2 incontinent of bowe be checked/change expect staff to repo- and follow the care Review of facility po- Plans-Comprehens indicated an individu plan that includes m timetables to meet function and maintains a con each resident that in	a getting him up for supper." a.m. registered nurse (RN)-C a routinely incontinent of bowel beded to be checked/changed very two hours. RN-C also plan and stated "I would w the care plan and to make be repositioned every two a.m. NA-H confirmed R99 tinent of bowel and bladder thecked/changed and two hours. NA-H also verified iosition R99 and stated "we did we only adjusted the bed d "it is so painful for him to ot to mess with him too much." A. director of nursing confirmed d verified he was to be 2 hours and was routinely el and bladder and needed to ad. The DON stated she would sition R99 every two hours plan.	F 2	282			

If continuation sheet Page 26 of 54

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/08/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245463	B. WING	i		/28/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PIONEEF	R CARE CENTER				31 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 F 314 SS=G	483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil does not develop pr	ENT/SVCS TO		314 314		3/1/16
	they were unavoida pressure sores rece services to promote prevent new sores	ble; and a resident having eives necessary treatment and healing, prevent infection and				
	Based on observat review, the facility fa reassess, develop a promote healing, pr pressure ulcers for reviewed for pressu practice resulted in developed worsenir addition, the facility interventions to pre- pressure ulcers for	ion, interview and document ailed to comprehensively and implement interventions to event the worsening of 1 of 3 residents (R96) are ulcers. This deficient actual harm for R96 who ng pressure ulcers. In failed to implement vent the development of 1 of 5 residents (R99) the development of pressure			 R 96 expired 2/5/16 and R 99 expired 2/11/16 All resident s Braden scores were reviewed and those who are at risk (Braden score of 15-18 or lower) and with present skin alterations can be affected by this. Those residents who are at risk and/or present skin alterations will have tissue tolerance tests completed. Each resident will have their repositioning schedule determined. Care plans will be reviewed and updated as needed with current repositioning schedule. 	
	(MDS) dated 12/15, cognitive impairment included: femoral fr pressure ulcers. The totally dependent on living (ADL's.) The	mission Minimum Data Set (15, identified R96 had severe at and had diagnoses which acture, dementia and e MDS identified R96 was n staff for all activities of daily MDS identified R96 had two cers (observable pressure			3) A comprehensive skin assessment will be completed upon admission, weekly fo the first four weeks after admission for each resident at risk, then quarterly, or whenever there is a change in cognition o functional ability. Policy Pressure Ulcer Risk Assessment reflects these changes.	

Facility ID: 00443

If continuation sheet Page 27 of 54

		& MEDICAID SERVICES	(X2) MET				0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245463	B. WING			01/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 314	Continued From pa	-	F 31	4			
	compared to an adj body may include c following parameter consistency, sensa persistent redness, ulcers (partial thick as a shallow open to bed, without slough intact or open/ruptu present upon admis pressure ulcer inter device for the bed a did not include a tur for R96. Review of R96's pro- Assessment (CAA) had two stage 1 pre- two stage 2 pressure and received treatm The CAA identified development of furf required staff assis CAA further identified	f intact skin whose indicators jacent or opposite area on the ihanges in one or more of the rs: skin temp, tissue tion, and or a defined area of) and two stage 2 pressure ness loss of dermis presenting ulcer with a red-pink wound a. May also present as an ured blister,) which were ssion. The MDS further listed a rvention of a pressure relieving and chair for R96. The MDS rn and repositioning program essure ulcer Care Area dated 12/15/15, identified R96 essure ulcers to the buttocks, re ulcers, one on each heel nents to the pressure ulcers. R96 was at risk for ther pressure ulcers and tance with bed mobility. The ed R96 required staff positioning every 2 hours and			Nursing assistants will complete repositioning worksheets each shift. Times will be communicated to once shifts of the last time the residents we repositioned to ensure continuity of Charge Nurse and Clinical Coordina will review these worksheets each se compliance. All nursing staff will atter in-service training to include the importance of following the resident care plan for timely repositioning. In-service will include education on pressure ulcer prevention and repositioning policy will be reviewed will in-service will occur February 26 and 29th , 2016. The Licensed Staff received education on wound assess and documentation on Feb. 23rd, 20 4) Quality Assurance audits will be to ensure compliance of completing comprehensive skin assessments of admit and then weekly for the first for weeks after admission. These audit be conducted on the residents reco- including, skin assessments, brader scale, comprehensive note in progra- notes, and care plans. Audits will be	oming were care. ator shift for end t s l. This 5th f will ssment 019. done jon our is will rd ns ess	
	comprehensive and admission. Review of R96's cu identified R96 had a	d lacked documentation of a alysis of R96's skin status on mrent care plan dated 12/8/15, an actual skin impairment to			completed weekly for 4 weeks, then randomly by DON and/or designee. Quality Assurance audits by observa and review of care plan, will be done ensure compliance of following the residents care plan for timely reposi	ation, e to itioning	
	R96 required assist reposition in bed. H to identify a turn an	. R96's care plan identified tance of 2 staff to turn and lowever, R96's care plan failed d repositioning schedule. ed various interventions of			and completion of the repositioning These audits will be done weekly or household x 4 weeks, then randoml DON and/or designee. Results of th audits will be taken to the Quality	n each ly by	

Facility ID: 00443

If continuation sheet Page 28 of 54

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:		I	COI	MPLETED
		245463	B. WING		01	/28/2016
NAME OF F	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
PIONEEF	CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 314	Continued From pa	-	F 314			
	reducing mattress,	nging every 2 hours, pressure , apply booties to both feet o keep R96's skin clean and		Assurance Committee for fur recommendations.	iner	
	dry.	0 p.m. registered nurse (RN)-B		e) Completion date: March 1,	2016	
	had significantly w RN-B stated she h R96 to be seen at weeks ago when F had developed eso that is hard or soft brown, or tan in co Necrotic tissue and adherent to the ba sides/edges of the RN-B indicated R9 on 1/21/16, and R debrided (removal at that time. RN-B diagnosed with one thickness tissue lo or muscle. Slough some parts of the undermining and th stated R96 needed repositioning every relief of the sacrum treatment to R96's were to wear press On 1/28/16, during	S's two stage 2 pressure ulcers orsened within the last week. ad set up an appointment for a wound clinic almost two R96's buttocks pressure ulcer char (dead or devitalized tissue in texture; usually black, olor, and may appear scab like. d eschar are usually firmly se of the wound and often the wound,) tissue on the ulcer. 66 was seen at the wound clinic 196's buttocks ulcer had been of dead or devitalized tissue) confirmed R96 had been e stage 4 pressure ulcer (full ss with exposed bone, tendon or eschar may be present on wound bed. Often includes unneling,) to the sacrum. RN-B d staff assistance with y 2 hours to aid in pressure n. RN-B stated the only bilateral heel pressure ulcers sure relieving boots.				

If continuation sheet Page 29 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245463	B. WING			01/:	28/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	her back, eyes clos to her neck. R96's I were uncovered, ar observed on both fe - At 8:52 a.m. R96 i same position, on h covering up to her r observed to enter F - At 9:10 a.m. R96 i same position, on h covering. - At 9:45 a.m. R96 position, on her bac and a blanket cover make no changes in No staff had been c - At 10:17 a.m. R96 back, eyes open, a chin. Nursing assisti walking down the h NA-A looked at R96 however, did not sta was not observed to - At 10:19 a.m. the (CNP) entered R96 R96's bed. The CN immediately exited same position, on her bac blanket was coverin	ed, with a blanket covering up bilateral bottom of both feet and black padded boots were eet. remained lying in bed in the her back with a blanket neck. No staff had been R96's room. remained lying in bed in the her back with a blanket remained lying in the same ck, in bed with her eyes open ring her. R96 was observed to n her position independently. observed to enter R96's room. 6 continued to lay in bed on her blanket covering up to her tant (NA)-A was observed all outside of R96's room. 6's room as she walked past, op or enter R96's room. NA-A o offer R96 assistance. certified nurse practitioner f's room and approached P briefly spoke with R96 and the room. R96 remained in the g on her back in bed.	F	314			

If continuation sheet Page 30 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245463	B. WING			01/:	28/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	NA-A and NA-E ent assistance with per the blanket covering down her slacks an brief. NA-A assisted towards NA-E. NA- her left side while N slacks to expose th remove R96's brief brown drainage was of the brief, a 4 inch dressing was obser area. The dressing brown, pungent, fou seeped through R9 brief. - At 11:01 a.m. licer and RN-A entered R the 4 in x 8 in absor R96's sacrum. A me pungent, foul smell the dressing. LPN-A packing gauze from ulcer. The gauze w pungent, foul smell R96 had a current s sacrum and confirm RN-A stated he hac pressure ulcer since wound clinic. RN-A R96's pressure ulcer measurements of 4 cm wide x 2 cm dee pressure ulcer had edges of the entire to 1.8 cm. He stated the surrounding ski	tered R96's room to provide sonal cares. NA-E removed g R96 and proceeded to pull id checked the front of R96's d to turn R96 onto her left side E assisted to hold R96 onto IA-A pulled the back of R96's ie brief. NA-A proceeded to and a moderate amount of s on the brief. Upon removal n (in) by 8 in absorbent ved covering R96's sacral had a moderate amount of ul smelling drainage which had 6's dressing and onto her nsed practical nurse (LPN)-A R96's room. LPN-A removed rbent dressing which covered oderate amount of brown, ing drainage was observed on A proceeded to remove n the inside of the pressure as saturated with brown, ling drainage. RN-A confirmed stage 4 pressure ulcer on the ned the odor and drainage. d not observed R96's stage 4 e it had been debrided at the observed and confirmed		314			

If continuation sheet Page 31 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY PLETED
		245463	B. WING			01/;	28/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	R96's stage 4 press at the time of the la necrotic tissue note proceeded to place R96's sacral press soaked with normal ulcer with an absord dressing in place. F relieving black boot heel was observed which measured 1.3 RN-A stated he felt pressure ulcer on h was observed to ha surrounded in pink x 3.0 cm, depth obs RN-A stated R96 ha slough or eschar: w visualized due to th eschar,) ulcer on he R96 left heel had a ulcer that had wors RN-A confirmed R9 pressure ulcer had to a stage 4 pressu On 1/28/16, at 11:0 assisted R96 to get a.m. and confirmed since that time. NA- reposition herself a for repositioning evo On 1/28/16, at 11:0 aware R96 had blac 1/24/16, and a sligh that time. LPN-A state treatment of applyin	sure ulcer had not been open st assessment, nor was ed at the that time. LPN-A fresh packing gauze into ure ulcer with two gauze pads I saline and covered R96's bent pad and taped the RN-A removed the pressure is from R96's feet. R96's right to have a flat, hard, blister 5 cm x 1.6 cm with no depth. R96 had a healing stage 2 er right heel. R96's left heel twe hard, eschar tissue, skin, which measured 2.5 cm scured by the eschar tissue. ad an unstagable (related to yound bed cannot be e presence of slough or er left heel. RN-A confirmed previous stage 2 pressure ened to an unstagable ulcer. 06's current stage 4 sacral also worsened from a stage 1 re ulcer.	F	314			

If continuation sheet Page 32 of 54

		AND HUMAN SERVICES				FORM	: 03/08/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245463	B. WING	ì		01/	28/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PIONEE	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	LPN-A stated she w care plan directed f should be reposition relieve pressure on On 1/28/16, at 11:0 not repositioned R9 shift (7:00 a.m.,) an was last repositioned R96 should be repo R96 had not been r 10:58 a.m. a total o Review of R96's we from 12/8/15, to 1/2 -On 12/8/15, identiff with stage 1 pressu buttocks and stage as fluid filled blister assessment revealed pressure ulcer mea the left buttocks pre x 6.0 cm x 0.0, righ measured 1.5 x 1.5 pressure ulcer mea cm The assessment intervention of air m booties. The assess on a turning and report -On 12/17/15, rever were unchanged. T had a stage 2 press described as an inti- brown edges and m 0.0 cm. The assess	vas unaware of what R96's for repositioning, but felt R96 ned at least every 2 hours to ther sacrum. 4 a.m. NA-A stated she had 96 since the beginning of her nd was unsure of when R96 ed. NA-A stated she thought ositioned every 2-3 hours. repositioned from 6:45 a.m. to of 4 hours and 13 minutes. eekly wound assessments 21/16, revealed the following; fied R96 had been admitted ure ulcers, one on each 2 pressure ulcers described s, one on each heel. The ed R96's right buttocks asured 2.0 cm x 6.0 cm x 0.0, essure ulcer measured, 2.4 cm t heel pressure ulcer 5 cm x 0.0 and the left heel asured 5.0 cm x 3.5 cm x 0.0 nt identified a current nattress, cushion to chair and sment did not identify R96 was	F	314	4		

Facility ID: 00443

If continuation sheet Page 33 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245463	B. WING			01/;	28/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	as an irregular, inta measured 5.0 cm x assessment reveals both heel ulcers wa assessment did not and repositioning ro -On 12/18/15, revea were unchanged. T R96's right heel sta fluid filled blister an 0.0 cm The asses heel stage 2 pressu blister and measure The assessment id stage 1 pressure ul x 0.0 cm R96's left ulcer measured 2.4 assessment lacked characteristics and not identify R96 wa routine. -On 12/23/15, ident pressure ulcer was measured 1.5 cm x assessment identifi 1 pressure ulcer ma cm R96's left buttoo measured 2.4 cm b assessment reveals no drainage, no odo The assessment di turn and repositioni	tified R96's right heel stage 2 a fluid filled blister and 2.5 cm $\times 0.0$ cm. The ed R96's skin surrounding as intact and normal The t identify R96 was on a turn outine. aled R96's pressure ulcers The assessment identified age 2 pressure ulcer was a d measured 1.5 cm $\times 1.5$ cm \times assment identified R96's left ure ulcer was a fluid filled ed 5.0 cm $\times 3.5$ cm 0.0 cm. entified R96's right buttocks lcer measured 2.0 cm $\times 6.0$ cm buttocks stage 1 pressure t cm by 6.0 cm $\times 0.0$ cm. The d surrounding skin coloring. The assessment did s on a turn and repositioning tified R96's right heel stage 2 a fluid filled blister and a 1.5 cm $\times 0.0$ cm. The ied R96's left heel stage 2 a fluid filled blister and a 3.5 cm 0.0 cm. The ied R96's right buttocks stage easured 2.0 cm $\times 6.0$ cm $\times 0.0$ cks stage 1 pressure ulcer by 6.0 cm $\times 0.0$ cm. The ied R96's right buttocks stage easured 2.0 cm $\times 6.0$ cm $\times 0.0$ cks stage 1 pressure ulcer by 6.0 cm $\times 0.0$ cm. The ed R96's pressure ulcers had or and areas were improving;. d not identify R96 was on a	F 3	14			

If continuation sheet Page 34 of 54

		AND HUMAN SERVICES				FORM	: 03/08/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245463	B. WING	i		01/	28/2016
NAME OF I	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	ulcers had worsene The assessment id pressure ulcer was 4.0 cm x 0.0 cm. Re ulcer was a stage 2 x 0.0 cm. The asse 2 heel ulcers were for measured; right heel left heel measured assessment indicate healing. (The assess ulcers were healing indicated R96's pre)The assessment a interventions in place booties in bed. The R96 was on a turn a -On 1/14/16, identif 2 pressure ulcer me cm, left buttocks sta measured 2.4 cm x assessment identifii pressure ulcer was measured 1.5 cm x heel stage 2 pressu- blister and measure The assessment in were improving and been in place that in loading boots on wh areas on bottom. The referral to a wound improvement in 2 w identify R96 was or routine.	ge 34 ed from a stage 1 to stage 2. entified R96's right buttocks a stage 2, measured 2.0 cm x 96's left buttocks pressure 2, measured 2.4 cm x 3.0 cm ssment revealed R96's stage fluid filled blisters and el 1.5 cm x 1.5 cm x 0.0 cm, 5.0 cm x 3.5 cm x 0.0 cm. The ed the pressure ulcers were ssment indicated the pressure by however, the progress notes ssure ulcers were worsening. Iso revealed R96 had ce of an air mattress and assessment did not identify and repositioning routine. fied R96's right buttocks stage easured 2.0 cm x 3.5 cm x 0.0 age 2 pressure ulcer 3.0 cm x 0.0 cm. The ed R96's right heel stage 2 a fluid filled blister and 1.5 cm x 0.0 cm. R96's left ure ulcer was a fluid filled ed 5.0 cm x 3.5 cm x 0.0 cm. dicated R96's pressure ulcers d revealed interventions had ncluded air mattress, off hen in bed and udder balm to he assessment listed a clinic would be done if no weeks. The assessment did not in a turn and repositioning	F	314	1		

If continuation sheet Page 35 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245463	B. WING			01/2	28/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	cm, left buttocks sta measured 2.4 cm x assessment identifi pressure ulcer was measured 1.5 cm x heel stage 2 pressu- blister and measure The assessment re the wound clinic. Th tissue type, surrour the presence of the Review of R96's nu 12/8/15, to 1/25/16, -On 12/8/15, identifi and heel protectors issues. -On 12/10/15, revea breakdown on R96' the coccyx area and progress note also right heel and a hee -On 12/11/15, revea skin breakdown on the coccyx, cream note also revealed protector was in pla -On 12/15/15, revea blisters on both hee had booties on both -On 12/22/15, revea the buttocks were of surrounding skin with	age 2 pressure ulcer 3.0 cm x 0.0 cm. The ied R96's right heel stage 2 a fluid filled blister and 1.5 cm x 0.0 cm. R96's left ure ulcer was a fluid filled ed 5.0 cm x 3.5 cm x 0.0 cm. evealed a referral was made to he assessment did not identify nding skin and did not reflect e eschar tissue. arsing progress notes from , revealed the following; fied R96 had an air mattress in place for identified skin aled staff had noted some skin 's left butt cheek proximal to d a cream was applied. The revealed redness on R96's el protector was in place. aled R96 continued to have the left butt cheek proximal to was applied. The progress redness on R96's heel, a heel ace. aled R96 continued to have the left butt cheek proximal to was applied. The progress redness on R96's heel, a heel ace. aled R96 continued to have els. The note indicated R96 in feet and an air mattress. aled R96's pressure ulcers on	F 3	14			

If continuation sheet Page 36 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245463	B. WING	i		01/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	applied to R96's co cm x 1.7 cm. The n coordinator was infu up to monitor R96's dressing every 3 da note revealed R96 of times. -On 1/4/16, reveale changed to the ope noted serous drainage -On 1/5/16, reveale changed to the ope serous drainage on identified R96's ulca right buttocks was of surrounding skin wa -On 1/7/16, identifie physician with a new to the coccyx woun wound clinic in 1-2 -On 1/17/16, identifie ulcer had black new covered the wound cm and surrounding color. The note furtt R96's buttocks had ulcer. The note reve 1/7/16, for the wour wound did not impro- note was placed in book. The note did been made. R96's clinical record	ccyx ulcer which measured 2 note indicated the unit ormed and treatment was set is ulcer and to change the ays and as needed. A further was to wear pillow boots at all of R96's dressing was en areas on the coccyx and age on the old dressing. In areas on the coccyx with in the old dressing. The note er to the inner coccyx area and dark, had a foul odor and the as dark pink and moist. The old reasen by the w order to apply Udder Balm d as needed and to refer to a		314			

If continuation sheet Page 37 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245463	B. WING			01/:	28/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa worsened.	.ge 37	FS	314			
		ied R96's coccyx pressure ng and an appointment had e would clinic.					
	ulcer had a scant a wound bed was dau surrounding skin wa	ied R96's coccyx pressure mount of bloody drainage, rk black in color and the as firm with redness and revealed R96 exhibited pain hange.					
	wound clinic with a pressure ulcer. The receive the followin pressure ulcer; star wound, change eve cover with gauze. F wheelchair pad, ma wear heel boots at	led R96 had returned from the diagnosed stage 4 sacral e note revealed R96 was to g treatment to the sacral t saline moistened 4 x 4's into ery eight hours, wet to dry and R96 was to have a ROHO type attress pad and to continue to all times. The note further another appointment with the ther care.					
	risk for skin breakd assessments dated	aden (a tool used to identify own/pressure ulcers) scale 1 12/9/15, 12/15/15, 12/22/15 iified R96 was at moderate risk					
	used to determine s pressure and deter repositioning sched	sue tolerance test (TTT-tool skin's ability to withstand mine appropriate turning and Jules) dated 12/8/15, identified mal on the buttocks after 2					

Facility ID: 00443

If continuation sheet Page 38 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245463	B. WING			01/;	28/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	hours of lying. The dated 12/12/15, ide the buttocks at 2 ho entry dated 12/25/1 normal on the butto fourth entry undated pink/red after lying f identify an analysis not identify R96's re also indicated R96's updated to include a schedule. Review of R96's ph 12/18/15 to 1/20/16 -A resident fax cond 12/18/15, revealed notified of stage 2 p The fax lacked notif pressure ulcers. -A podiatry clinic ref identified R 96 had with the left ulcer gr ulcer measured 3.5 ulcer measured 1.6 indicted R96 was to at all times. -A physician progre identified R96 had u coccyx areas. The n were improving and The note revealed F	TTT while sitting entry was intified R96 had no redness on ours. The TTT revealed a third 5, identified R96's skin was ocks after 2 hours of lying. A d, identified R96's skin was for 3 hours. The TTT did not of R96's TTT results and did epositioning needs. The form s care plan had not been a routine repositioning bysician correspondences from a revealed the following; dition report to physician dated R96's physician had been pressure ulcers on both heels. fication of R96's buttocks ferral dated 12/22/15, decubitus ulcers of the heels reater then right ulcer, the left of m x 4.0 cm and the right of m x 1.9 cm. The note be wear pressure relieving boots ss note dated 1/7/16, ulcers on both heels and note revealed R96's heels d R96's coccyx was worsening. R96's coccyx ulcer was to be Balm cream as needed and a nd clinic in 1-2 weeks if no	F	314			

Facility ID: 00443

If continuation sheet Page 39 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245463	B. WING			01/2	28/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	-A wound physician identified R96 had a which required full t necrotic tissue. The revealed R96's sac 4.0 cm x 4.0 cm x 2 amount of odorous, progress note revea dry dressing change to return in one wee On 1/28/16, at 11:24 sacral pressure ulca admission. RN-A id pressure ulcer on th stage 4 pressure ul pressure ulcer on th unstagable pressur nurses who comple R96's pressure ulca him of any changes assessments. RN-A confirmed he assessments on RS admission. RN-A co assessment he had 1/21/16. RN-A indic pressure ulcers at t assessments. RN-A did not include a re confirmed R96 was schedule. RN-A sta independently repou usually waited for si then he would deter program/schedule. received the results	 progress note dated 1/25/16, a stage 4 sacral pressure ulcer thickness debridement of e progress note further ral pressure ulcer measured 2.0 cm and had a moderate, green drainage. The aled R96 was to receive wet to es every 8 hours and R96 was ek for further debridement. 4 a.m. RN-A verified R96's er had worsened since R96's entified R96's stage 1 he sacrum had worsened to a cer and R96's stage 2 he left heel had worsened to re ulcer. RN-A stated the floor eted the daily treatment for ers were expected to notify 	F	314			

Facility ID: 00443

If continuation sheet Page 40 of 54

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			0	FORM. MB NO.	03/08/2016 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
		245463	B. WING			01/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	indicated R96 requi repositioning every new pressure reliev into place for R96 s worsened. RN-A lis responsible for whice admissions in the la care planning. RN-/ explanation for the pressure ulcers fou assessments and F On 1/28/16, at 11:30 (DON) stated she fe to lay on her back fe sacral pressure ulce expected staff to im when R96's pressur DON confirmed she pressure ulcer had stage 4 and stated have a repositioning stated she expected have been reassess that the nurse mana and all changes wit On 1/28/16, at 2:01 conducted with R96 MD stated he had la when she had pressur unstagable pressur stage 4 sacral press necrosis (the soft tis bone had liquefied,), tissue which had co MD stated he had co	ired assistance with 2 hours. RN-A confirmed no ving interventions had been put since the pressure ulcers had sted various tasks he was ch included, admissions(30 ast year), assessments and	F	314			

Facility ID: 00443

If continuation sheet Page 41 of 54

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245463	B. WING			01/:	28/2016
NAME OF F	PROVIDER OR SUPPLIER	•	<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	tissue. The MD stat depth was down to future debridment's packing's. The MD caused by pressure around the sacrum with continued unre- sacrum soft tissue MD stated he felt R repositioned to prev Review of facility po- treatment revised 2 the procedure was care of existing pre prevention of additi policy directed staff plan to assess for a revealed the pressu- included, assessing pressure ulcers, cu education and qual revealed a definition types of pressure u 2, stage 4 and unst protocol for individu policy directed staff interventions for sta and redistribute pre- reduction of friction policy directs facility a wound did not im re-evaluate nutritior off-loading/redistrib products.	ted R96's pressure ulcer the sacral bone, required s and routine wet to dry stated R96's sacral ulcer was e which caused the soft tissue to liquefy. The MD also stated elieved pressure, R96's would continue to liquefy. The R96 should be routinely vent pressure on her sacrum. olicy titled, Pressure Ulcer 2/2014, revealed a purpose of to provide guidelines for the essure ulcers and the ional pressure ulcers. The f to review the residents care any special needs. The policy ure ulcers treatment program g resident and current status of irrent support surfaces, lity improvement. The policy ns and descriptions of the ulcers including, stage 1, stage tagable. The policy revealed a ual pressure ulcers, relieve essure, turn schedule, h, shear and incontinence. The y staff to notify the physician of prove in 2-3 weeks, to		14			

If continuation sheet Page 42 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245463	B. WING	i		01/	28/2016
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PIONEE	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	facility nursing staff assessment which stage, length, width exudates or necroti residents mobility s interventions and a Review of a facility revised 5/2013, rev procedure was to p evaluation of reside in the development for repositioning, to breakdown, promot pressure relief. The was critical for resid dependent on staff directed staff to eva develop and implen residents at risk for immobile and reside policy directed facili a resident on an ex additional pressure policy directed staff were in bed should repositioning sched	to complete a thorough was to include; the location, and depth, presence of ic tissue, pain presence, tatus, current treatment and ctive diagnoses. policy titled, Repositioning ealed a purpose of the rovide guidelines for the ent repositioning needs, to aid of an individualized care plan promote comfort, prevent skin te circulation and provide policy revealed repositioning dents who were immobile or for repositioning. The policy aluate residents skin condition, nent repositioning plans for breakdown, who were ents with pressure ulcers. The ity staff to avoid positioning of isting pressure ulcer as may impede healing. The to reposition residents who be on at least every 2 hour dule. The policy directed staff tor and evaluate resident	F	314			

Facility ID: 00443

If continuation sheet Page 43 of 54

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245463	B. WING			01/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 43	F 3	314			
	did not receive time R99's significant ch indicated R99 had of Alzheimer's demen incontinence and di identified R99 was and required extens transfers, bed mobi assistance of one s extensive assist of personal hygiene. T risk for the develop listed various treatm reducing device on MDS indicated R99 bowel and bladder. R99's CAA dated 1 ⁺ extensive assistance Braden Score indic development of pre indicated R99 need toileting and was fre bowel/bladder, and two hours and as m R99's Braden Scale Risk form, dated 11 risk for the develop was very moist, spe	ange MDS dated 11/20/2015, diagnoses which included non- tia, unspecified urinary abetes mellitus. The MDS severely cognitively impaired sive assistance of two staff for lity, toilet use, limited taff for ambulation and one staff for dressing, The MDS identified R99 was at ment of pressure ulcers and nents which included pressure bed and on chair. Further, the was frequently incontinent of 1/20/15, indicated R99 needed ated R99 was at risk for ssure ulcers. The CAA also ed extensive assistance with equently incontinent of was offered toileting every eeded. ated R99 was at ment of pressure Sore /19/15, identified R99 was at ment of pressure ulcers, skin ent majority of shift in bed or n of friction and shearing and					

PRINTED: 03/08/2016

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245463	B. WING	i		01/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 44	F:	314			
	R99 had impairment cyst to buttocks, oct and refusal of cares to keep skin clean at various intervention area with each inco- able to tolerate repor no alterations in ski Review of R99's cu- plan, provided by the monitor, document skin breakdown, as reposition in bed, to change as needed, incontinent episode During observation was observed seate wheelchair at the di assistant (NA)-H ar his room and proce wheelchair to his be NA-H checked R99 bowel and bladder at NA-H asked R99 "h he did not respond proceeded by positi on a white cloth pate a pillow on his upper upper left side, heat approximately 30 de call light placed, be- with a blanket which	rrent nursing assistant care he facility, directed staff to and report any changes in sist with one staff to turn and o use disposable briefs, clean peri area after each a. on 1/27/16 at 1:17 p.m. R99 ed in a red tilt and space ining room table, when nursing nd NA-J wheeled R99 back to be ded to assist R99 from the ed via total mechanical lift. To see if he was incontinent of and NA-H stated "he was dry." now he would like to lay" and to her. NA-H and NA-J ioning R99 on his back laying d underneath him, then placed er right side of his body and d of bed slightly elevated egrees, bed in low position, d alarm functioning, covered h came up to his mid chest initor in place, at 1:23 p.m.					

If continuation sheet Page 45 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245463	B. WING	i		01/:	28/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	At 1:52 p.m. NA-H due to call light goir off and NA-H stated adjusted the bed al R99 continued to la positioned on his up upper left side, hea approximately 30 d call light placed, be with a blanket which area. NA-H and NA assist with toileting At 2:33 p.m. license another staff memb proceeded to count medication drawer R99 continued to la back, with a pillow p side of his body and slightly elevated ap in low position, call functioning, covere- up to his mid chest member did not offi- toileting for R99. At 3:03 p.m. R99's entered the room a on the call light pad repositioned the ca his back, with a pillow position, covere- up to his mid chest member did not offi- toileting for R99.	and NA-J entered R99 room ng off, NA-H turned call light d "bed alarm was going off, we arm" then exited the room, and on his back, with a pillow oper right side of his body and d of bed slightly elevated egrees, bed in low position, d alarm functioning, covered h came up to his mid chest L-J did not offer to reposition or	F	314			

If continuation sheet Page 46 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245463	B. WING _			01/:	28/2016
NAME OF	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PIONEE	R CARE CENTER				31 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 46	F 3	14			
	hanging off the edg lay on his back, with upper right side of h head of bed slightly degrees, bed in low alarm functioning, of came up to his mid R99's room and sta NA-K and NA-I also LPN-C was asking and he stated "yes asked R99 his leve pain", R99 respond NA-I applied dispos removed R99's blar right and left side of his pants down to h indicated R99's inco urine and soiled wit change his incontin NA-K provided peri which was bright re At 4:20 p.m. NA-K a side and NA-I proce rectal/buttocks whic it which extended u that he had on his r During the observa- to be slightly red ar extended to the out with no open areas At 4:31 p.m. NA-I b got R99's red tilt an bathroom with chait	had his right leg slightly ge of the bed and continued to h a pillow positioned on his his body and upper left side, y elevated approximately 30 y position, call light placed, bed covered with a blanket which chest area. LPN-C entered ated "he is on the move." o entered R99's room while R99 if he was having any pain on my butt." LPN-C then d of pain by saying "is it crying led by saying "yes." NA-K and sable gloves to both hands, nket, then the pillows from the f his upper body, then pulled his knees. NA-K and NA-I ontinent product was wet with th stool and proceeded to hent product. At 4:18 p.m. cares to R99's scrotal area ad and shiny in color. and NA-I rolled R99 to his left eeded by cleaning up R99 ch had soft brown stool all over up underneath R99 dressing right upper buttocks area. tion R99's buttocks was noted round the rectal area which ter edges of his buttock crease noted.					

If continuation sheet Page 47 of 54

		AND HUMAN SERVICES				FORM	: 03/08/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245463	B. WING	à		01/	28/2016
NAME OF I	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PIONEEI	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	sling under R99, the from his bed to whe lift. R99 had not been r until 4:20 p.m., a to R99 was unable to independently and repositioned every plan and had not be incontinence as dire On 1/27/16 at 7:33 care plan directed r every two hours. N/ incontinent of bowe be checked/change indicated she was u been repositioned of stated "he was in be in when you watche On 1/27/16 at 7:39 routinely incontinen needed to be check every two hours. N/ reported to her that repositioned around was to be reposition pain he has on his and stated "I was m antsy from watching went in there to get did not realize that for more than two h prior to us getting h	en proceeded to assist R99 eelchair via total mechanical repositioned from 1:17 p.m. tal of 3 hours and 3 minutes. reposition himself was not assisted by staff to be two hours per his current care een checked or changed for ected by the care plan. p.m. NA-I confirmed R99's R99 was to be repositioned A-I indicated R99 was routinely el and bladder and needed to ed every 2 hours. NA-I unaware when R99 had last or checked or changed and ed when I got here and I went ed me." p.m. NA-K confirmed R99 was t of bowel and bladder and ked/changed and repositioned A-K indicated day shift R99 had last been d 2:00 p.m. NA-K verified R99 ned every two hours due to buttocks area from his cyst hisinformed, he was getting g him on the monitor, so we chim up." NA-K also stated "I he had not been repositioned hours and I did not repo him	F	314	4		

Facility ID: 00443

If continuation sheet Page 48 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245463	B. WING	i		01/	28/2016
NAME OF	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PIONEER CARE CENTER					1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	routinely incontinent needed to be check LPN also verified by not repositioning hit off loaded him to a moved slightly to ac R99's current care repositioned every if On 1/28/16 at 8:32 confirmed R99 was and bladder and ne and repositioned every verified R99's care expect staff to follow sure the resident is hours." 1/28/16 at 9:26 a.m routinely incontinent needed to be check every two hours. N/ not reposition R99 a reposition him we of NA-H stated "it is so we try not to mess 1/28/16 at 5:07 p.m R99's care plan and repositioned every incontinent of bowe be checked/change expect staff to repo and follow the care Review of a facility revised 5/2013, rev procedure was to p	th of bowel and bladder and ked/changed every 2 hours. y adjusting R99 bed alarm was m and stated "they should of different position, he was only djust the pad." LPN-C verified plan directed R99 was to be 2 hours. a.m. registered nurse (RN)-C a routinely incontinent of bowel eeded to be checked/changed very two hours. RN-C also plan and stated "I would w the care plan and to make be repositioned every two hours. RN-C also plan and stated "I would w the care plan and to make be repositioned every two hours. A. NA-H confirmed R99 was th of bowel and bladder and ked/changed and repositioned A-H also verified that she did and stated "we did not only adjusted the bed alarm." o painful for him to reposition, with him too much."	F	314			

Facility ID: 00443

If continuation sheet Page 49 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245463	B. WING _			01/2	28/2016
NAME OF PROVIDER OF	R SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER CARE CE	NTER				31 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
PREFIX (EACH	I DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
in the dev for repos breakdow pressure was critic depended directed s develop a residents immobile policy dire a residen additiona policy dire a residents additiona policy dire a resident additiona policy dire were in b reposition to docum reposition 483.25(h HAZARD The facili environm as is pos adequate prevent a This REC by: Based o interview preventio minimize	itioning, to vn, promot relief. The al for resic nt on staff staff to eva and implen at risk for and reside ected facilit t on an ex l pressure ected staff ed should hing sched bent, monit hing plans.) FREE OF S/SUPER ty must en ent remain sible; and e supervision ccidents.	of an individualized care plan promote comfort, prevent skin te circulation and provide policy revealed repositioning dents who were immobile or for repositioning. The policy aluate residents skin condition, nent repositioning plans for breakdown, who were ents with pressure ulcers. The ity staff to avoid positioning of isting pressure ulcer as may impede healing. The to reposition residents who be on at least every 2 hour lule. The policy directed staff or and evaluate resident	F 3		 1)R99 is Deceased. 2)All residents, and their care plans reviewed by the fall team, those that a potential for falls were identified, a can be affected by this. 	were t have	3/1/16

Facility ID: 00443

If continuation sheet Page 50 of 54

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		ING	· · /	IPLETED
		245463	B. WING		01/	28/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
PIONEEI	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From pa Findings include:	ge 50	F 3	23		
	(MDS) dated 11/20/ diagnoses which ind dementia, cancer a MDS identified R99 impairment, and red 2 staff for transfers, assistance of one s identified R99 was with staff assistance standing position, w moving on and off t transfers. Further, t required use of a w ambulation. The MI since prior assessm R99's significant Ca dated 11/20/15, ide and only stabilized moving from seated around, moving on surface transfers. T had fallen at least of assessment, and have recent falls and fred R99's Risk Assess identified R99 was only, was moderate fallen in the past 4 assistive device/hel assessment identifif further falls.	are Area Assessment (CAA), ntified R99 was not steady with staff assistance for d to standing position, turning and off toilet and surface to The CAA also identified R99		 3) The policy Falls and Fall Managing was reviewed. States, staff will identify and relevant interventions to try serious consequences of f policy was also updated to Individualized fall intervent on the residents Care Plan on the Care Card located i closet. Staff education will be held nursing staff on Feb 26th a This education reviewed th and Fall Risk, Managing. T includes education on iden implementing fall interventil location of information of ir residents fall interventing fall interventions. 4) The Director of Nursing a will conduct audits by obserimplementing fall interventing fall interventing fall interventing for one month, then month months, results will be comfor one month, then month months, results will be repord Quality Assurance Commit recommendations given by be followed. 5) Corrective Action Comp 1st , 2016. 	This policy d implement y to minimize alling. The state, ions are located and as needed in the resident l held for all and 29th , 2016. This education tifying and ions, as well as individual and or designee ervation of staff ions, and care intervention sidents, are care plan. ducted weekly ly for three ported to the tee, and y that team, will	

Facility ID: 00443

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED		
		245463	B. WING			01/:	28/2016
NAME OF F	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 51	F3	323	3		
	indicated R99 was a de-conditioning, and R99's care plan liste included chair alarn wheelchair, Wande and indicated R99 r was not safe and st down or use of hoya a safe place. R99's current nursin provided by the faci which included R99 may use a tilt and s may self transfer at During observation was observed seate wheelchair at a tabl R99 was drinking ju chair alarm was obse At 12:25 p.m. R99 r eating the lunch me a chair alarm on the At 12:31 p.m. R99 r room table, and beg left in his wheelchait meal. At 12:34 p.m. (LPN)-C briefly app to lean back in the w R99 continued to no wheelchair.	plan revised on 9/25/15, at risk for falls related to d gait/balance problems. ed various interventions which n on the seat of the rguard, use of a baby monitor may self transfer at times, but aff should assist R99 to sit er lift as needed to get R99 to ng assistant care plan ility listed various interventions o utilized a chair alarm, and pace wheelchair if really tired, times but is not safe. on 1/27/15, at 11:50 a.m. R99 ed in a red tilt and space e in the facility dining room. lice independently, and no served on R99's chair. remained seated at the table, eal. R99 was not observed with e tilt and space wheelchair. remained seated at the dining gan to lean forward and to the ir while he continued to eat his . licensed practical nurse roached R99 and assisted him wheelchair and left the area. ot have a chair alarm on his					
		t to R99 and placed his plate					

If continuation sheet Page 52 of 54

PRINTED: 03/08/2016

		AND HUMAN SERVICES			FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY IPLETED
		245463	B. WING		01/:	28/2016
NAME OF F	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PIONEER	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	of food items on the staff member and L continued to consult alarm was observed At 1:17 p.m. a staff his room from the d into his bed utilizing was observed in the no alarm sounded w wheelchair to the be On 1/27/16, at 1:22 and NA-J confirmed his tilt and space wh recently started utili wheelchair. NA-H ir chair alarm in a reg unsure if he was su and space wheelch On 1/27/16, during NA-H and NA-J at 1 was at risk for falls, alarm on the seat o NA-H indicated the transferred from the and space wheelch NA-H confirmed RS of a chair alarm and On 1/27/16, at 1:25 (FM)-H confirmed h and he got anxious would attempt to se why a monitor was On 1/27/16, at 1:35	e table in front of him. The _PN-C exited the area and R99 me a piece of cake. No chair d on R99's wheelchair. member wheeled R99 back to dining room and transferred g a mechanical lift. No alarm e seat of the wheelchair and when R99 was lifted from the ed. p.m. nursing assistant (NA)-H d R99 had not had an alarm in heelchair and indicated R99 izing the tilt and space indicated R99 had utilized a gular wheelchair but was upposed to have one in the tilt air. a follow up interview with 1:54 p.m., they verified R99, and was to have a chair of his tilt and space wheelchair. chair alarm had not been e regular wheelchair to the tilt air and it should of been. 99's care plan directed the use d indicated it was an oversight. 6 p.m. R99's family member he had a lot of falls recently at times. FM-H indicated R99 elf transfer and stated that is	F 323			

If continuation sheet Page 53 of 54

		AND HUMAN SERVICES				FORM	03/08/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245463	B. WING _			01/2	28/2016
NAME OF !	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	wheelchair and indi a different type of w confirmed R99 had place for the entire was at risk for falls using the alarm." On 1/27/16, at 7:33 at high risk for falls, transfer and utilized On 1/28/16, at 8:32 confirmed R99 was and had recently ha R99 had a recent d to attempt to self tra confirmed R99's cu was to have alarms and wheelchair. On 1/28/16, at 5:07 (DON) confirmed R was at risk for furth utilized a chair alarr stated she would ex on R99's wheelchai follow the care plan Review of facility po Managing, revised o on previous evaluat staff will identify inte resident's specific r	cated the facility was "trialing" wheelchair for R99. LPN-C not had the chair alarm in morning. She confirmed R99 and stated "staff should be p.m. NA-I confirmed R99 was made attempts to self d chair alarms and bed alarms. a.m. registered nurse (RN)-C at high risk for further falls ad a lot of falls. RN-C indicated ecline in health but continued ansfer at times. LPN-C mrent care plan and stated R99 a utilized on his bed, recliner f p.m. director of nursing 199's care plan, confirmed R99 er falls and confirmed R99 m the wheelchair. The DON er falls and confirmed R99 m the wheelchair. The DON er falls and confirmed R99 m the wheelchair. The DON er falls and confirmed R99 m the wheelchair. The boon context staff to have the alarm ir and would expect the staff to have the staff to have the alarm the eventions related to the isks and causes to try to the falling or to try to	F 3	23			

If continuation sheet Page 54 of 54

Concernation of the second	and the second second second	AND HUMAN SERVICES	F	64103026	FORM	02/19/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 02 - MAIN BLDG TWO	(X3) DAT	E SURVEY PLETED
		245463	B. WING		01/	26/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000		rs	K 00	0		
	FIRE SAFETY Building 02					
	Minnesota Departm time of this survey, Building was found the requirements for Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 18 New He The facility was sur Pioneer Care Cente Building 02 main bu basement and is Ty Building 03 is a 1-s	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),		*		
	accordance with NI Installation of Sprin The facility has a co smoke detection in the corridor and all accordance with NI Alarm Code" 2007 monitored for autor notification. The sle detection in them a automatic fire detec Minnesota State Fin	fully sprinkler protected in FPA 13 Standard for the ikler Systems 2007 edition. omplete fire alarm system with the corridors, spaces open to common areas installed in FPA 72 "The National Fire edition. The fire alarm is matic fire department being rooms have smoke and all hazardous areas have ction in accordance with the re Code 2007 edition.		EPO	С	
ABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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.

		AND HUMAN SERVICES			RINTED: 02/19/2016 FORM APPROVED MB NO: 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 02 - Main Bldg Two	(X3) DATE SURVEY COMPLETED
		245463	B. WING		01/26/2016
	PROVIDER OR SUPPLIER	1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
K 000	Continued From pa	age 1	K 000		
1	The requirement at MET.	t 42 CFR, Subpart 483.70(a) is			12
	£.	,			
		ĩ			
ORM CMS-25	67(02-99) Previous Versions	S Obsolete Event ID: 9Q512	1 Fa	cility ID: 00443 If continu	ation sheet Page 2 of

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

PRINTED: 02/19/2016 FORM APPROVED OMB NO. 0938-0391

		A BUILD	NG 03 - SOUTH BLDG 3	COM	PLETED
	245463	B. WING		01/:	26/2016
NAME OF PROVIDER OR SUPPLIER PIONEER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000 INITIAL COMMENT	S	KC	00		
FIRE SAFETY					
Building 03					
ALLEGATION OF C DEPARTMENT'S AC SIGNATURE AT TH	DC WILL SERVE AS YOUR OMPLIANCE UPON THE CCEPTANCE. YOUR E BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.				
ONSITE REVISIT O CONDUCTED TO V SUBSTANTIAL COM REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE WALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION.				
Minnesota Departmo Fire Marshal Division Pioneer Care Cente compliance with the in Medicare/Medicai 483.70(a), Life Safe edition of National F	Survey was conducted by the ent of Public Safety, State n. At the time of this survey, r was not found in substantial requirements for participation d at 42 CFR, Subpart ty from Fire, and the 2000 ire Protection Association 01, Life Safety Code (LSC), alth Care.				
DEFICIENCIES (K 1	R THE FIRE SAFETY FAGS) TO:		EPOC		
Health Care Fire Ins State Fire Marshal E 445 Minnesota Stree St. Paul, MN 55101	Division				
LABORATORY DIRECTOR'S OR PROVIDE Electronically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE 02/19/2016

Electronically Signed

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.

		AND HUMAN SERVICES			FORM	D: 02/19/2016 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION ING 03 - SOUTH BLDG 3		TE SURVEY MPLETED
		245463	B. WING		01	/26/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
PIONEEI	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 000	Or by e-mail to: Marian.Whitney@s or Angela.Kappenmar THE PLAN OF COU DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pro 3. The name and/o responsible for corr prevent a reoccurre The facility was sur Pioneer Care Cente Building 02 main bub basement and is Ty Building 03 is a 1-s basement, Type V The building is fully accordance with NH Installation of Sprin The facility has a co smoke detection in the corridor and all accordance with NH Alarm Code" 2007	tate.mn.us m@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. veyed as two buildings. er is made up of two buildings. uilding is a 2-story, without a ype II (111) construction. tory building without a (111). sprinkler protected in FPA 13 Standard for the kler Systems 2007 edition. omplete fire alarm system with the corridors, spaces open to common areas installed in FPA 72 "The National Fire edition. The fire alarm is	K	DEFICIENC	Υ)	
	accordance with NI Installation of Sprin The facility has a co smoke detection in the corridor and all accordance with NI Alarm Code" 2007 monitored for autor notification. The sle detection in them a automatic fire detection	FPA 13 Standard for the kler Systems 2007 edition. omplete fire alarm system with the corridors, spaces open to common areas installed in FPA 72 "The National Fire		er e		

Event ID: 9Q5I21

Facility ID: 00443

If continuation sheet Page 2 of 4

	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0938-039 E SURVEY
FCORRECTION	DENTIFICATION NUMBER:			COM	IPLETED
	245463	B. WING _		01/	26/2016
PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO		+
R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIO DATE
Continued From pa	age 2	K 00	00		
NOT MET as evide	enced by:	K 02	5		2/18/16
Smoke barriers are least a one-hour fir accordance with 8. terminate at an atri protected by fire-ra panels in approved separate compartin floor. Dampers are penetrations of sm heating, ventilating	e constructed to provide at re resistance rating in 3. Smoke barriers may ium wall. Windows are sted glazing or by wired glass d frames. A minimum of two ments are provided on each not required in duct oke barriers in fully ducted , and air conditioning systems.	K UZ	.5		2/10/10
Based on observa determined that the smoke barrier walls 101-2000 edition, § 18.3.7.3, 8.3.2, and could allow the pro throughout the sou event of a fire whic residents as well a staff and visitors.	tions and staff interview, it was e facility failed to maintain s in accordance with NFPA Sections 18.3.7, 18.3.7.1, d 8.3.6. This deficient practice ducts of combustion spread th end of the facility in the sh could affect 44 of the 105		with the correct fire barrier s Completed on 2/18/2016	ealant.	
Findings include:					
	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER CARE CENTER SUMMARY STA (EACH DEFICIENC REGULATORY OR I Continued From pa The facility has a li and had a census The requirement a NOT MET as evide NFPA 101 LIFE SA Smoke barriers are least a one-hour fir accordance with 8. terminate at an atri protected by fire-ra panels in approved separate compartin floor. Dampers are penetrations of sm heating, ventilating 18.3.7.3, 18.3.7.5, This STANDARD Based on observa determined that the smoke barrier wall 101-2000 edition, S 18.3.7.3, 8.3.2, and could allow the pro throughout the sou event of a fire whic residents as well a staff and visitors.	F CORRECTION IDENTIFICATION NUMBER: 245463 PROVIDER OR SUPPLIER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 The facility has a licensed capacity of 105 beds and had a census of 99 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 8.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread throughout the south end of the facility in the event of a fire which could affect 44 of the 105 residents as well as an undetermined number of staff and visitors.	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 245463 B. WING	OF DEFICIENCIES (X1) PROVIDERSUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION A BUILDING 63 - SOUTH BLDG 3 245463 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER FORD page 2 K 000 Continued From page 2 K 000 The facility has a licensed capacity of 105 beds and had a census of 99 at the time of the survey. PREPX The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: K 025 Smoke barriers are constructed to provide at least a one-hour fir resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, emilitating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 Cable Pipe Sleeve now has with the correct fire barrier so may termined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 18.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread throughout the south end of the facility in the evev	OF DEFICIENCIES F CORRECTION (X1) PROVIDERUSPLIERCLA IDENTIFICATION NUMBER: 245483 (X2) MULTPLE CONSTRUCTION A BUILDING 03 - SOUTH BLDB 3 (X3) PAT CON A BUILDING 03 - SOUTH BLDB 3 PROVIDER OR SUPPLIER 245483 B. WING 01/ CON CARE CENTER STMET ADDRESS, CITY, STATE, ZIP CODE 1131 SOUTH MABELLE AVENUE FERCUS FALLS, NM 56537 01/ CON FROVIDER OF LADRESS, CITY, STATE, ZIP CODE 1131 SOUTH MABELLE AVENUE FERCUS FALLS, NM 56537 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIEDE DY FULL RECULATORY OR LSC DEATTFYNG INFORMATION) D PROVIDERS PLAN OF CORRECTION 12ACH CONSTRUCTION FERCULATORY OR LSC DEATTFYNG INFORMATION) PROVIDERS PLAN OF CORRECTION 13ACH CONSTRUCTION 14AC

Event ID: 9Q5I21

Facility ID: 00443

If continuation sheet Page 3 of 4

STATURENT OF DEFIDENCIES AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPRO CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP GODE PIONEER CARE CENTER STREET ADDRESS, CITY, STATE ZIP GODE PREIN TAG SUMMARY STATEMENT OF DEFICIENCES In PREIN REQULATORY OR LSC IDENTIFYING INFORMATION In PREIN TAG PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENT MAST DE PRECIDE BY FULL (EACH DEFICIENCY MUST DE PRECIDE BY FULL (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) PRECIN TAG K 025 Continued From page 3 01/26/2015, it was observed that the smoke barrier for the Deerwood wing had a cable pipe sideeve that was found to be passing through the smoke barrier wall without firestopping inside of it. K 025 This deficient practice was confirmed by the Environmental Services Director In an	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STRELEY CODE PIONEER CARE CENTER Ital South MABELLE AVENUE PREROUS FALLS, MIN 56537 (M) D TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) PREV (EACH DEFICIENCY K 025 Continued From page 3 01/26/2015, it was observed that the smoke barrier for the Deerwood Wing had a cable pipe sieeve that was found to be passing through the smoke barrier wall without firestopping inside of it. K 025 This deficient practice was confirmed by the Environmental Services Director This deficient practice was confirmed by the Environmental Services Director			245463	B. WING		01	01/26/2016	
(x) D PROUGER SPLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PROPERTY REGULATORY OR ISCIDENTIFYING INFORMATION) PROPERTY TAG PROPERTY (EACH ORRECTIVE ACTION BE PRECEDED BY FULL (EACH ORRECTIVE ACTION BY OLD BE ORDESR-REFERENCED TO THE APPROPRIATE DEFICIENCY) DMIL Convertion (EACH ORRECTIVE ACTION BY OLD BE ORDESR-REFERENCED TO THE APPROPRIATE DEFICIENCY) DMIL Convertion (EACH ORRECTIVE ACTION BY DEFICIENCY) DMIL Convertion (EACH ORRECTIVE DEFICIENCY) DMIL					STREET ADDRESS, CITY, STATE, ZIP CODE 1131 SOUTH MABELLE AVENUE			
Préérix TAG ICACH DEFICIENCY MUST BE PRÉCEBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREEX TAG ICACH DERTIFYING INFORMATION PREEX TAG K 025 Continued From page 3 01/26/2016, it was observed that the smoke barrier for the Deerwood wing had a cable pipe sleeve that was found to be passing through the smoke barrier wall without firestopping inside of it. K 025								
01/26/2015, it was observed that the smoke barrier for the Deerwood wing hed a cable pipe sleeve that was found to be passing through the smoke barrier wall without firestopping inside of it. This deficient practice was confirmed by the Environmental Services Director	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ION SHOULD BE COMPLETION THE APPROPRIATE DATE		
	K 025	01/26/2015, it was barrier for the Deer sleeve that was fou smoke barrier wall This deficient pract	observed that the smoke wood wing had a cable pipe and to be passing through the without firestopping inside of it.	К 0				