Electronically Delivered

May 12, 2026

Licensee
Pioneercare - Memory Cottages
1317 South Mabelle Avenue
Fergus Falls, MN 56537

RE: Project Number(s) SL21568016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21568016-0 On April 20, 2026, through April 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 29 residents; all 29 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an accurate daily work schedule at the beginning of each work shift. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 2 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care license effective April 1, 2026, and was licensed for a capacity of 52 residents, with a current census of 29 residents. During the entrance conference on April 20, 2026, at 10:25 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee was familiar with the current minimum living requirements. In addition, they stated they had two houses with three shifts as follows: - morning shift (6:30 a.m. to 2:30 p.m. / 7:00 a.m. - 3:00 p.m.) 3 unlicensed personnel (ULP) per house; - evening shift (2:30 p.m. to 10:30 p.m. / 3:00 p.m. to 11:00 p.m. / 4:30 p.m. to 9:30 p.m.) 3 ULP per house; and - night shift (10:30 p.m. to 6:30 p.m. / 11:00 p.m. to 7:00 a.m.) 2 ULP per house. The licensee's Direct-Care Staffing Plan dated March 23, 2026, noted the following staffing including: - morning shift 3 ULP per house; - evening shift 3 ULP per house; and - night shift 1 1/2 - 2 ULP per house. The licensee's schedule noted the following: - April 20, 2026, 5 ULP on the morning shift, 6 ULP on the evening shift, and 3 1/2 ULP on the night shift;	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 3 - April 21, 2026, 5 ULP on the morning shift, 6 ULP on the evening shift, and 4 ULP on the night shift; - April 22, 2026, 5 ULP on the morning shift, 6 ULP on the evening shift, and 4 ULP on the night shift; - April 23, 2026, 6 ULP on the morning shift, 6 ULP on the evening shift, and 4 ULP on the night shift; - April 24, 2026, 6 ULP on the morning shift, 6 ULP on the evening shift, and 3 ULP on the night shift; - April 25, 2026, 6 ULP on the morning shift, 6 ULP on the evening shift, and 4 ULP on the night shift; and - April 26, 2026, 5 ULP on the morning shift, 5 ULP on the evening shift, and 3 1/2 ULP on the night shift. On April 20, 2026, at 11:10 a.m., during the facility tour with CNS-A, the surveyor observed two buildings with a great room, offices, living room, kitchen, dining room, and resident rooms. Postings were noted inside the main entrance, and the staff posting was located on the dining room door. The licensee's Current Staffing Pattern (posting) dated September 4, 2024, and signed as current as of March 23, 2026, noted: - 3 ULP per building on the morning shift; - 3 ULP per building on the evening shift; and - 2 ULP per building on the night shift. On April 21, 2026, at 7:30 a.m., two ULP were working in the Heartland building on the morning shift. On April 21, 2026, at 2:45 p.m., LALD-B stated they do not change the schedule to reflect the	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 4 current number of staff working each day. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of three employees (unlicensed personnel/ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 5 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 21, 2026, at 7:27 a.m., the surveyor observed ULP-C perform cares for R1 in her room. With gloved hands, ULP-C provided perineal cares with a washcloth to R1 moving from back to front. ULP-C then dried the perineal area with a towel going from front to back, pulled up R1's incontinent brief, removed her gloves, and washed her hands. On April 21, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-A stated staff are trained and expected to perform perineal cares from front to back to prevent infection. D&S Diversified Technologies LLP Minnesota Nurse Aide Candidate Handbook dated January 2, 2023, instructed to "wash genital area from front to back." The Centers for Disease Control's (CDC), undated Skin, Perineal, and Urinary Catheter Care: Maintaining the Body's First Lines of Defense Against Infections, instructed to wash the perineal area from front to back to avoid a urinary tract infection. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 550	Continued From page 6 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the name, telephone number, and email contact information for the individuals who were responsible for handling resident grievances. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 550	Continued From page 7 On April 20, 2026, at 11:10 a.m., during the facility tour with CNS-A, the surveyor observed two buildings with a great room, offices, living room, kitchen, dining room, and resident rooms. Postings were noted inside the main entrance. The complaint posting lacked the name, telephone number, and email contact information of the person designated to handle and resolve complaints. The licensee's Complaint policy dated August 1, 2021, noted the written notice would include the name and contact information of the person designated to handle and resolve complaints. On February 21, 2026, at 2:40 p.m., licensed assisted living director (LALD)-B stated the policy lacked the name, telephone number, and email contact information required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 8 self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included dementia (a progressive disease causing cognitive decline) and Type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin). On April 21, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-C perform cares for R1 in her room. R1's Service Plan Report dated March 20, 2026, noted R1 received services including assistance with bathing, dressing, and medication administration. R1's IAPP dated March 22, 2026, noted in the	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 9 instructions "For each area, assess whether the client [resident] is susceptible to maltreatment by others and the client's [resident's] risk of maltreating other vulnerable people. If susceptible, indicate why by checking the appropriate reason or by adding a reason. Identify specific measures to be taken to minimize the risk within the scope of licensed services and identify referrals needed when the client [resident] is susceptible outside the scope or control of the licensed services. If the client [resident] does not need specific risk reduction measures in addition to those identified in the program abuse prevention plan, document this determination and identify the area of the program prevention plan that addresses the area of susceptibility." The plan then lists the following: - sexual abuse - "Is the resident susceptible to abuse in this area," A box was marked yes with vascular dementia listed and specific measures included "supervision, redirection"; - physical abuse - "Is the resident susceptible to abuse in this area." A box was marked yes with vascular dementia listed and specific measures included "redirection, distraction"; - self abuse - "Is the resident susceptible to abuse in this area." The box was marked yes with vascular dementia listed and specific measures included "redirection, distraction"; and - financial exploitation - "Is the resident susceptible to abuse in this area." The box was marked for "Inability to handle financial matters" and specific measures included "supervision family (POA) [power of attorney] manages." R2 R2 admitted for services on August 30, 2023. R2's diagnoses included dementia and atherosclerotic heart disease of native coronary	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 10 artery (where plaque builds up inside of the walls of the arteries). R2's Service Plan Report dated February 17, 2026, indicated R2 received services including assistance with bathing, toileting, and medication administration. R2's IAPP dated February 3, 2026, noted in the instructions "For each area, assess whether the client [resident] is susceptible to maltreatment by others and the client's [resident's] risk of maltreating other vulnerable people. If susceptible, indicate why by checking the appropriate reason or by adding a reason. Identify specific measures to be taken to minimize the risk within the scope of licensed services and identify referrals needed when the client [resident] is susceptible outside the scope or control of the licensed services. If the client [resident] does not need specific risk reduction measures in addition to those identified in the program abuse prevention plan, document this determination and identify the area of the program prevention plan that addresses the area of susceptibility." The plan then lists the following: - sexual abuse - "Is the resident susceptible to abuse in this area," A box was marked yes with cognitive impairment listed and specific measures included "redirect, distract, reorient, see care plan"; - physical abuse - "Is the resident susceptible to abuse in this area." A box was marked yes with inability to identify potentially dangerous situations marked, inappropriate interactions with others marked, verbally/physically abusive to others marked, and cognitive impairment listed and specific measures included "distract, redirect, reorient," It also noted same as A (physical abuse section);	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 11 - self abuse - "Is the resident susceptible to abuse in this area." The box was marked yes with inability to care for self-help needs with medication administration, reminders, reorientation listed, lack of self-preservation skills (ignores client safety marked, and cognitive impairment listed and specific measures included "Same as A (physical abuse section) distract, redirect, reorient"; and - financial exploitation - "Is the resident susceptible to abuse in this area." Other was marked with a note family manages finances, and specific measures included "family manages finances and Same as A (physical abuse)." On April 21, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-A stated staff document any concerns in their electronic documenting system and 1:1 or redirect are the only interventions listed to choose from when monitoring behavior type occurrences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 12 and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee records contained the required content for four of four employees (clinical nurse supervisor/CNS-A, registered nurse/RN-E, unlicensed personnel/ULP-C, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 13, 2026, at 12:55 p.m., licensed assisted living director (LALD)-B and CNS-A stated the licensee was	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 13 aware of the required contents of the employee records. CNS-A CNS-A was hired on September 23, 2019, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. CNS-A's record lacked documented evidence of the following: - annual performance reviews identifying areas of improvement needed and training needs for 2025; and - annual training including a review of the provider's policies and procedures. RN-E RN-E was hired on September 1, 2025, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. RN-E's record lacked documented evidence of the following: - a review of the licensee's policies and procedures during orientation; and - a review of the types of Assisted Living services the employee would provide and the provider's scope of license during orientation. ULP-C ULP-C was hired on November 7, 2020, to provide direct care and services to the licensee's residents. ULP-C's record lacked documented evidence of the following: - annual performance reviews identifying areas of improvement needed and training needs for	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 14 2025; - annual training including a review of the provider's policies and procedures. ULP-F ULP-F was hired on October 13, 2025, to provide direct care and services to the licensee's residents. ULP-F's record lacked documented evidence of the following: - training and competency on the licensee's policy and procedure for preparing medications for unplanned times away. On April 22, 2026, at 2:20 p.m., LALD-B and CNS-A stated the required training had been provided but was not documented in the employee records. The licensee's Personnel Records policy dated August 1, 2021, noted the personnel record for each employee would include: - record of orientation; - record of annual training; - performance evaluations done annually; and - record of training and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 15 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 16 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 20, 2026, at 11:10 a.m., during the facility tour with clinical nurse supervisor (CNS)-A, the surveyor observed two buildings with a great room, offices, living room, kitchen, dining room, and resident rooms. Postings were noted inside the main entrance. However, no posting was noted regarding the location of the EPP. The licensee's white binder labeled "Emergency Operations Program and Plan Manual" dated last reviewed on January 26, 2026, lacked the following required content: - contact information for the Office of Ombudsman for Long-Term Care. On April 22, 2026, at 1:30 p.m., licensed assisted living director (LALD)-B and CNS-A stated the contact information was not included as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced	0 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 690	Continued From page 17 by: Based on interview and record review, the licensee failed to maintain records for each resident, with resident record entries dated and authenticated with the name and title of the person making the entry, for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included Alzheimer's disease (a progressive brain disorder that destroys memory and thinking skills). R3 admitted for services on March 13, 2024, and discharged to the hospital on April 14, 2026. R3's Service Plan Report dated January 27, 2026, indicated R3 received services including assistance with bathing, toileting, dressing, and medication administration. R3's Discharge Summary lacked a date and the name and title of the person completing the report. On April 21, 2026, at 12:55 p.m., clinical nurse supervisor (CNS)-A stated she had completed the discharge summary and noted it lacked the date of completion and her name and title.	0 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 690	Continued From page 18 The licensee's Resident Records policy dated August 1, 2021, noted entries in the record would be legible, permanently recorded, dated, and signed by the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 19 Environment Inspection Report (PEIR) dated April 22 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 20 be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for one of one resident (R2) who was hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included dementia (a progressive disease causing cognitive decline) and atherosclerotic heart disease of native coronary artery (where plaque builds up inside of the walls	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 21 of the arteries). R2's Service Plan Report dated February 17, 2026, indicated R2 received services including assistance with bathing, toileting, and medication administration. R2's Progress Notes included the following: - January 27, 2026, at 5:01 p.m., R2 fell in the living room after attempting to get off the couch independently. R2 hit her head and sustained a small laceration. R2 was taken to the emergency department for evaluation; - January 28, 2026, at 7:23 a.m., resident admitted to the hospital last night with a diagnosis of atrial fibrillation (a rapid, irregular heartbeat), hypotension (low blood pressure), and tachycardia (a resting heart rate over 100 beats per minute). It also noted staples were placed for the head laceration; and - January 28, 2026, at 1:46 p.m., resident returned to the facility. On April 21, 2026, at 1:45 p.m., licensed assisted living director (LALD)-B stated an emergency relocation had not been completed since R2 returned the next day. LALD-B stated her process was to complete one if the resident was gone for more than 24 hours. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 22 living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 23 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to assess residents after a fall and develop and implement new interventions related to the root cause of falls for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 20, 2026, at 10:25 a.m., clinical nurse supervisor (CNS)-A stated after a fall there is a fall note made by nursing or a fall report made by staff. Staff notify the nurse on call nurse or her. The on call nurse puts in a preliminary note of what is found and any monitoring, and she does a fall note when she comes in and sees the resident. R1	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 24 R1's diagnoses included dementia (a progressive disease causing cognitive decline) and Type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin). On April 21, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-C perform cares for R1 in her room. R1's Service Plan Report dated March 20, 2026, noted R1 received services including assistance with bathing, dressing, and medication administration. R1's Progress Notes included the following: - October 23, 2025, at 9:00 a.m. - resident fell in her bedroom near the bed. No new interventions were implemented; - November 22, 2025, at 4:28 p.m. - resident fell while walking. Staff suspect resident put herself on the floor. No new interventions were implemented; - November 30, 2025, at 12:06 a.m. - resident found on his knees by the recliner. Assisted with room rearranging. No new interventions were implemented; - December 10, 2025, at 12:06 p.m. - resident fell in his bedroom with a bruise to his hand. No new interventions were implemented; - December 17, 2026, at 8:58 a.m. - resident fell in the hallway. Intervention added to assist with ambulation as needed for increased weakness; - March 3, 2026, at 8:36 a.m. - resident attempting to walk to her bedroom without her walker and fell. Resident was assisted with toileting and a note was placed on her walker to use at all times; and - March 5, 2026, at 11:47 a.m. - found on her right side next to her bed. Bed was rearranged to	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 25 prevent rolling out. R2 R2's diagnoses included dementia and atherosclerotic heart disease of native coronary artery (where plaque builds up inside of the walls of the arteries). R2's Service Plan Report dated February 17, 2026, indicated R2 received services including assistance with bathing, toileting, and medication administration. R2's Progress Notes included the following: - December 1, 2026, at 4:19 p.m. - resident stood up from her chair and stumbled and fell to her knees. Physical therapy (PT) evaluation for unsteadiness and concern with gait and strength; - December 26, 2025, at 7:15 a.m. - resident fell near the recliner. Note placed on her walker to reminder her to talk the walker with her when walking; - January 27, 2026, at 5:01 p.m. - resident attempted to self transfer in the living room and fell to the ground. Resident assisted from the floor and sent to the emergency department for evaluation. No new interventions were implemented; - March 20, 2026, at 7:53 a.m. - resident stood up and caught her arm and staff lowered her to the ground. Resident was assisted to the bathroom and back to bed. No new interventions were implemented; and - March 29, 2026, at 4:00 p.m. - resident running and fell in the living room. Staff assisted resident to a chair. No new interventions were implemented. On April 21, 2026, at 1:05 p.m., CNS-A stated residents should be assessed after falls and not	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 26 all falls included new interventions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans included a signature documenting agreement on the services for three of three residents (R1, R2,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 27 R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted for services on July 13, 2023. R1's diagnoses included dementia (a progressive disease causing cognitive decline) and Type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin). On April 21, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-C perform cares for R1 in her room. R1's Service Plan Report dated March 20, 2026, noted R1 received services including assistance with bathing, dressing, and medication administration. However, the service plan lacked a signature by or other authentication by the facility and the resident/representative documenting on the services to be provided. R2 R2 admitted for services on August 30, 2023. R2's diagnoses included dementia (a progressive disease causing cognitive decline) and	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 28 atherosclerotic heart disease of native coronary artery (where plaque builds up inside of the walls of the arteries). R2's Service Plan Report dated February 17, 2026, indicated R2 received services including assistance with bathing, toileting, and medication administration. However, the service plan lacked a signature by or other authentication by the facility and the resident/representative documenting on the services to be provided. R3 R3 admitted for services on March 13, 2024, and discharged to the hospital on April 14, 2026. R3's diagnoses included Alzheimer's disease (a progressive brain disorder that destroys memory and thinking skills). R3's Service Plan Report dated January 27, 2026, indicated R3 received services including assistance with bathing, toileting, dressing, and medication administration. However, the service plan lacked a signature by or other authentication by the facility and the resident/representative documenting on the services to be provided. On April 21, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-A stated it was not their practice to have the service plan report signed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 29 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 30 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 admitted for services on July 13, 2023. R1's diagnoses included dementia (a progressive disease causing cognitive decline) and Type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin). On April 21, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-C perform cares for R1 in her room. R1's Service Plan Report dated March 20, 2026, noted R1 received services including assistance with bathing, dressing, and medication administration. However, the service plan lacked: - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On April 21, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-A stated R1's service plan did not include the above required content. R2	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 31 R2 admitted for services on August 30, 2023. R2's diagnoses included dementia and atherosclerotic heart disease of native coronary artery (where plaque builds up inside of the walls of the arteries). R2's Service Plan Report dated February 17, 2026, indicated R2 received services including assistance with bathing, toileting, and medication administration. However, the service plan lacked: - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On April 21, 2026, at 1:45 p.m., CNS-A stated R2's service plan lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	Continued From page 32 This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment to determine what medication management services would be provided and how the services would be provided, for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	Continued From page 33 The findings include: During the entrance conference on April 20, 2026, at 10:25 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents at the facility. R1 R1's diagnoses included dementia (a progressive disease causing cognitive decline) and Type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin). On April 21, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-C perform cares for R1 in her room. R1's Service Plan Report dated March 20, 2026, noted R1 received services including assistance with bathing, dressing, and medication administration. R1's Medication Administration Record (MAR) for April 2026, included the names and dosage of medications, times to administer, and staff initials indicating the medications had been administered. R1's record lacked a medication assessment including: - an identification and review of all medications the resident was known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	Continued From page 34 R2 R2's diagnoses included dementia and atherosclerotic heart disease of native coronary artery (where plaque builds up inside of the walls of the arteries). R2's Service Plan Report dated February 17, 2026, indicated R2 received services including assistance with bathing, toileting, and medication administration. R2's MAR for April 2026, included the names and dosage of medications, times to administer, and staff initials indicating the medications had been administered. R2's record lacked a medication assessment including: - an identification and review of all medications the resident was known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues. On April 21, 2026, at 1:05 p.m., CNS-A stated they currently did not include the above required content in the medication assessment for any residents. The licensee's undated Individualized Medication, Treatment & Therapy Management Plans policy noted the RN would develop a medication management plan based upon the resident assessment and services provided. No further information was provided.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	Continued From page 35 TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an as needed (PRN) medication was administered as ordered for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 36 R1's diagnoses included dementia (a progressive disease causing cognitive decline) and Type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin). On April 21, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-C perform cares for R1 in her room. R1's Service Plan Report dated March 20, 2026, noted R1 received services including assistance with bathing, dressing, and medication administration. R1's prescriber orders dated April 2, 2026, included: - loperamide hydrochloride 2 milligrams (mg) - give 4 mg (2 tablets) as needed after initial loose stool; and - loperamide hydrochloride 2 mg - give one tablet by mouth as needed after each loose stool thereafter. R1's Medication Administration Record (MAR) for April 2026, identified medications had been given as follows: - April 3, 2026, at 9:25 a.m., - loperamide hydrochloride 2 mg administered (no initial dose of 4 mg documented); and - April 5, 2026, at 7:51 a.m., - loperamide hydrochloride 2 mg administered (no initial dose of 4 mg documented). On April 21, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-A stated staff may have signed off on the wrong dose. CNS-A stated the initial dose should be administered first.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 37 The licensee's Administration and Documentation of PRN Medications policy dated August 1, 2021, noted staff would administer PRN medications exactly as prescribed and document administration of PRN medication on the form. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement policies and procedures with the required content for giving accurate and current medications for those residents who received medication management services having planned and unplanned times away from home. This practice resulted in a level two violation (a	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01780	Continued From page 38 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 20, 2026, at 10:25 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. The licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away From Home policy dated August 1, 2023, lacked a statement to include: - for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; and - for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days. On April 22, 2026, at 1:25 p.m., CNS-A stated the policy did not include the required statements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure complete written or electronically recorded prescriptions were obtained for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 20, 2026, at 10:25 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents at the facility. R1's prescriber orders dated April 2, 2026, included: - Bisacodyl suppository 10 milligrams (mg) insert one suppository rectally as needed for constipation (lacked the frequency); - loperamide hydrochloride 2 mg give one tablet	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 40 after each loose stool thereafter (no maximum dose indicated); - Milk of Magnesia give 30 milliliters (ml) by mouth as needed for constipation (lacked the frequency); and - Nystatin powder 100,000 unit/gram (gm) apply to rash areas as needed for skin (lacked the frequency). On April 21, 2026, at 1:05 p.m., CNS-A stated the above PRN orders lacked a frequency or maximum dose. The licensee's Medication Orders policy dated August 1, 2021, noted medication orders are to include the time or frequency of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two medication refrigerators (Heritage) maintained an acceptable temperature to ensure medications were stored according to manufacturer's recommendations.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 41 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Night Shift Refrigerator and Freezer Temp (Temperature) Checks form for April 2026, indicated the medication refrigerator temperatures ranged from 32 to 34 degrees Fahrenheit (F). On April 22, 2026, at 12:40 p.m., the surveyor observed the Heritage building refrigerator with clinical nurse supervisor (CNS)-A, and noted the temperature was 33 degrees F. The refrigerator contained one unopened bottle of lorazepam (a medication used to treat anxiety, insomnia, and acute seizures) 2 milligrams (mg) / milliliters (ml). At this time, CNS-A stated the temperatures were out of range, and the medication was disposed. The manufacturer's instructions for lorazepam dated May 2021, indicated the medication should be stored between 36 - 46 degrees F. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 42	02110		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 43 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed and provided to each resident and the residents' legal and designated representative at the time of move-in. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care license effective April 1, 2026, and was licensed for a capacity of 52 residents, with a current census of 29 residents. The licensee lacked the required policies to include: - limiting the use of public address and intercom systems for emergencies and evacuation drills only. On April 22, 2026, at 1:13 p.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they did not have a policy regarding, nor did they use an intercom system.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 44 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, a complete description of the dementia care training program to include the required content. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an assisted living with dementia care license effective April 1, 2026.	02260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02260	Continued From page 45 The licensee's Dementia Program Disclosure dated March 7, 2022, lacked the basic topics covered including: - recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma and stressor related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; - de-escalation techniques and communication; and - crisis resolution and suicide prevention, including procedures for contacting crisis response teams and 988 suicide and crisis lifelines. On April 21, 2026, at 2:35 p.m., licensed assisted living director (LALD)-B stated the disclosure lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02410	Continued From page 46 shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of two residents (R1) observed during personal cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia (a progressive disease causing cognitive decline) and Type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin).	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02410	Continued From page 47 R1's Service Plan Report dated March 20, 2026, noted R1 received services including assistance with bathing, dressing, and medication administration. On April 21, 2026, at 7:27 a.m., the surveyor observed ULP-C perform cares for R1 in her room. The bedroom blinds were open half way. The surveyor observed construction workers outside the window walking towards the fence and let ULP-C know they were there. ULP-C then closed the blinds, leaving around six inches open on the bottom. On April 21, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-A stated the blinds should be closed completely during personal cares. Minnesota Bill of Rights for Assisted Living dated January 1, 2026, noted "Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discretely." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Pioneercare Memory Cottages
1317 SOUTH MABELLE AVENUE
Fergus Falls, MN 56537
Otter Tail County
Parcel:

Phone:

License Info

License: HFID 21568

Risk:
License:
Expires on:
CFPM: Taylor Alysa Ness
CFPM #: 61240; Exp: 9/7/2028

Inspection Info

Report Number: F7935261045
Inspection Type: Full - Single
Date: 4/20/2026 Time: 11:59:08 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Fergus Falls District Office inspection report number F7935261045 from 4/20/2026

Rebecca Tonneson

Karen Wulfekuhle
karenw@pioneercare.org

Rebecca Tonneson, RS
Public Health Sanitarian Supervisor
218-332-5142
rebecca.tonneson@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

Pioneercare Memory Cottages
Fergus Falls
County/Group: Otter Tail County

Inspection Info

Report Number: F7935261045
Inspection Type: Full
Date: 4/20/2026
Time: 11:59:08 AM

Equipment Temperature: Product/Item/Unit: Fridge**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Fridge**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Hotdish**; Temperature Process:** Cooking
Location: Oven at 202 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

Pioneercare Memory Cottages
Fergus Falls
County/Group: Otter Tail County

Inspection Info

Report Number: F7935261045
Inspection Type: Full
Date: 4/20/2026
Time: 11:59:08 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 160+ Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL21568016-0	**Date:** 4/22/2026
Facility Name: Pioneercare Memory Cottages	
Facility Address: 1317 Mabelle Ave, Fergus Fall, Mn 56537	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: At the time of survey in the Heartland, Heritage and Homestead cottages there was only one carbon monoxide detector in each building in the same location near the laundry rooms. This location does not meet the requirements of being installed within 10 feet of any bedroom for all the bedrooms.

3. Listed single and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

   Comments: At the time of survey there were no smoke alarms installed in the Heartland, Heritage and Homestead cottages.

4. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable

appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: At the time of survey there was an extension cord going through the ceiling in the Heartland cottage great rooms mechanical room.

5. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: At the time of survey in the Heartland, Heritage and Homestead cottages all the magnetic locked doors did not have the capability to be unlocked from a nursing station, or other approved location.