DEPARTMENT O	F HEALTH A	ND HUMAN	SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: EPDS Facility ID: 00443

	MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL						
	PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY						
R NO	3 NAME AND ADDRESS OF FACILITY	4	TYPE C				

1. MEDICARE/MEDICAID PROVID (L1) 245463 2.STATE VENDOR OR MEDICAID N (L2) 707342900		 NAME AND ADDRESS OF FACILITY (L3) PIONEER CARE CENTER (L4) 1131 SOUTH MABELLE AVENUE (L5) FERGUS FALLS, MN 			(L6) 56537		 TYPE OF ACTION: <u>7</u> (L8) Initial 2. Recertification Termination 4. CHOW Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEGORY 05 HHA 0	9 ESRD	<u>02</u> (L7) 13 PTIP 22 (CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 07 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	r (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	07 X-Ray 1	0 NF 1 ICF/IID 2 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING DATE: (L35) 09/30
 11. LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	105 (L18) 105 (L17)	Compliand 1. 4 B. Not in Cor			And/Or Approved Wa 2. Technical 3. 24 Hour R 4. 7-Day RN 5. Life Safety * Code: A	Personnel N (Rural SNF) y Code	Collowing Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room L12)
14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SN 105 (L37)		ICF (L42)	IID (L43)		15. FACILITY MEET: 1861 (e) (1) or 1861 ((L15)
16. STATE SURVEY AGENCY REN See Attached Remarks	ARKS (IF APPLICABL	E SHOW LTC CANCE	ELLATION DATE):				
17. SURVEYOR SIGNATURE Date :					18. STATE SURVEY	AGENCY API	PROVAL Date:
Susan Bachleitner, HFE - NE II 08/01/2018							
Susan Bachleitner,	HFE - NE II	(08/01/2018	(L19)	Joanne Simor	n, Enforc	ement Specialist 08/01/2018
<u>Susan Bachleitner</u>					Joanne Simor		· (L20)
Susan Bachleitner, Susan Bachleitner, 19. DETERMINATION OF ELIGIBI X 1. Facility is Eligible t 2. Facility is not Eligi	PART II - TO BE LITY o Participate	20. COM		IONAL	21. 1. Statem 2. Owner	GLE STAT	· (L20)
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CCN: 245463

Continued non-compliance was found at the onsite revisit on 05/17/2018

An onsite PCR revisit was completed at this facility on 06/19/2018 at which time an IJ was called and removed" with the highest S/S being K with substandard quality of care. The IJ began on June 18, 2018, at 9:25 a.m, and was removed on June 19, at 1:09 p.m.

A 2nd PCR onsite revisit was completed on 07/03/2018 this agency found to be in compliance.



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 245463

August 1, 2018

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

Dear Ms. Watkins:

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

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

Effective July 3, 2018 the above facility is recommended for:

105 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 1, 2018

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

RE: Project Number S5463028 and H5463024

Dear Ms. Watkins:

On April 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey completed on March 22, 2018 that included an investigation of complaint number H5463024. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

On May 17, 2018, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 22, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on March 22, 2018. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), whereby corrections are required.

As a result of our finding that your facility was not in substantial compliance, this Department imposed the following category 1 remedy:

• State Monitoring effective June 5, 2018. (42 CFR 488.422)

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

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 22, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new

Pioneer Care Center August 1, 2018 Page 2

admissions is effective June 22, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 22, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Pioneer Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 22, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

On June 19, 2018, the Minnesota Department of Health completed an extended survey PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to PCR completed on May 17, 2018. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required.

This department also verified, on June 18, 2018, that the conditions resulting in our notification of immediate jeopardy had been removed. Therefore, the CMS Region V Office was notified that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

Based on our June 19, 2018 visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard survey PCR completed on May 17, 2018. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

You were also notified of the following actions related to the imposed remedies in our letter of June 29, 2018:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 22, 2018. (42 CFR 488.417 (b))

• Civil money penalty. (42 CFR 488.430 through 488.444)

On July 3, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 17, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 3, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on May 17, 2018. As a

Pioneer Care Center August 1, 2018 Page 3

result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 3, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective be discontinued effective July 3, 2018. (42 CFR 488.417 (b))
- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

As we notified you in our letter of June 29, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 19, 2018. The effective date change is due to the extended survey conducted on June 19, 2018.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

August 1, 2018

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

Re: State Licensing Orders - Project Number SE507027

Dear Ms. Watkins:

On July 3, 2018, staff of the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on March 22, 2018, with orders received by you on April 5, 2018; and follow-up survey completed on June 19, 2018, with orders including penalties received by you on June 29, 2018. At this time these correction orders were found corrected.

If you have questions, contact Susanne Reuss, Unit Supervisor at (651) 201-3793 or susanne.reuss@state.mn.us.

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF	HEALTH ANI	D HUMAN	SERVICES
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DEPARTMENT OF HEALT								DICARE	& MEDICAID S	
		CARE/MEDICAL							ID: EPD	
	PARTI	- TO BE COMP	LETED BY T	THE STAT	E SURVI	EY AGE	NCY		Facility II): 00443
1. MEDICARE/MEDICAID PROVID (L1) 245463	ER NO.	3. NAME AND AD (L3) PIONEER C						4. TYPE OF ACTION: <u>7</u> (L8)		-
2.STATE VENDOR OR MEDICAID N	O.	(L4) 1131 SOUTH	I MABELLE A	VENUE				1. Initial 2. Recertification 3. Termination 4. CHOW		
(L2) 707342900		(L5) FERGUS FALLS, MN		(L6) 56537		37	5. Validation 6. Complaint 7. On-Site Visit 9. Other		omplaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP		7. PROVIDER/SUPPLIER CATEGORY			02	(L7)			Survey After Complaint	lilei
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP	22	CLIA			
• • •	/19/2018 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			FISCAL Y	EAR ENDING DATE:	(L35)
8. ACCREDITATION STATUS: (L10)		03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC					()
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPI	CE			09/30	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED AS	S:						
From (a):		A. In Complia	nce With		And/Or A	Approved W	aivers Of The	Following Re	equirements:	
To (b) :			Requirements ce Based On:		2. Technical Personnel6. Scope of Services Limit			át		
				3. 24 Hour RN7. Medical Director						
12.Total Facility Beds	1. Acceptable POC			4.	. 7-Day RN	I (Rural SNF)	— ^{8.}	Patient Room Size		
13.Total Certified Beds	105 (L17)	X B. Not in Con	mpliance with Prog	gram	5.	. Life Safet	y Code	9.	Beds/Room	
		Requirements	and/or Applied Wa	aivers:	* Code:	B *		(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACII	LITY MEET	ſS			
18 SNF 18/19 SNF	F 19 SNF	ICF	IID		1861 (e)	(1) or 1861	(j) (1):		(L15)	
105										
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE	E):						
See Attached Remarks										
17. SURVEYOR SIGNATURE		Date :			18. STAT	E SURVEY	AGENCY A	PPROVAL	Dat	e:
			06/29/2018							
Denise Erickson, HF	= - NE II		00/29/2018	(L19)	Joann	e Simo	n, Enfor	cement	<u>Specialist</u>	07/16/2018 (L20)
	PART II - TO BE	COMPLETED	BY HCFA R	EGIONAL	OFFICE	E OR SIN	IGLE STA	TE AGE	NCY	
19. DETERMINATION OF ELIGIBIL	JTY		MPLIANCE WITH GHTS ACT:	CIVIL	21.				(HCFA-2572) osure Stmt (HCFA-151	3)
X 1. Facility is Eligible to	Participate	N.	onits Act.				of the Above :	Interest Diser	osure Sunt (Her A-151	3)
2. Facility is not Eligib										
	(L21)									
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEN	/IENT	26. TERI	MINATION	ACTION:		(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	ſΈ	<u>VOLUNTA</u>	ARY	00		INVOLUNTARY	
04/11/1987					01-Merger,	Closure			05-Fail to Meet Healt	h/Safety
(L24)	(L41)		(L25)		02-Dissatis	faction W/ H	Reimbursemen	t	06-Fail to Meet Agree	ement
25. LTC EXTENSION DATE:	27. ALTERNATIV	/E SANCTIONS			03-Risk of	Involuntary	Termination		<u>OTHER</u>	
	A. Suspensior	of Admissions:			04-Other R	eason for W	ithdrawal		07-Provider Status Cl	nange
·····			(L44)						00-Active	
(L27)	B. Rescind Sus	pension Date:								
			(1.45)							

(L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 05/03/2018 (L32) (L33) DETERMINATION APPROVAL

CCN: 245463

Continued non-compliance was found at the onsite revisit on 05/17/2018

An onsite PCR revisit was completed at this facility on 06/19/2018 at which time an IJ was called and removed; with the highest S/S being K with substandard quality of care. The IJ began on June 18, 2018, at 9:25 a.m., and was removed on June 19, at 1:09 p.m.



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically Submitted

June 29, 2018

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

RE: Project Number S5463028 and H5463024

Dear Ms. Watkins:

On April 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 22, 2018 that included an investigation of complaint number H5463024. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 17, 2018, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 22, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on March 22, 2018. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), whereby corrections were required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective June 5, 2018. (42 CFR 488.422)

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

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 22, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new

admissions is effective June 22, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 22, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Pioneer Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 19, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

On June 19, 2018, an extended survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> means one or more deficiencies related to participation requirements under 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm; Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on June 18, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective June 5, 2018 will remain in effect. (42 CFR 488.422)

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 22, 2018, will remain in effect. (42 CFR 488.417 (b))

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.24, Quality of Life, and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Pioneer Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 19, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of

care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 22, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as

mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 22, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Feel free to contact me if you have questions.

Pioneer Care Center June 29, 2018 Page 8 Sincerely,

6 >~

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245463	B. WING				R 19/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DIONEEE				11	31 SOUTH MABELLE AVENUE		
PIONEEF	R CARE CENTER			F	ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 00	00}			
	survey 06/19/2018	re noted at the time of the					
{F 000}	INITIAL COMMENT	ſS	{F 00)0}			
	by the Minnesota D 18, and 19, 2018, t Federal deficiencies recertification surver The survey resulted (IJ) at F689 when a was left on and una staff for a total of te cognitively impaired stove and kitchen. 2018, at 9:25 a.m, a at 1:09 p.m	ification revisit was conducted epartment of Health on June to determine the status of s issued during a ey exited on March 22, 2018. d in an Immediate Jeopardy household stovetop burner attended and unsecured by en observed minutes with d residents in the vicinity of the The IJ began on June 18, and was removed on June 19,					
		survey was conducted on June					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the potance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.					
F 000	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with	F 0				0/00/10
F 689 SS=K	• • • · · · · · · · · · · · · · · · · ·	azards/Supervision/Devices 1)(2)	F 6	09			6/20/18
LABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						06/29/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 06/29/2018

		AND HUMAN SERVICES			FORM	: 06/29/2018 APPROVED
STATEMENT OF	DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DAT	. 0938-0391 TE SURVEY IPLETED
		245463	B. WING			R (19/2018
NAME OF PRO	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
				1.	131 SOUTH MABELLE AVENUE	
PIONEER C	ARE CENTER				ERGUS FALLS, MN 56537	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 Co	ontinued From pag	ge 1	Fe	689		
Th §4 as §4 su ac Th by B rev su sta for ha ind at co ind ind at co ind ind at co ind ind at co ind ind at at at at at at at at at at at at at	a free of accident h 83.25(d)(2)Each i pervision and ass acidents. his REQUIREMEN ased on observativity view, the facility fa pervision and acco aff when a stove to r 4 of 21 residents ad severe cognitive dependent in mob risk for burn from officient practice ha ognitively impaired dependent with m mediate jeopardy and R4. holings include: he IJ began on 6/1 trance on the Dea observed to be turn ossing a risk for ser 18/18, at 1:32 p.m e dietician were no entified residents a 2, R3,and R4. The 1:09 p.m., howey a isolated score a				 R1, R2, R3, and R4 are safe. Staff will be present and supervise at all times when burners are on in order to assure residents are safe. All Residents are safe. Staff are present and supervise at all times when burners are on in the household kitchens. Procedure "Safe Practices in the Household Kitchen" was reviewed and updated on 6/19/2018. Education of the Procedure "Safe Practices in the Household Kitchen" was completed with the Dietary Staff 6/18/2018 to 6/20/2018. HM-A was immediately re educated on the procedure, "Safe Practices in the Household Kitchen," on 6/18/2018, following this incident. HM-A received a Disciplinary Action as a result of his actions on 6/18/2018. Random Audits are being conducted to assure stovetop burners that are on, are not left unattended, by staff. These audits 	

Facility ID: 00443

If continuation sheet Page 2 of 14

						. 0938-039 E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
			-			R
		245463	B. WING		06/	19/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
PIONEE	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 689	Deerwood unit kitch and four burners (a the right and in the burners, one on the on the left) was pre- kitchen adjacent to and a counter top of the stove top right f be on as indicated of the stove top. Th on either side of the chains were observ- walls on on both sid chain was across th No staff were prese observations begar observed seated in room seated at the and in the activity a -At 9:28 a.m. the ki burner remained or kitchen or dining ar neighborhood. The	-	F 68		a daily for one conducted on m meals 3 Then these random a 1 time a week udits will be seholds, es 3 months. will be ty Assurance tions for	
	seated in a wheeld wheeled herself tow entrance and stated breakfast. R6 prope front of the counter were observed sea	At that time R6 was observed hair in the dining room, she wards the unchained kitchen d she had been waiting for her elled herself back to a table in of the kitchen area. Residents ted in wheelchairs in the dining tables, the hallway of the unit				

		AND HUMAN SERVICES			FORM	06/29/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245463	B. WING			R 19/2018
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PIONEE	R CARE CENTER			131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	with no staff obser of the Deerwood ur her wheelchair at th Residents remained including the dining adjacent to the kitcl -At 9:35 a.m. a staff from the hall adjace neighborhood and I gloved hand. He sta (HM)-A for the Dee the Deerwood neigh Cherrywood neight HM-A confirmed the was left on unatten had only been gone immediately shut th burner was hot. HM work on the Deerwo how many english r run out. He stated h stove top on unatten have applied the ye entrances to the kit kitchen. On 6/18/18, from 9 right burner of the I stove top was obse hot for a total of ter staff. No staff were neighborhood durin duration. The hot si accessible to reside hazard, including co	age 3 tove top burner remained on, ved in the kitchen or dining are hit, and R6 remained seated in he dining room table. d in various areas of the unit, room, seating area near hen and in the hallways. If member entered the kitchen ent to the outside of the held an english muffin in his ated he was the homemaker rwood neighborhood, had left hborhood and walked to the borhood for an english muffin. e front right burner of the stove ded and stated he thought he e a few seconds. He he burner off and confirmed the 1-A stated he did not usually ood unit and was not aware of muffins were needed, and had he usually would not leave the inded and indicated he should ellow chains across both ichen area before leaving the :25 a.m. to 9:35 a.m. the front Deerwood neighborhoods erved to be on, unattended and in minutes unsupervised by observed to walk out or in the ag the entire ten minute tove top would have been ents on the unit posing a safety ognitively impaired residents.	F 689			

Facility ID: 00443

If continuation sheet Page 4 of 14

		AND HUMAN SERVICES				FORM	06/29/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245463	B. WING	i			R 19/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER CARE CENTER					131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	unit was conducted observed lying in be observed to be lying observed seated in seated in recliners i dining room seated various areas of the seating area adjace On 6/18/18, at 10:0 interview, HM-A sta the Deerwood unit a of any residents atte He indicated he tho dementia and were indicated he was ur wandered. On 6/18/18, at 10:0 (LPN)-A indicated s Deerwood unit at the the residents on the dementia and had r attempting to enter been unaware the H and unattended. Sh asked to supervise interview. On 6/18/18, at 10:1 practice would be to during a meal service leave, she would sh entrances of the kity yellow chains and s know she was leavi	I, one resident, R7 was ed. No other residents were g in bed. Residents were wheelchairs in their rooms, in the common area and in the at the tables. observed in e unit, seated in recliners in the	F	689			

Facility ID: 00443

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		AND HUMAN SERVICES				FORM	06/29/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245463	B. WING				R 19/2018
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	On 6/18/18, at 10:1 manager (NM)-A fo current census on the wanderguards on the of wandering. A list the Deerwood unit of following informatio mobility status and time, NM-A stated the left unattended whe was a safety conce Review of R1's Sign Assessment (SCSA dated 5/28/18, iden impairment and had Alzheimer's disease MDS identified R1 of and indicated staff the ambulation and loca assessment period R1's SCSA Care Arr identified R1 had co periods of inattention was able to stabilized a sitting to standing indication of R1's sa judgement. R1's current care pl R1 had impaired co was independent w without an assistive revealed R1 was at had left the unit and left ankle. Further, I	5 a.m. registered nurse r the Deerwood unit stated the the unit was 21. NM-A stated e Deerwood unit wore heir persons, due to a history of residents which resided on was requested with the m: resident name, cognition, history of wandering. At that the stove top should "never" be en it was on. NM-A confirmed it rn for residents. nificant Change of Status A) Minimum Data Set (MDS) tified R1 had severe cognitive d diagnoses which included, e, anxiety and depression. The did not use a mobility device had supervised R1 during omotion during the	F	589			

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	06/29/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245463	B. WING			R 19/2018
NAME OF I	PROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PIONEER	R CARE CENTER			131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ige 6	F 689			
	6/18/18, revealed F wandering, had a w	ant (NA) care guide printed on R1 was at high risk for vanderguard on his left ankle ent with transfers and				
	severe cognitive im which included dem and seizure disorder required extensive daily living (ADL's) locomotion and limi	ated 5/3/18, identified R2 had pairment and had diagnoses nentia, Alzheimer's disease er. The MDS identified R2 had assistance with activities of in areas of transfers, ited assistance with DS identified R2 had used a valker.				
	disorganized thinkir impairment. The C/ extensive assistance transfers, locomotic assistance with am identified R2 was a	ated 5/3/18, identified R2 had ng and had cognitive AA revealed R2 received ce with ADL's including on and required limited ibulation. Further, the CAA it risk for falls due to impaired As lacked indication of R2's and judgement.				
	R2 had impaired co processes. R2's ca assistance of one s walker, transfers ar wheelchair. R2's ca self transfer, was a	lan revised 5/3/18, revealed ognition and thought ire plan revealed she required staff with ambulation with a nd locomotion with a are plan revealed she would t a high risk for falls and ticipate her needs and ty.				
		printed 6/18/18, revealed R2 falls, self transferred and				

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	06/29/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245463	B. WING			R 19/2018
NAME OF	PROVIDER OR SUPPLIER	•	;	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PIONEE	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	required assistance and locomotion. R3's quarterly MDS had severe cognitiv diagnoses which in Disease, anxiety, ir identified R3 had ver R3 had required ex transfers, walking a walker and a wheel R3's annual CAA da had disorganized th cognitive loss. The impaired memory, y for falls. R3's care plan revis impaired cognition Lewy body dementi R3's care plan rever with transfers, amb locomotion with a w revealed R3 was al wheelchair with his R3's care plan rever falls and had variou including bed and c unattended in his re directed staff to use mat and staff notific household. Further facility staff to main R3's NA care guide was at high risk for aforementioned fall	e with transfers, ambulation a dated 5/25/18, identified R3 ve impairment and had icluded dementia, Parkinson's ritability and anger. The MDS erbal behaviors, and identified tensive assistance with and locomotion, and used a lchair for mobility devices. ated 11/24/17, identified R3 hinking, inattention and CAA identified R3 had was impulsive and was at risk sed 5/29/18, revealed R3 had and communication related to ia and Parkinson's disease. ealed he required assistance bulation with a walker and wheelchair. The care plan ble to propel himself in a feet around the household. ealed he was at high risk for us interventions in place, chair alarms, not to be left com when restless or anxious, e recliner in the day room, fall cation when family leaves the r, R3's care plan directed train his safety. e printed 6/18/18, revealed R3	F 689			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	06/29/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY PLETED
		245463	B. WING			R 19/2018
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PIONEE	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	walker and locomo care guide revealed himself in a wheelc household. R4's quarterly MDS had moderate cogr diagnoses including hypertension. The I required extensive transfers and locom period. The MDS ic assistance with Am during the assessm R4's annual CAA da had memory impain reminders and suppi identified R4 had hi of hearing, had imp assistance with AD transfers and locom revealed R4's confu was fatigued. R4's safety awareness a R4's care plan revis impaired thought po hearing and require transfers, bed mob locomotion with a w revealed staff were R4's NA care guide R4's required assis ambulation and loc On 6/18/18, at 10:2	tion with a wheelchair. The d R3 was able to propel thair with his feet around the S dated 4/3/18, identified R4 hitive impairment and had g macular degeneration and MDS identified R4 had assistance with bed mobility, notion during the assessment dentified R4 had received ibulation on two occasions nent. ated 10/13/17, identified R4 rment, needed cues, ervision daily. The CAA ighly impaired vision, was hard paired cognition and required L's of bed mobility, ambulation, notion. The CAA further usion would worsen when she CAA lacked indication of R4's and judgement. sed 4/11/18, revealed R4 had rocesses, impaired vision and ed staff assistance with ility, ambulation with a walker, wheelchair. R4's care plan to maintain her safety.				

If continuation sheet Page 9 of 14

		AND HUMAN SERVICES				FORM	06/29/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATI COM	E SURVEY PLETED
		245463	B. WING	i			R 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER	R CARE CENTER				131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From par service, or when a of stated if she had to stove off, chain off th with the two plastic let a staff member H On 6/18/18, at 10:2 the kitchenette stow residents breakfast had a locking mech with a key when the stated she would "m burner on, unattend were not present in chain would be app the kitchen to detou On 6/18/18, at 10:2 process when leavi neighborhood was stove with the key t turn the stove back apply the yellow cha the kitchen area. On 6/18/18, at 10:3 process when prep to remain in the near indicated she would unattended. She sta outside of the neigh another staff member	ge 9 cooking surface was hot. She leave she would shut the the entrances of the kitchen yellow chains and she would know she was leaving. 3 a.m. HM-D stated she used re daily when preparing meals. She stated the stove hanism which was to be locked e stove was not in use. HM-D hever" leave the stovetop ded and indicated when staff the kitchen a plastic yellow lied across both entrances to ar wandering residents. 8 a.m. HM-E stated her usual ng the kitchen area of a to shut off the stove, lock the o ensure residents could not on. She stated she would also ains across both entrances to 4 a.m. HM-F stated her usual aring resident meals would be ar the cooking surfaces and d not leave the stove ated if she needed an item aborhood, she would ask per to get it for her or she	1	689	DEFICIENCY)		
	kitchen area while s she stated if no stat shut off the stoveto and place the yellow	r staff member supervise the she obtained the item. Further, ff were available, she would p, lock the stove with a key w plastic chains across both chen to detour residents from					

Facility ID: 00443

If continuation sheet Page 10 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/29/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245463	B. WING	i			R 19/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	131 SOUTH MABELLE AVENUE		
PIONEEI	R CARE CENTER			F	ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 10	Fe	689			
	(NA)-A stated she f the Deerwood unit v she felt no resident unit. She stated more residents needed s however, she indicat to freely move arou she was in a wheel a walker. NA-A stat resident entering th enter the kitchen ar indicated when the yellow chains were entrances of the kit entering. Further, N asked to supervise interview and was u left on without staff On 6/18/18, at 11:2 interview, the Deerview were reviewed with residents had diagr of the nine, four resi independently move walking or wheelch following: R1 had a was able to be inde a wanderguard in p the unit. R2 had a c Alzheimer's disease once she was up in diagnosis of Lewy b dementia that can h and communication about the unit once	 0 a.m. nursing assistant elt most of the residents on were cognitively impaired and s currently wandered off of the st of the cognitively impaired taff assistance with mobility, ated a few residents were able nd the unit, such as R4, when chair and R1 when he utilized ed she was unaware of any e kitchen area or attempting to ea in her memory. She kitchen was not in use, plastic to be affixed across the chen to detour residents from IA-A stated she had not been the kitchen area prior to unaware the stove had been supervision. 5 a.m. during a follow up wood residents care guides NM-A. NM-A confirmed nine tosis dementia and confirmed idents had the ability to e about the unit, whether by air. NM-A confirmed the a diagnosis of dementia and pendent with mobility and had lace due to a history of leaving diagnosis of dementia and e and was able to self propel a wheelchair. R3 had a body dementia (type of nave focal affects on behavior h,) and was able to move he was up in a wheelchair. R4 i confusion and was able 					

If continuation sheet Page 11 of 14

						FORM	APPROVED	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED	
		245463	B. WING					
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PIONEE	OPE CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED 245463 B. WING B. WING B. WING ER CARE CENTER SUMMARY STATE, ZIP CODE TIST SOUTH MABELLE AVENUE FERGUS FALLS, NN 56537 Image: SumMARY STATE, STATE, ZIP CODE TIST SOUTH MABELLE AVENUE FERGUS FALLS, NN 56537 Development PROVIDERS PLAN OF OPRECTION ENDITIENT MARKELLE AVENUE FERGUS FALLS, NN 56537 Image: SumMARY STATE, ZIP CODE TIST SOUTH MABELLE AVENUE FERGUS FALLS, NN 56537 Development PROVIDERS PLAN OF OPRECTION ENDITIENT MARKELLE AVENUE FERGUS FALLS, NN 56537 Image: SumMARY STATE, ZIP CODE TIST SOUTH MARKELLE AVENUE FERGUS FALLS, NN 56537 Development PROVIDERS PLAN OF OPRECTION ENDITIENT MARKELLE AVENUE FERGUS FALLS, NN 56537 Image: SumMARY STATE, ZIP CODE TIST SOUTH MARKELLE AVENUE FERGUS FALLS, NN 56537 Development PROVIDERS PLAN OF OPRECTION ENDITIENT MARKELLE AVENUE FERGUS FALLS, NN 56537 Image: SumMARY STATE, ZIP CODE TIST SOUTH MARKELLE AVENUE FERGUS FALLS, NN 56537 Development PROVIDERS PLAN OF OPRECTION ENDITIENT MARKELLE AVENUE FERGUS FALLS, NN 56537 Image: South State State Colest Destrophysics the area on the state dist oper south and the state factors from entering and indicated she would operate the state dist operate the avenue state mather should supervise the area unitified were not present in order to ensure residents from entering and indicated she would operate from state factor stated factors both ontimes thate factors stated factors state from entering and indicated she would operate from state factor state factors were safe. The administrator state factors from ente							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	SHOULD BE COMPLETION		
F 689	independently move in a wheelchair. On 6/18/18, at 11:50 (RD)-A stated she e off when the HM was confirmed staff were when the stove was residents. She state received orientation safe practices in ne stated if the HM ass needed to leave the reason, the stove si staff member shoul HM returned. Furth expect the yellow of both entrances to th from entering and in necessarily expect the key if they were On 6/18/18, at 12:0 administrator stated neighborhood stove were not present in were safe. The adm member needed to meal service, then a to be informed in or area. Further, the a of the residents on cognitively impaired On 6/18/18, at 2:48 with the facility adm both confirmed they stove top to be shut	 about the unit once she was a.m. registered dietician expected stove surfaces to be as not present. RD-A e expected to be present in use in order to supervise ed dietary and HM staff had upon hire and annually on ighborhood kitchens. RD-A signed to the neighborhood e stove or kitchen for any hould be shut off and another d supervise the area until the er, she indicated she would nains to be applied across he kitchen to prevent residents hoicated she would not staff to lock the stoves with going to return. 6 p.m. the facility d he expected the e tops to be shut off when staff order to ensure residents ninistrator stated if a staff leave the kitchen area during another staff member needed der to monitor the kitchen dministrator confirmed "some" the Deerwood unit were p.m. during a group interview inistrator and vice president, 	F	589				

Facility ID: 00443

If continuation sheet Page 12 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/29/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245463	B. WING				R 19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	confirmed multiple in Deerwood unit were required staff super the hot burner left of significant safety con not feel it was a cor once the stove was administrator and v felt the issue was re- stove top off and inter- residents on the un- kitchen area. The IJ that began of 6/19/18, at 1:09 p.m the following: -policy and procedur Household Kitchen resident safety. -education was pro- policy and procedur in the neighborhood safety. -auditing is in place cooking services ar A facility policy titled Household Kitchen, was the facility's po team members who would follow safety and residents. The procedures staff we resident safety which appliances when no disconnect stovetop Further the policy d	residents which resided on the e cognitively impaired and vision. They both confirmed on and unattended was a oncern and indicated they did ntinued immediate safety risk turned off. Further, the ice president indicated they esolved when the HM shut the dicated they did not feel it would wander into the an 6/18/18, was removed on n. when the facility completed are for Safe Practives in the was updated to reflect vided to staff on the updated re and safety measures used d units to ensure resident for monitoring safe use of	F	\$89			

If continuation sheet Page 13 of 14

		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES				0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
					F	7
		245463	B. WING _		06 /1	19/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
TAG F 689	Continued From pa unattended.		F 68	DEFICIENCY)		

Facility ID: 00443

PRINTED: 06/29/2018



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

June 29, 2018

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

RE: Project Number S5463028

Dear Ms. Watkins:

On June 18, 2018, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on June 18, 2018, imposed a daily fine in the amount of \$350.00.

On June 18, 2018, an acknowledgement was received by the Department stating that the violation(s) had been corrected. A reinspection was held on June 19, 2018 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is \$350.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$696.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$1046.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minneso	ta Department of He	DEFICIENCIES (M) PROVIDERISUPPLIENCLIA IDENTIFICATION NUMBER: ABUILDING: 				
	IT OF DEFICIENCIES OF CORRECTION					
		00443	TION NUMBER: A. BUILDING: COMPLETED B. WING B. WING R D6/13/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 1131 SOUTH MABELLE AVENUE FERCUS FALLS, MN 56537 D PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE DED BY FULL D PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETE VORDER ICAOH CORRECTIVE ACTION SHOULD BE DATE DATE VORDER ICAOH CORRECTIVE ACTION SHOULD BE COMPLETE DATE NORDER ICAOH CORRECTIVE ACTION SHOULD BE COMPLETE DATE NORDER ICAOH CORRECTIVE ACTION SHOULD BE COMPLETE DATE NORDER Icae Collation ICAOH CORRECTIVE ACTION SHOULD BE COMPLETE NORDER Icae Collation ICAE CORRECTIVE ACTION SHOULD BE COMPLETE Italue Icae Collation Icae Collation Icae Collation Icae Collation Icae Collation Icae Collation Icae Collation Icae Collation Icae Collation Itae Collation Icae Collation Icae Collation Icae Collation Icae Collation Icae Collation Icae Collation Icae Collation I			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PIONEE	R CARE CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
{2 000}	Initial Comments		{2 000}			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. The ther a violation has been compliance with all rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item				
	that may result from orders provided that the Department with	n non-compliance with these t a written request is made to hin 15 days of receipt of a				PLETED R 19/2018
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health 7 DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		

Electronically Signed

6899

If continuation sheet 1 of 15

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00443	B. WING		R 06/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PIONEE	R CARE CENTER		UTH MABELLE FALLS, MN 5			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
{2 000}	Continued From pa	age 1	{2 000}			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departn On June 18, June Department's staff, the following correct Please indicate in y correction that you	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for n indicate in the electronic cess, under the heading ne date your orders will be electronically submitting to the nent of Health. 19, 2018. surveyors of this , visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, te when they will be completed				
	the State Licensing federal software. Ta	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IE statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUM "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. NR ON EACH PAGE.				

EPDS13

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00443	B. WING			R 06/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
PIONEE	R CARE CENTER		ITH MABELI FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
{2 000}	Continued From pa	ge 2	{2 000}				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			6/20/18	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.					
	by: Based on observati review, the facility fa supervision and acc staff when a stove to for 4 of 21 residents had severe cognitiv independent in mot at risk for burn from deficient practice ha cognitively impaired independent with m	ent is not met as evidenced on, interview and document ailed to ensure adequate cident prevention by facility top was left on and unattended s (R1, R2, R3 and R4) who re impairment and were pility on the Deerwood unit and n the hot stove top. The ad the potential to affect all the d residents who were poblity. This resulted in an y (IJ) situation for R1, R2, R3,		Completed			

EPDS13

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING: _				
		00443	B. WING			R 06/19/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
PIONEEF	R CARE CENTER		UTH MABELLI FALLS, MN 5				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 3	2 830				
	Findings include:						
	entrance on the De kitchen, the stove to observed to be turn posing a risk for se 6/18/18, at 1:32 p.r the dietician were r identified residents R2, R3, and R4. Th at 1:09 p.m., howen at a isolated score	(18/18, at 9:25 a.m. when upon berwood neighborhoods top front right burner was ned on and left unattended erious injury for a burn. On m. the facility administrator and notified of the IJ for the at risk for possible injury R1, e IJ was removed on 6/19/18, ver, non-compliance remained and severity which indicated h potential for more than el D.)	ł				
	Deerwood unit kitcl and four burners (a the right and in the burners, one on the on the left) was pre- kitchen adjacent to and a counter top of the stove top right be on as indicated of the stove top. Th on either side of the chains were observ- walls on on both side chain was across the No staff were prese observations began observed seated in room seated at the	5 a.m. upon entrance to the hen, a flat top stove and oven a large burner in the front on back on the left, two small e left front and one in the back esent on the back wall of the a steam table on the left side on the right side. At that time front burner was observed to by a red light on the right side ne kitchen had two entrances, e kitchen area, yellow plastic ved to be hanging from the des of the entrances, neither he entrances to the kitchen. ent in the area, continuous n at that time. Residents were ne wheelchairs in the dining tables, the hallway of the unit area behind the dining room.					
	burner remained or	itchen stove top, right front n, with no staff observed in the rea of the Deerwood					

EPDS13
	NT OF DEFICIENCIES	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _	<u></u>			
		00443	B. WING			R 06/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
PIONEE	R CARE CENTER		UTH MABELLE FALLS, MN 5	-			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 4	2 830				
	the right front burner from the surface and from the stove top, seated in a wheeled wheeled herself tow entrance and stated breakfast. R6 proper front of the counter were observed sea room seated at the and in the activity at -At 9:31 am. the s with no staff obser of the Deerwood un her wheelchair at the Residents remaine including the dining adjacent to the kitc -At 9:35 a.m. a staff from the hall adjace neighborhood and gloved hand. He sta (HM)-A for the Deer the Deerwood neigh HM-A confirmed the was left on unatten had only been gone immediately shut the burner was hot. HM work on the Deerwo how many english of run out. He stated he stove top on unatten have applied the year	surveyor placed a hand over er, approximately 4 inches and heat could be felt radiating At that time R6 was observed hair in the dining room, she wards the unchained kitchen d she had been waiting for her elled herself back to a table in of the kitchen area. Residents ted in wheelchairs in the dining tables, the hallway of the unit trea behind the dining room. tove top burner remained on, ved in the kitchen or dining are hit, and R6 remained seated in he dining room table. d in various areas of the unit, room, seating area near hen and in the hallways. if member entered the kitchen ent to the outside of the held an english muffin in his ated he was the homemaker rwood neighborhood, had left hborhood and walked to the porhood for an english muffin. e front right burner of the stove ded and stated he thought he e a few seconds. He he burner off and confirmed the <i>I</i> -A stated he did not usually ood unit and was not aware of muffins were needed, and had he usually would not leave the ended and indicated he should ellow chains across both tochen area before leaving the					

Minnesota Department of Health STATE FORM

EPDS13

If continuation sheet 5 of 15

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _			R	
	00443		B. WING			06/19/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
PIONEEI	R CARE CENTER		JTH MABELLE FALLS, MN 5				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 5	2 830				
	right burner of the I stove top was obser hot for a total of ter staff. No staff were neighborhood durin duration. The hot s accessible to reside hazard, including c On 6/18/18, at 9:58 unit was conducted observed lying in be observed to be lyin observed seated in seated in recliners dining room seated various areas of the seating area adjace On 6/18/18, at 10:0 interview, HM-A stat the Deerwood unit of any residents att He indicated he tho	25 a.m. to 9:35 a.m. the front Deerwood neighborhoods erved to be on, unattended and a minutes unsupervised by observed to walk out or in the ng the entire ten minute tove top would have been ents on the unit posing a safety ognitively impaired residents. B a.m. a tour of the Deerwood d, one resident, R7 was ed. No other residents were g in bed. Residents were wheelchairs in their rooms, in the common area and in the l at the tables. observed in e unit, seated in recliners in the ent to the kitchen. 00 a.m. during a follow up ated he did not usually work on and stated he had not aware empting to enter the kitchen. bught several residents had a cognitively impaired and naware of any residents that					
	On 6/18/18, at 10:0 (LPN)-A indicated s	07 a.m. licensed practical nurse she was the nurse on the nat time. LPN-A stated most of					
	the residents on the dementia and had attempting to enter	e unit had diagnosis of not seen any resident the kitchen. LPN-A stated she					
	and unattended. Sh	HM had left the stovetop on he stated she had not been the kitchen area prior to the					

Minnesota Department of Health STATE FORM

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	IOI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:	·····			
		00443	B. WING			R 06/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
PIONEEI	R CARE CENTER		UTH MABELLI FALLS, MN 5				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 6	2 830				
	practice would be t during a meal serv leave, she would sl entrances of the ki yellow chains and s know she was leav	10 a.m. HM-B stated her usual to not leave the kitchen area ice. She stated if she had to hut the stove off, chain off the tchen with the two plastic she would let a staff member ring the area. HM-B indicated eave a burner on and walk					
	manager (NM)-A for current census on t two residents on th wanderguards on t of wandering. A list the Deerwood unit following information mobility status and time, NM-A stated	15 a.m. registered nurse or the Deerwood unit stated the the unit was 21. NM-A stated be Deerwood unit wore heir persons, due to a history of residents which resided on was requested with the on: resident name, cognition, history of wandering. At that the stove top should "never" be en it was on. NM-A confirmed in ern for residents.					
	Assessment (SCS, dated 5/28/18, ider impairment and ha Alzheimer's diseas MDS identified R1 and indicated staff	nificant Change of Status A) Minimum Data Set (MDS) ntified R1 had severe cognitive d diagnoses which included, e, anxiety and depression. The did not use a mobility device had supervised R1 during comotion during the I.					
	identified R1 had c periods of inattention was able to stabiliz a sitting to standing	rea Assessment dated 5/28/18 ognitive impairment with on, was hard of hearing and the himself during transition from g position. R1's CAAs lacked afety awareness and					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED		
	of connection	IDENTIFICATION NOMBER.	A. BUILDING:					
		00443	B. WING			R 06/19/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE				
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			SFALLS, MN 5					
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION				(X5) COMPLET DATE
2 830	Continued From pa	age 7	2 830					
	judgement.							
	R1 had impaired c was independent w without an assistive revealed R1 was a had left the unit an left ankle. Further,	olan revised 5/31/18, revealed ognition and decision making, vith transfers and ambulation e device. The care plan t high risk for wandering as he d had a wanderguard on his R1's care plan revealed he staff to maintain his safety.						
	6/18/18, revealed F wandering, had a v	tant (NA) care guide printed on R1 was at high risk for vanderguard on his left ankle ent with transfers and						
	severe cognitive in which included der and seizure disord required extensive daily living (ADL's) locomotion and lim	ated 5/3/18, identified R2 had npairment and had diagnoses nentia, Alzheimer's disease er. The MDS identified R2 had assistance with activities of in areas of transfers, nited assistance with IDS identified R2 had used a valker.						
	disorganized thinki impairment. The C extensive assistan transfers, locomoti assistance with am identified R2 was a	ated 5/3/18, identified R2 had ing and had cognitive AA revealed R2 received ce with ADL's including on and required limited abulation. Further, the CAA at risk for falls due to impaired As lacked indication of R2's and judgement.						
	R2 had impaired c	blan revised 5/3/18, revealed ognition and thought are plan revealed she required						

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00443	B. WING			R 06/19/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
PIONEEI	R CARE CENTER		UTH MABELLI FALLS, MN 5	-			
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2 830		-	2 830				
	walker, transfers ar wheelchair. R2's ca self transfer, was a	staff with ambulation with a nd locomotion with a are plan revealed she would It a high risk for falls and ticipate her needs and ty.					
	was at high risk for	e printed 6/18/18, revealed R2 falls, self transferred and e with transfers, ambulation					
	had severe cognitive diagnoses which in Disease, anxiety, ir identified R3 had vo R3 had required ex transfers, walking a	S dated 5/25/18, identified R3 ve impairment and had included dementia, Parkinson's rritability and anger. The MDS erbal behaviors, and identified and locomotion, and used a lchair for mobility devices.					
	had disorganized th cognitive loss. The	ated 11/24/17, identified R3 hinking, inattention and CAA identified R3 had was impulsive and was at risk					
	impaired cognition Lewy body dement R3's care plan reve with transfers, amb locomotion with a w revealed R3 was al	sed 5/29/18, revealed R3 had and communication related to ia and Parkinson's disease. ealed he required assistance bulation with a walker and wheelchair. The care plan ble to propel himself in a feet around the household.					
	falls and had variou including bed and c unattended in his ro	ealed he was at high risk for us interventions in place, chair alarms, not to be left oom when restless or anxious, e recliner in the day room, fall					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:				
		00443	B. WING			R 06/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
PIONEEI	R CARE CENTER		UTH MABELLI FALLS, MN 5	-			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 9	2 830				
		cation when family leaves the r, R3's care plan directed ntain his safety.					
	was at high risk for aforementioned fal assistance with tra walker and locomo care guide revealed	e printed 6/18/18, revealed R3 r falls, listed the Il interventions and required nsfers, ambulation with a otion with a wheelchair. The d R3 was able to propel chair with his feet around the					
	had moderate cogr diagnoses including hypertension. The required extensive transfers and locor period. The MDS in	S dated 4/3/18, identified R4 nitive impairment and had g macular degeneration and MDS identified R4 had assistance with bed mobility, motion during the assessment dentified R4 had received abulation on two occasions nent.					
	had memory impai reminders and sup identified R4 had h of hearing, had im assistance with AD transfers and locor revealed R4's conf	lated 10/13/17, identified R4 rment, needed cues, pervision daily. The CAA highly impaired vision, was hard paired cognition and required PL's of bed mobility, ambulation motion. The CAA further fusion would worsen when she CAA lacked indication of R4's and judgement.	2				
	impaired thought p hearing and require transfers, bed mob locomotion with a v	sed 4/11/18, revealed R4 had rocesses, impaired vision and ed staff assistance with bility, ambulation with a walker, wheelchair. R4's care plan e to maintain her safety.					

	ta Department of He	(X1) Provider/Supplier/Clia	(X2) MUITIPI F	CONSTRUCTION	(X3) DATE	ESURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
					R	
		00443	B. WING		06/	19/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
PIONEE	R CARE CENTER		JTH MABELLE FALLS, MN 5			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 10	2 830			
		e printed 6/18/18, revealed tance with transfers, omotion.				
	"never" leave the k service, or when a stated if she had to stove off, chain off with the two plastic	20 a.m. HM-C stated she would itchen area during a meal cooking surface was hot. She leave she would shut the the entrances of the kitchen yellow chains and she would know she was leaving.				
	the kitchenette stov residents breakfast had a locking mech with a key when the stated she would "r burner on, unattend were not present in chain would be app	23 a.m. HM-D stated she used ve daily when preparing t meals. She stated the stove hanism which was to be locked e stove was not in use. HM-D hever" leave the stovetop ded and indicated when staff the kitchen a plastic yellow blied across both entrances to ur wandering residents.				
	process when leave neighborhood was stove with the key t turn the stove back	28 a.m. HM-E stated her usual ing the kitchen area of a to shut off the stove, lock the to ensure residents could not on. She stated she would also ains across both entrances to				
	process when prep to remain in the new indicated she would unattended. She st outside of the neigh another staff memb	44 a.m. HM-F stated her usual aring resident meals would be ar the cooking surfaces and d not leave the stove ated if she needed an item aborhood, she would ask per to get it for her or she r staff member supervise the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
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PIONEE	R CARE CENTER		FALLS, MN 5	-			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO				
2 830	Continued From pa	age 11	2 830				
	she stated if no sta shut off the stoveto and place the yello	she obtained the item. Further, ff were available, she would p, lock the stove with a key w plastic chains across both chen to detour residents from					
	(NA)-A stated she f the Deerwood unit she felt no resident unit. She stated mo residents needed s however, she indica to freely move arous she was in a wheel a walker. NA-A stat resident entering th enter the kitchen ar indicated when the yellow chains were entrances of the kit entering. Further, N asked to supervise	O a.m. nursing assistant felt most of the residents on were cognitively impaired and is currently wandered off of the ost of the cognitively impaired taff assistance with mobility, ated a few residents were able and the unit, such as R4, when chair and R1 when he utilized ted she was unaware of any he kitchen area or attempting to rea in her memory. She kitchen was not in use, plastic to be affixed across the techen to detour residents from IA-A stated she had not been the kitchen area prior to unaware the stove had been supervision.					
	interview, the Deen were reviewed with residents had diagr of the nine, four res independently mov walking or wheelch following: R1 had a was able to be indep a wanderguard in p	5 a.m. during a follow up wood residents care guides NM-A. NM-A confirmed nine nosis dementia and confirmed sidents had the ability to e about the unit, whether by air. NM-A confirmed the a diagnosis of dementia and ependent with mobility and had place due to a history of leaving diagnosis of dementia and					
	Alzheimer's diseas	e and was able to self propel a wheelchair. R3 had a					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
				A. BUILDING:		_	
		00443	B. WING			R 06/19/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
PIONEEF	R CARE CENTER		UTH MABELLE FALLS, MN 5				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLET	
2 830	Continued From pa	age 12	2 830				
	dementia that can l and communication about the unit once had daily periods o independently mov in a wheelchair. On 6/18/18, at 11:5 (RD)-A stated she off when the HM was confirmed staff wer when the stove was residents. She state received orientation safe practices in ne stated if the HM as needed to leave the reason, the stove s staff member shou HM returned. Furth expect the yellow c both entrances to the from entering and i necessarily expect the key if they were On 6/18/18, at 12:0	06 p.m. the facility					
	were safe. The adr member needed to meal service, then	n order to ensure residents ninistrator stated if a staff leave the kitchen area during another staff member needed					
	area. Further, the a	rder to monitor the kitchen administrator confirmed "some" the Deerwood unit were d.	,				
	On 6/18/18 at 2:48	p.m. during a group interview					

Minnes	ota Department of He	alth			FORM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00443		B. WING			R 19/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
PIONEE	R CARE CENTER		JTH MABELLI			
			FALLS, MN 5			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	with the facility adm both confirmed they stove top to be shur present. The admin confirmed multiple Deerwood unit were required staff super the hot burner left of significant safety con not feel it was a cor once the stove was administrator and v felt the issue was re- stove top off and in- residents on the un- kitchen area. A facility policy titled Household Kitchen, was the facility's po- team members who would follow safety and residents. The procedures staff we resident safety which appliances when no disconnect stovetop Further the policy d table was in use, the unattended. SUGGESTED MET director of nurses (fi- provide inservice tra- nursing staff on the An audit could be d cooking equipment	A safe Practices in the dicated they did not feel it would wander into the dicated they did not feel it would wander into the precautions to protect staff policy listed various ere to implement to ensure ch included, to turn off all ot in use, when leaving kitchen of and unplug small appliances. irected staff when a steam e kitchen should not be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00443	B. WING			R 06/19/2018
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻			
PIONEE	R CARE CENTER		UTH MABELLE 5 FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (CONTRICTIVE ACTIVE AC				(X5) COMPLE DATE
2 830	Continued From pa	age 14	2 830		·	
	TIME PERIOD FOI days.	R CORRECTION: Seven (7)				

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

ICARE/MEDICAID	CERTIFICATION	AND TRANSMITTAI	

				ICATION AND TRANSMITTAL ID: EPDS			ID: EPDS		
		- TO BE COMP			TE SURVI	EY AGENCY	1	Facility ID: 00443	
 MEDICARE/MEDICAID PROVIDER N (L1) 245463 	0.	3. NAME AND AD (L3) PIONEER C					4. TYPE OF ACTI	` ´	
2.STATE VENDOR OR MEDICAID NO.		(L4) 1131 SOUTH	H MABELLE A	VENUE			1. Initial 3. Termination	 Recertification CHOW 	
(L2) 707342900		(L5) FERGUS FA	LLS, MN			(L6) 56537	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF OWN	ERSHIP	7. PROVIDER/SU	PPLIER CATEGO	RY	02	(L7)	8. Full Survey After Complaint		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA			
 DATE OF SURVEY 05/17/2 ACCREDITATION STATUS: 	2018 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC		FISCAL YEAR END	NG DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	04 SNF	08 OPT/SP	12 RHC	16 HOSPI	CE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	5:			1		
From (a):		A. In Complia	nce With		And/Or A	Approved Waivers Of The	e Following Requirement	S:	
To (b) :			Requirements ce Based On:			Technical Personnel		Services Limit	
		*	Acceptable POC			24 Hour RN 7-Day RN (Rural SNF)	 Medical I 8. Patient Ro 		
12. Total Facility Beds	105 (L18)					Life Safety Code	9. Beds/Roo		
13.Total Certified Beds	105 (L17)		mpliance with Prog			-			
14. LTC CERTIFIED BED BREAKDOWN		Requirements	and/or Applied Wa	ivers:	* Code:	B*	(L12)		
14. ETC CERTIFIED BED BREARDOWN 18 SNF 18/19 SNF	19 SNF	ICF	IID			(1) or 1861 (j) (1):	(L15)		
105	17 51 12	101	110		1001 (0)	(1) 01 1001 () (1).			
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE):					
See Attached Remarks									
17. SURVEYOR SIGNATURE		Date :			18. STAT	E SURVEY AGENCY A	APPROVAL	Date:	
			05/21/2019						
<u>Denise Erickson, HFE -</u>			05/31/2018	(L19)			rcement Speci	alist_07/13/2018 (L20)	
PAI	RT II - TO BI	E COMPLETED	BY HCFA RI	EGIONAI	L OFFICE	COR SINGLE STA	ATE AGENCY		
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH GHTS ACT:	CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) 				
X 1. Facility is Eligible to Parti	cipate					3. Both of the Above		()	
2. Facility is not Eligible	(L21)								
	. ,			1					
22. ORIGINAL DATE	23. LTC AGREEN	IENT 2	4. LTC AGREEM	IENT	26. TERN	MINATION ACTION:		(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Έ	<u>VOLUNTA</u>			INTARY	
04/11/1987					01-Merger,	Closure faction W/ Reimburseme		D Meet Health/Safety	
(L24)	(L41)		(L25)			Involuntary Termination		o Meet Agreement	
25. LTC EXTENSION DATE: 2	27. ALTERNATI					eason for Withdrawal	OTHER	der Status Change	
	A. Suspension	n of Admissions:	(L44)				00-Activ	-	
(L27)	B. Rescind Sus	spension Date:							
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/0	CARRIER NO.		30. REMA	RKS			
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE					
	(L32)	05/03/2018		(L33)	DETED	MINATION APPR	OVAL		
				,	DETERT	MINATION AFPR	UTAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 245463

Continued non-compliance was found at the onsite revisit on 05/17/2018

Facility ID: 00443



Electronically delivered May 31, 2018

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

RE: Project Number S5463028 and H5463024

Dear Ms. Watkins:

On April 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 22, 2018 that included an investigation of complaint number H5463024. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 17, 2018, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 22, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on March 22, 2018. The deficiency not corrected is/are as follows:

F0812 -- S/S: D -- 483.60(i)(1)(2) -- Food Procurement, store/prepare/serve-Sanitary

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

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective June 5, 2018. (42 CFR 488.422)

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

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 22, 2018. (42 CFR 488.417 (b))

Pioneer Care Center May 31, 2018 Page 2

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 22, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 22, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Pioneer Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 22, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644

Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov</u>.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

Pioneer Care Center May 31, 2018 Page 4

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 22, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is Pioneer Care Center May 31, 2018 Page 5

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

		AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY IPLETED
		245463	B. WING				R 1 7/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	R CARE CENTER				31 SOUTH MABELLE AVENUE		
				FE	ERGUS FALLS, MN 56537		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	rs	{F 00	00}			
	During this visit it w following citations w	rvey was conducted 5/17/18. as determined that the vere NOT Corrected.					
	Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.						
{F 812} SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat	Store/Prepare/Serve-Sanitary	{F 81	12}			6/7/18
	§483.60(i) Food sat The facility must -	fety requirements.					
	approved or consid state or local autho (i) This may include from local producer and local producer (ii) This provision de facilities from using gardens, subject to safe growing and fo (iii) This provision de from consuming for	e food items obtained directly rs, subject to applicable State					
							(X6) DATE
	ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		06/04/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 06/05/2018

		& MEDICAID SERVICES	1			0938-039	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		E SURVEY IPLETED	
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		245463	B. WING			17/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PIONEE	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537			
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{F 812}	serve food in accor standards for food This REQUIREMEN by: Based on observat review, the facility food items were dis and were properly s when the original p 5 households. Findings include: On 5/17/18, at 10:3 kitchenettes was co dietitian. During this The Short Stay unit contained the follow -An undated and un of shredded Mozza cheese had green s from 0.5 c.m. (cent - One fourth of an a unlabeled and unse The Cherry Wood u contained the follow -A small zip lock ba expired single serve packet expired Apri April 26, 2018. The Deer Wood un contained the follow -An undated small s	dance with professional service safety. NT is not met as evidenced tion, interview, and document failed to ensure refrigerated sposed of after expiration date stored, labeled and dated ackaging was opened in 3 of 7 a.m. a tour of the 5 unit onducted with the facility s tour the following was noted. t kitchenette refrigerator ving: nlabeled 1 pound zip lock bag rella cheese. The shredded spots of mold ranging in size imeters) to 1 c.m. in diameter. angel food cake in an undated, ealed plastic bag. unit kitchenette refrigerator ving: ggie dated 5/9/18, contained e packets of sour cream. 1 if 18, 2018, 5 packets expired	{F 812	 1) On 5/17/2018 the following were taken: The Short Stay Un Kitchenette Refrigerator- the Zij of Mozzarella cheese and Ange Cake was discarded. The Chel Unit Kitchenette refrigerator- the serve packets of sour cream packet and ham was discarded. 2) All residents in the facility h potential to be affected by this p 3) The policy Food Storage was reviewed and updated. Dietary be educated on this policy. Edutake place on June 6th and 7th; 4) Audits of household Refrige and freezers, to ensure food is packaged and dated will be cordaily for 1 week, 2 times a weel month, and weekly for a month of Audits will be brought to the CAssurance Committee and will further recommendations from committee. 5) The facility will have correct actions in place and be in subsice compliance by June 7th, 2018. 	it b Lock bag I Food rry Wood e Single ere henette tts, turkey ave the bractice. as Staff will cation will 2018. erators, properly ducted c for a Results Quality follow this		

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 2 of 3

		AND HUMAN SERVICES				FORM	06/05/2018 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		245463	B. WING			R 05/17/2018		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537			
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{F 812}	four slices remainin -A package of three On 5/17/18, at 11:0 above findings and deli meat should be The dietitian indicat label foods, keep th do not keep food ite expiration date. The storage problem in corrected. On 5/17/18, at 2:15 the facility had not of food storage in the The facility policy tit 4/1/09, instructed le covered containers securely. Each iter dated before being be used within 3 da should be covered, A facility form titled 7/11/11, directed tin food which included - deli meat, seven of	a Ham slices dated 5/7/18. 3 a.m. the dietitian verified the indicated opened packages of a discarded after seven days. ted the expectation that staff nem in sealed containers and ams in refrigerators after the a dietitian indicated the food the refrigerators had not been a p.m. the administrator agreed corrected the problem with unit kitchenette refrigerators. ted Food Storage, revised actiover food to be stored in or wrapped carefully and n to be clearly labeled, and refrigerated. Leftover food to uss or discarded. Frozen foods labeled and dated. Food Storage Guide revised ne frames for use of opened d: days after opening 10 days after opening	{F 8 ⁻	12}				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00443

If continuation sheet Page 3 of 3



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on June 18, 2018.

June 18, 2018

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

Re: Project #'s S5463028 and H5463024

Dear Ms. Watkins:

On May 17, 2018, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction orders found on the survey completed on March 22, 2018 with orders received by you electronically on April 4, 2018.

State licensing orders issued pursuant to the survey completed on March 22, 2018 have been found corrected at the time of this May 17, 2018 revisit.

State licensing orders issued pursuant to the last survey completed on March 22, 2018, found not corrected at the time of this May 17, 2018 revisit and subject to penalty assessment are as follows:

21100 -- MN Rule 4658.0650 Subp. 5 -- Food Supplies; Storage Of Perishable Food \$350.00

The details of the violations noted at the time of this revisit completed on May 17, 2018 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$350.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to:

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Pioneer Care Center May 31, 2018 Page 2

> Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Shellae Dietrich, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00443	B. WING		F 05/1	₹ 7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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{2 000}	Initial Comments		{2 000}			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	17, 2018. During th	TS: visit was completed on May his visit it was determined that tion order, #0812, was NOT				
	will be reviewed at t	der will remain in effect and the next onsite visit. To be				
ABORATOR	epartment of Health 7 DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 06/04/18

STATE FORM

6899

If continuation sheet 1 of 4

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
PIONEE	R CARE CENTER		JTH MABELI		
	1	FERGUS	FALLS, MN	56537 PROVIDER'S PLAN OF CORRECTION	N (ME)
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{2 000}	Continued From pa	ge 1	{2 000}		
	reviewed for possib	le penalty assessment.			
{21100}	MN Rule 4658.0650 Storage of Perishat) Subp. 5 Food Supplies; ble food	{21100}		6/7/18
	perishable food mu washable, corrosior	of perishable food. All st be stored off the floor on n-resistant shelving under and at temperatures which spoilage.			
	by: Uncorrected based original licensing or	ent is not met as evidenced on the following findings. The der issued on 3/22/18 will malty assessment issued.		Corrected	
	review, the facility f food items were dis and were properly s	on, interview, and document failed to ensure refrigerated posed of after expiration date stored, labeled and dated ackaging was opened in 3 of			
	Findings include:				
	kitchenettes was co	7 a.m. a tour of the 5 unit onducted with the facility a tour the following was noted.			
	contained the follow -An undated and ur of shredded Mozza cheese had green s from 0.5 c.m. (centi	nlabeled 1 pound zip lock bag rella cheese. The shredded spots of mold ranging in size imeters) to 1 c.m. in diameter. ungel food cake in an undated,			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
			A. DOILDING.			R	
		00443	B. WING			05/17/2018	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
PIONEE	R CARE CENTER		UTH MABELLI FALLS, MN 5				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET	
PRÉFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE	
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	contained the follow -A small zip lock ba expired single serv packet expired Apr April 26, 2018. The Deer Wood un contained the follow -An undated small single serve packe on April 26, 2018. -An undated zip loo four slices remainin -A package of three On 5/17/18, at 11:0 above findings and deli meat should be The dietitian indica label foods, keep th do not keep food itte expiration date. Th storage problem in corrected. On 5/17/18, at 2:15 the facility had not food storage in the	aggie dated 5/9/18, contained re packets of sour cream. 1 il 18, 2018, 5 packets expired hit kitchenette refrigerator wing: zip lock baggie contained 4 ts of sour cream which expired ck package of turkey meat with ng. e Ham slices dated 5/7/18. 03 a.m. the dietitian verified the l indicated opened packages of e discarded after seven days. ted the expectation that staff hem in sealed containers and ems in refrigerators after the e dietitian indicated the food the refrigerators had not been 5 p.m. the administrator agreed corrected the problem with unit kitchenette refrigerators.	F				
	4/1/09, instructed le covered containers securely. Each iter dated before being be used within 3 da	itled Food Storage, revised eftover food to be stored in s or wrapped carefully and m to be clearly labeled, and refrigerated. Leftover food to ays or discarded. Frozen foods , labeled and dated.	3				
		Food Storage Guide revised me frames for use of opened					

If continuation sheet 3 of 4

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	0. 00		A. BUILDING: _			
		00443	B. WING			R 1 7/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PIONEEF	R CARE CENTER		UTH MABELLI S FALLS, MN 5			
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	food which included: - deli meat, seven days after opening -shredded cheese, 10 days after opening -leftovers, within three days.					
	TIME PERIOD FO (14) days.	R CORRECTION: Fourteen				

DEPARTMENT	OF	HEALTH	AND	HUMAN	SERVICES
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DEPARTMENT OF HEALTH	I AND HUMAN	SERVICES			C	ENTERS FOR	MEDICARE	S & MEDICA	ID SERVICES
DEFACTIVIENT OF HEALTH	MEDIC	CARE/MEDICAL - TO BE COMP			AND TRA	NSMITTAL	MEDICAR	ID:	EPDS lity ID: 00443
I. MEDICARE/MEDICAID PROVIDER (L1) 245463 2.STATE VENDOR OR MEDICAID NO. (L2) 707342900	NO.	 NAME AND AL (L3) PIONEER C (L4) 1131 SOUTH (L5) FERGUS FA 	CARE CENTER H MABELLE A	1		(L6) 56537	1. Ini 3. Ter	E OF ACTION:	<u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint
 5. EFFECTIVE DATE CHANGE OF OW (L9) 6. DATE OF SURVEY 03/22 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 		 PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	<u>02</u> 13 PTIP 14 CORF 15 ASC 16 HOSPI	(L7) 22 CLIA CE	8. Fu	-Site Visit Il Survey After Comp /EAR ENDING D. 09/30	
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	105 (L18) 105 (L17)	Complian1 X B. Not in Co	nce With Requirements ce Based On: Acceptable POC	ram	2. 3. 4.	Approved Waivers (Technical Person 24 Hour RN 7-Day RN (Rural Life Safety Code B *	nel 6. 7. I SNF) 8.	Requirements: Scope of Service Medical Director Patient Room Si: Beds/Room	s Limit
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 105 (L37) (L38)	VN 19 SNF (L39)	ICF (L42)	IID (L43)			LITY MEETS (1) or 1861 (j) (1):		(L15)	
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICABL		ELLATION DATE):					
17. SURVEYOR SIGNATURE <u>Christina Martinson, I</u>	HFE NE-II	Date :	04/26/2018	(L19)	18. STATE SURVEY AGENCY APPROVAL Date: Douglas S. Larson, Enforcement Specialist 04/30/2018				
P	ART II - TO BE	COMPLETED	BY HCFA R	EGIONAI	OFFICE	OR SINGLE	STATE AGE	ENCY	(===*)
19. DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to P 2. Facility is not Eligible	articipate		MPLIANCE WITH GHTS ACT:	CIVIL	21.	 Statement of 1 Ownership/C Both of the A 	ontrol Interest Disc	(HCFA-2572) losure Stmt (HCFA	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 04/11/1987	23. LTC AGREEM BEGINNING		4. LTC AGREEN ENDING DAT		<u>VOLUNT</u> 01-Merger,			(L30 <u>INVOLUNTAR</u> 05-Fail to Meet	Y Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATI A. Suspension B. Rescind Sus	n of Admissions:	(L25) (L44) (L45)		03-Risk of	faction W/ Reimbur Involuntary Termin eason for Withdraw	ation	06-Fail to Meet <u>OTHER</u> 07-Provider Sta 00-Active	-
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMA	RKS			
	2,	03001							
	(L28)	05001		(L31)					

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered April 4, 2018

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

RE: Project Number S5463028 and H5463024

Dear Ms. Watkins:

On March 22, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the March 22, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5463024.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 1, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 1, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 22, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 22, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES			0		. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	СОМ	E SURVEY IPLETED
		245463	B. WING				C 22/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PIONEEF	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments			000			
F 000	Emergency Prepare conducted on 3/19/ recertification surve	iance with CMS Appendix Z edness Requirements, was 18, to 3/22/18, during a ey. The facility is in compliance Z Emergency Preparedness	F0	000			
	through 3/22/18, an were also complete survey. At the time of complaint H5463	rvey was conducted 3/19/18 ad complaint investigations ad at the time of the standard of the survey, an investigation 8024 were completed and were ntiated. The complaint was 07 and F609.					
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with					
F 607 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat	Abuse/Neglect Policies	F 6	07			5/1/18
		ility must develop and policies and procedures that:					
		ibit and prevent abuse, ation of residents and					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						04/12/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 04/26/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391							
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING		COMPLETED C		
		245463	B. WING _	WING 03/		22/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
PIONEER CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 607	misappropriation of §483.12(b)(2) Estat to investigate any s §483.12(b)(3) Inclue paragraph §483.95. This REQUIREMEN by: Based on interview facility failed to impl procedures to ensu immediately notified for 1 of 1 resident (1 of abuse. In addition the SA an incident of of 1 (R77) resident of care. Findings include: R49's quarterly Min 2/7/18, indicated R4 impaired with diagn failure, dementia ar indicated R49 requi two staff with all act and had no behavio R49's current care various intervention provide consistent of possible in order to confusion, encourage concerns, staff will report any suspected policy.	resident property, blish policies and procedures uch allegations, and de training as required at NT is not met as evidenced and document review, the lement policies and re the State agency (SA) was d for mental/emotional abuse R49) reviewed for allegations in the facility failed to report to of injury of unknown source 1 reviewed for potential neglect imum Data Set (MDS) dated 49 was severely cognitively oses which included heart ind depression. The MDS red extensive assistance of divities of daily living (ADL's) ors.	F 60	 It is the practice of this facility to develop and implement policies for abuse/neglect. LPN-D will be educa the Abuse, Neglect, Mistreatment, a Misappropriation of Resident Proper policy, including timely reporting of potential abuse/neglect by April 18, On April 6, 2018 a report was submit OHFC for potential neglect for R77. All current residents have the potential to be affected. Abuse, Neglect, Mistreatment, a Misappropriation of Resident Proper policy includes immediately reportin suspected/alleged abuse, neglect, a injuries of unknown origin to the designated state agency/common e point. Re-Education has been cond by the Administrator on April 17, 201 immediate reporting to the State Ag of all incidents of suspected/ alleged abuse, neglect, and injuries of unkn origin - Education was provided for care center staff. Staff will be educated during orientation and will also be educated yearly on this topic. Progress notes will be reviewed 	and rty 2018. itted to and rty g and entry ducted 18, on ency d iown all ated		

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 04/26/2018
CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		FORM / MB NO.	04/26/2018 APPROVED 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			COMI	PLETED
		245463	B. WING			03/2	; 22/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	had occurred. The assistant (NA)- B re to cause mental/em was no injury or cha listed on 2/13/18 sc an interview with R4 the SW the nursing stated the nursing a her. The SW asked pictures of her, she perpetrator has lots "little boy." R49 stat show anyone those	ge 2 did not list a time the incident report indicated a nursing eported a cell phone was used notion abuse to R49 and there ange in life style. The report ocial worker (SW) completed 49, and R49 was able to tell assistant's name and R49 assistant had been good to lif the perpetrator took stated "yes" and indicated the of pictures of R49 and her red she "hoped she doesn't pictures." When SW asked picture taken, R49 had stated	Fε	607	by the DON or her designee, to ass immediate reporting of suspected/ abuse, neglect, and injuries of unkr origin are properly reported for until 31st, following this the progress no be reviewed randomly to assure immediate reporting of suspected/ abuse, neglect, and injuries of unkr origin are properly reported. Result be brought to the QA meeting and recommendations will be followed. 5. The facility will have corrective in place and be in substantial comp by May 1, 2018.	alleged nown I May tes will alleged nown ts will actions	
	the SA on 2/13/18 a of emotional or men the incident had occ nursing assistant ha another nursing assist picture of R1 to her sexual, she was clo by the facility revea stated she did not li stated "I hope she oc pictures." The invest reported she had re alleged perpetrator. On 3/22/18 at 8:38 (LPN)-D stated she and confirmed NA-1 another NA(perpetr R49 on her cell pho	Report #310516, submitted to at 4:39 p.m. listed an allegation ntal abuse for R1, and listed curred on 2/12/18 at 1 p.m. A ad reported to her nurse that sistant had snap chatted . The pictures of R1 were not othed. The investigation done led during an interview R1 had ke pictures taken of her and doesn't show anyone those stigation listed NA-B had eccived pictures of R1 from the a.m. licensed practical nurse aware of the incident with R1 B came to her and reported ator) had taken pictures of one and snap chatting them to ated she told NA-B that she					

If continuation sheet Page 3 of 28

		AND HUMAN SERVICES			FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245463	B. WING			C 22/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 607	NA-B was scared to indicated NA-B had over the weekend a to the SW the next reported the incider confirmed staff wer immediately and co immediately. On 3/22/18 at 8:52 had reported the all (perpetrator) taking phone and sending her. The SW confin needed to be repor on weekends the cl the report to the SA On 3/22/18 at 9:03 reported the allegat (perpetrator) taking them to her. The DO incident over the we and LPN-D then rep confirmed the current the incident had not the SA. On 3/22/18 at 9:19 worked with the per and was not the first of R49. NA-B verifies she understood LPI someone about it. N LPN-D on the week reported the incider to work on Monday	e incident right away, but o report the incident. LPN-D I reported the incident to her and she reported the incident day because NA-B had not nt to anyone. The LPN-D e to report incidents of abuse onfirmed it was not reported a.m. SW confirmed the facility legations of abuse of a NA pictures of R49 with her cell the pictures on snap chat to rmed the allegations of abuse ted to the SA immediately and harge nurse should be making A.	F 60			

If continuation sheet Page 4 of 28

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI 1	TIP	UI PLE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			G		PLETED
						(C
		245463	B. WING			03/2	22/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
ind		,	in G		DEFICIENCY)		
			I				
F 607	Continued From pa	-	F 6	07	7		
		not a SW available on the					
	to report to on the v	it to and no one in the building veekends.					
		3 a.m. The administrator					
		ty policy, confirmed she was nt with R1 and indicated she					
		port the allegation of abuse					
		dministrator indicated she					
		o follow the policy and aware staff did not report the					
	allegation of abuse						
		3					
	R77's appual MDS	assessment dated 2/21/18,					
		diagnoses which included,					
	dementia, arthritis a	and hypertension and had					
		pairment. R77's MDS further					
		red extensive assistance with ng, but did not walk outside					
	her room.	ng, but did not waik outside					
		Assessments (CAA) dated					
		she was at risk for falls related s, use of antidepressant					
	medication and cog						
		riand 0/00/10 in dia ata d D77					
		vised 2/22/18, indicated R77 falls, history of left hip fracture					
		d various interventions which					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		PLE CONSTRUCTION	(X3) DAT	E SURVEY
THE FERRE		BERTHIO, THOR TOWNER.			3		C
		245463	B. WING			03/	22/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	included education caregivers for safet a fall occurred. The to ensure R77 wore mobilizing in wheek remote to the back from accidentally si Review of R77's pro 12/11/19 identified: -12/9/17, 8:00 a.m. Staff found R77 sitt bottom of her reclin complained of pain sent to the hospital -12/9/17, 10:30 a.m. writer that the resid would have surgery -12/11/17, 7:25 a.m. note, written by clin indicated the care p appropriate prior to staff to fasten the lif so that R77 did not that she slid out of it No further documer was provided by the On 3/21/18, at 2:26 practice for reportin was for the nurse in nurse and either nu to the SA. She indic report to the SA had	to the resident, family and y reminders and what to do if care plan also instructed staff appropriate footwear chair and for staff to move the of her recliner to prevent her tting on it. ogress notes from 12/9/17 to R77 was heard calling out. ing on the floor near the ter in her room. R77 in her left hip area and was emergency department. the hospital updated the ent had a left hip fracture and of that day. a fall follow up progress ical coordinator (CC)-A, olan was reviewed and was the fall. Fall intervention for ft chair remote to the recliner accidentally raise it up so high it again.	F	607			

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PRINTED: 04/26/2018

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY PLETED
		245463	B. WING			C 22/2018
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	fracture to the SA, I accident and she d On 3/22/18, at 12:4 facility process for n directed the floor nu complete and subm could call the LSW, they would report it would report major the care plan was r was notified of R77 it was not appropria DON indicated she reason to report R7 reasonable to fractu a chair. DON stated accidental fall with unless the care pla was a resident to re During a follow up i p.m. DON indicated serious injury if the explanation, such a pain, or bruising wit DON indicated she with fracture an inju On 3/22/18, at 1:24 R77's care plan wa	because it was just an id not suspect maltreatment. 46 p.m. DON indicated the reporting to the state agency urse or the charge nurse to nit the report. If needed they , administrator or herself and . DON indicated the facility injuries for abuse, neglect or if not followed. She indicated she "s fall with major injury, but felt ate to make a report to the SA. did not feel there was a 77's fall, since it was ure a hip if someone fell out of d she understood an injury would not be reportable, n was not followed or there esident altercation. interview on 3/22/18, at 1:15 d the facility would report re was no reasonable as a fracture after complaint of th no reasonable explanation. would not consider R77's fall ury of unknown origin. 4 p.m. administrator indicated as followed and addressed, and	F 607			
F 609 SS=D	CFR(s): 483.12(c)(§483.12(c) In respo	d Violations	F 609			5/1/18
	must:					

Facility ID: 00443

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES	(Y2) MUUT		E CONSTRUCTION		0938-0391 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				(-)	PLETED
						(2
		245463	B. WING				22/2018
NAME OF F	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	R CARE CENTER				31 SOUTH MABELLE AVENUE		
				F	ERGUS FALLS, MN 56537		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
F 000		-					
F 609	Continued From pa	ge /	F 6	09			
	8483 12(c)(1) Ensu	re that all alleged violations					
		glect, exploitation or					
	mistreatment, inclue	ding injuries of unknown					
		ropriation of resident property,					
		diately, but not later than 2 gation is made, if the events					
		ation involve abuse or result in					
	serious bodily injury	, or not later than 24 hours if					
		se the allegation do not involve					
		esult in serious bodily injury, to					
		o the State Survey Agency and					
	adult protective service	vices where state law provides					
		ng-term care facilities) in					
	procedures.	ate law through established					
	procedures.						
	§483.12(c)(4) Repo						
		e administrator or his or her					
		ntative and to other officials in ate law, including to the State					
		hin 5 working days of the					
		alleged violation is verified					
		ive action must be taken.					
		NT is not met as evidenced					
	by: Based on interview	v and document review, the			1. It is the practice of this facility to	n	
		nediately report to the state			report alleged violations of abuse/n		
	agency (SA) allegat	tions of mental/emotional			LPN-D will be educated on the Abu		
		sident (R49) reviewed			Neglect, Mistreatment, and	et c	
		se of cellular phone. In failed to immediately report to			Misappropriation of Resident Prope policy, including timely reporting of	nty	
		t a thorough investigation of			potential abuse/neglect by April 18,	2018.	
	an injury of unknow	n source for 1 of 1 (R77)			On April 6, 2018 a report was subm	itted to	
	resident reviewed for	or potential neglect of care.			OHFC for potential neglect for R77.		
	Findings include:				2. All current residents have the		
	. manigo moludo.				potential to be affected.		

Facility ID: 00443

If continuation sheet Page 8 of 28

PRINTED: 04/26/2018

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY PLETED
		245463	B. WING			03/2	, 22/2018
AME OF PR	OVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
IONEER	CARE CENTER				SOUTH MABELLE AVENUE IGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	{	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F22iiifiitta Fv ppccorp FcHatvillatsh pp" sF"	2/7/18, indicated R4 mpaired with diagn ailure, dementia ar ndicated R49 requi wo staff with all act and had no behavio R49's current care p various intervention provide consistent of confusion, encourage concerns, staff will nee port any suspected colicy. Review of Resident dated 2/11/18, and p assistant (NA)- B re- o cause mental/em vas no injury or cha- sisted on 2/13/18 so an interview with R4 he SW the nursing a her. The SW asked pictures of her, she perpetrator has lots little boy." R49 stat show anyone those R49 if she liked her no."	imum Data Set (MDS) dated 49 was severely cognitively oses which included heart ad depression. The MDS red extensive assistance of ivities of daily living (ADL's) ors. blan revised on 2/14/18, listed which included to try to care givers as much as	F 6	3 M psii o pbii o a o o o e - 4 bii a o 3 bii a o b F fi - 5 ii	 Abuse, Neglect, Mistreatmer Misappropriation of Resident Pro bolicy includes immediately repor- suspected/alleged abuse, neglect njuries of unknown origin to the designated state agency/commo point. Re-Education has been co by the Administrator on April 17, 2 mmediate reporting to the State of all incidents of suspected/ allege abuse, neglect, and injuries of ur origin - Education was provided f care center staff. Staff will be edu during orientation and will also be educated yearly on this topic. Progress notes will be review by the DON or her designee, to a mmediate reporting of suspected abuse, neglect, and injuries of ur origin are properly reported for ur atst, following this the progress re be reviewed randomly to assure mmediate reporting of suspected abuse, neglect, and injuries of ur origin are properly reported. Re be brought to the Quality Assurar Performance Improvement comruther recommendations The facility will have corrective on place and be in substantial cor by May 1, 2018. 	perty ting t, and n entry onducted 2018, on Agency ged known or all ucated y ed daily ssure d/ alleged known ntil May notes will d/ alleged known esults will nce nittee for	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	E SURVEY PLETED
		245463	B. WING			C 22/2018
NAME OF	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 609	the incident had oc nursing assistant had another nursing assistant had another nursing assistant had another nursing assistant had picture of R1 to her sexual, she was clo by the facility reveal stated she did not I stated "I hope she of pictures." The invest reported she had re alleged perpetrator On 3/22/18 at 8:38 (LPN)-D stated she and confirmed NA- another NA(perpetr R49 on her cell pho NA-B. LPN-D indica needed to report th NA-B was scared to indicated NA-B had over the weekend at to the SW the next reported the incider confirmed staff wer immediately and co immediately. On 3/22/18 at 8:52 had reported the all (perpetrator) taking phone and sending her. The SW confir needed to be repor on weekends the co the report to the SA	curred on 2/12/18 at 1 p.m. A ad reported to her nurse that sistant had snap chatted . The pictures of R1 were not othed. The investigation done led during an interview R1 had ike pictures taken of her and doesn't show anyone those stigation listed NA-B had eceived pictures of R1 from the a.m. licensed practical nurse e aware of the incident with R1 B came to her and reported rator) had taken pictures of one and snap chatting them to ated she told NA-B that she he incident right away, but o report the incident. LPN-D d reported the incident to her and she reported the incident day because NA-B had not int to anyone. The LPN-D re to report incidents of abuse onfirmed it was not reported a.m. SW confirmed the facility legations of abuse of a NA pictures of R49 with her cell the pictures on snap chat to rmed the allegations of abuse ted to the SA immediately and harge nurse should be making A. a.m. DON confirmed NA-B	F 609			

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		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245463	B. WING				C 22/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	them to her. The Do incident over the we and LPN-D then rep confirmed the current the incident had not the SA. On 3/22/18 at 9:19 worked with the per and was not the firs of R49. NA-B verifies she understood LPI someone about it. N LPN-D on the week reported the incider to work on Monday the incident was no because there was weekends to report to report to on the week confirmed the facilit aware of the incider expected staff to re- immediately. The a- would expect staff to indicated she was a- allegation of abuse R77's annual MDS identified R77 had dementia, arthritis a- severe cognitive im- identified she required	picture of R49 and sending ON verified NA-B reported the sekend to LPN-D right away ported it to the SW. The DON ent facility policy and confirmed t been reported immediately to a.m. NA-B stated she had rpetrator prior to the incident st time she had taken pictures ed she had told LPN-D and N-D was going to talk to NA-B indicated she had told kend and thought LPN-D nt to the SW when she came or Tuesday. NA-B indicated t reported over the weekend not a SW available on the it to and no one in the building weekends. B a.m. The administrator ty policy, confirmed she was nt with R1 and indicated she port the allegation of abuse dministrator indicated she to follow the policy and aware staff did not report the	F	609			

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		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245463	B. WING				C 22/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEP	R CARE CENTER				131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	Continued From pa her room.	ge 11	Fe	609			
	2/27/18, identified s	a Assessments (CAA) dated she was at risk for falls related s, use of antidepressant gnitive impairment.					
	was at high risk of f with repair and liste included education caregivers for safet a fall occurred. The to ensure R77 wore mobilizing in wheel	vised 2/22/18, indicated R77 falls, history of left hip fracture ed various interventions which to the resident, family and by reminders and what to do if e care plan also instructed staff e appropriate footwear chair and for staff to move the of her recliner to prevent her tting on it.					
	Review of R77's pro 12/11/19 identified:	ogress notes from 12/9/17 to					
	Staff found R77 sitt bottom of her reclin complained of pain	R77 was heard calling out. ing on the floor near the er in her room. R77 in her left hip area and was emergency department.					
		 the hospital updated the ent had a left hip fracture and that day. 					
	note, written by clini indicated the care p appropriate prior to staff to fasten the lif	a. a fall follow up progress ical coordinator (CC)-A, blan was reviewed and was the fall. Fall intervention for ft chair remote to the recliner accidentally raise it up so high it again.					

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		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245463	B. WING	i			C 22/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 609	No further documer was provided by the On 3/21/18, at 2:26 practice for reportin was for the nurse in nurse and either nu to the SA. She indic report to the SA had she did not see a re fracture to the SA, k accident and she di On 3/22/18, at 12:4 facility process for r directed the floor nu complete and subm could call the LSW, they would report it. would report major the care plan was no was notified of R77 it was not appropria DON indicated she reason to report R7 reasonable to fractu a chair. DON stated accidental fall with i unless the care plan was a resident to re During a follow up i p.m. DON indicated serious injury if ther explanation, such a pain, or bruising wit DON indicated she	A p.m.CC-A indicated the usual ag to the state agency (SA) hvolved to report to the charge irrse would complete the report cated she was not sure if a d been done, and indicated eason to report R77's fall with because it was just an id not suspect maltreatment. A p.m. DON indicated the reporting to the state agency urse or the charge nurse to hit the report. If needed they administrator or herself and DON indicated the facility injuries for abuse, neglect or if not followed. She indicated she 's fall with major injury, but felt ate to make a report to the SA. did not feel there was a '7's fall, since it was ure a hip if someone fell out of d she understood an injury would not be reportable, n was not followed or there	F	609			

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		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245463	B. WING		·····		C 22/2018
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609 F 756 SS=D	R77's care plan wa she felt it would not Review of facility po Mistreatment and M Property dated 11/2 Investigation, under suspected incident abuse, including inj misappropriation of IMMEDIATELY repor The Administrator of report of the incider State Agency imme Drug Regimen Rev CFR(s): 483.45(c)(§483.45(c) Drug Re §483.45(c)(1) The of must be reviewed a licensed pharmacis §483.45(c)(2) This of the resident's me §483.45(c)(4) The p irregularities to the facility's medical dir and these reports m (i) Irregularities inc drug that meets the (d) of this section fo (ii) Any irregularities during this review m separate, written re attending physician	p.m. administrator indicated s followed and addressed, and be reportable. blicy titled, Abuse, Neglect, Aisappropriation of Resident 28/16, indicated under r procedure 1) an incident or of mistreatment, neglect, or uries of unknown source, and property must be orted to the Administrator. 2) or designee will make an initial nt or suspected incident to the ediately in accordance with law. iew, Report Irregular, Act On 1)(2)(4)(5) egimen Review. drug regimen of each resident at least once a month by a it.		756			5/1/18

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 04/26/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (X3) DAT	E SURVEY IPLETED
		245463	B. WING	i		C / 22/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	minimum, the resid and the irregularity (iii) The attending p resident's medical r irregularity has bee action has been tak be no change in the physician should do the resident's medic §483.45(c)(5) The f maintain policies ar drug regimen review limited to, time fram the process and ste when he or she ide requires urgent acti This REQUIREMEN by: Based on interview facility failed to ensu- been completed for reviewed for unnec Findings include: R7's Medication Re physican on 2/20/18 included chronic kid (moderate), hyperte The report included and basic metabolid (August and Februa month related to ch moderate, weaknes kidney disease with fatigue.	ent's name, the relevant drug, the pharmacist identified. hysician must document in the record that the identified n reviewed and what, if any, sen to address it. If there is to a medication, the attending ocument his or her rationale in	F	756	 It is the practice of this facility to have a licensed pharmacist review the drug regimen of each resident at least monthly. On April 10, 2018 consulting pharmacist was educated on the Medication Regimen Review policy. On March 26, 2018, R7 had labs drawn that included a BMP and Hgb. All current residents have the potential to be affected. Policy titled Medication Regimen Review was reviewed and copy was provided to consulting pharmacist on April 10, 2018. Quality audits on the completion of ordered labs will be completed weekly for four weeks, then monthly for two months, 	

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		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
			A. DOILDING	۵ <u></u>	(С	
		245463	B. WING		03/2	22/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PIONEE	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		OULD BE	(X5) COMPLETIO DATE	
F 756	3/22/18, and reveal hemoglobin (protein completed on 8/7/1 11.9, (reference ran recent basic metab 8/7/17, with abnorn /deciliter (mg/dl) b (reference range: 7 creatinine, (referen of 100 chloride (CL and low results of 3 (GFR) (reference ra used to assess kidu laboratory tests we after 8/7/17. Review of R7's Pha Review form compl through 3/19/18, re pharmacist (CP) ha review was "ok." Th comments which in reported, recent fall medication related, did not identify R7's been completed as On 3/22/18 at 3:32 pharmacist confirm review notes, and co been completed in primary physician. should of been dom expect them to follo CP indicated staff s primary physician w The CP indicated th	led the most recent n in red blood cells) was 7, with abnormal low results of nge: 12.0-16.0). The most polic panel 8 was completed on nal high results of 38 milligram plood urea nitrogen (BUN), 7-20), high results of 1.4 mg/dl ce range: 0.6-1.1), low results .), (reference range: 101-109) 86 glomerular filtration rate ange: 60-250). These test are ney function. No further re documented as completed armacist Medication Regimen leted monthly from 9/14/17 vealed monthly the consulting ad documented the monthly ne notes listed various included no recent fatigue I does not appear to be however; the monthly reviews is laboratory testing had not	F 756	 and then PRN. The audit repor reviewed at the Quarterly Qual Assurance meetings and recommendations from the Qu will be followed. 5. The facility will have correct in place and be in substantial of by May 1, 2018. 	ty ality Team tive actions		

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		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245463	B. WING				22/2018
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From pa	ge 16	F 7	756			
	confirmed R7's had for a hemoglobin ar ordered by the prim indicated she expect	p.m. director of nursing (DON) I not recently had labs drawn nd basic metabolic panel 8 as ary physician. The DON also cted staff to make sure labs ted as ordered by the primary					
	Consultant Expecta the policy of Pionee pharmacy consultant	blicy titled Pharmacy ations undated, indicated it is er Care that the services of a nt will be obtained to provide aspects of the provision of in the facility.					
F 761 SS=E	reviews was reques		F7	761			5/1/18
	Drugs and biological labeled in accordant professional princip appropriate access	g of Drugs and Biologicals als used in the facility must be ace with currently accepted ales, and include the ory and cautionary e expiration date when					
	§483.45(h) Storage	of Drugs and Biologicals					
	Federal laws, the fa biologicals in locked	cordance with State and acility must store all drugs and d compartments under proper ls, and permit only authorized access to the keys.					
	§483.45(h)(2) The f	facility must provide separately					

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU	TIPI	LE CONSTRUCTION	<u>MB NO.</u> (X3) DATE	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						(2
		245463	B. WING			03/2	22/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Continued From page 17 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure expired			761	 It is the practice of this facility to ensure medications are labeled pro 		
	medication drawers R59) during observ addition the facility were labeled accura	emoved from resident s for 2 of 4 residents (R23, ations of medication pass. In failed to ensure insulin pens ately, and not expired for 2 of 84) who received insulin			 and are not outdated. On March 20 outdated medications were remove R23 s and R58 s drawers. On Ma 19, 2018 a refer to chart sticker was placed on R84 s insulin pen and R unlabeled insulin pen was replaced All residents receiving medicati have the potential to be affected by outdated medications. All residents 	d from arch 3 37 s ons	
	included orders for tablet by mouth one hyperlipidemia. On 3/20/18, at 10:1	cian orders signed 2/21/18, simvastatin 20 mg give 1 e time a day related to 8 a.m. during observations of			 receiving insulin via insulin pen hav potential to be affected by improper labeling. All insulin pens in facility v reviewed to assure appropriate labeland. All medications in facility were review assure they were not expired. 3. Policy titled Storage of Medicat 	vere eling. wed to ions	
	Simvastatin 20 milli observed in the me room. A bottle of Si an expiration date of in R23's medication supply of Simvastat LPN-B indicated he	partially used blister pack of gram (mg) tablets were dication box in the resident's mvastatin 20 mg tablets, with of 2/23/17, was also observed n box. LPN-B confirmed R77's tin in the bottle was expired. er usual practice was to s when they were expired, and			was reviewed. Nursing staff will rec education that all insulin pens must their own label on each pen, if a pe found not to have a proper label on nursing staff will sendback to pharn for proper labeling, or apply sticker indicating to refer to residents medi record for current order. RE Educat also include the need to destroy exp	have n is it, nacy cal ion will	

Facility ID: 00443

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		PLETED
		245463	B. WING			C 22/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		
PIONEE	R CARE CENTER			1131 SOUTH MABELLE A		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From pa	age 18	F 7	61		
	indicated she had done that on a different wing recently.				ensed nurses and trained (TMAs) will be educated	
	R59					
	did not include an of medication to preve medication. On 3/20/18, at 10:3 medication pass w ProAir inhaler was of 7/17. LPN-B con indicated R58 was inhaler, and indicat	ician orders signed 3/15/18, order for ProAir (an inhalation ent bronchospasms) 30 a.m. during observation of ith LPN-B in R58's room, a observed with expiration date nfirmed the finding and not currently receiving the ted the medication should of ot available to use for R58.		 x4, monthly x2, an audits will monitor of insulin pens, an medications. The reviewed at the Qu Assurance meetin recommendations will be followed. 5. The facility will 	will be completed weekly ad quarterly PRN. These for appropriate labeling ad monitoring for expired audit reports will be uarterly Quality	
	expected the licens resident medication medications and re CC-A confirmed the scheduled times to medications. CC-A	I p.m. CC-A indicated she sed nursing staff to go through n drawers when they gave emove expired medications. e facility had no process or o check medication drawers for a indicated if an expired yen it could potentially not be build deteriorate.		by May 1, 2016.		
	On 3/22/18, at 12:34 p.m. pharmacy consultant (PC)-A indicated she completed spot checks on the facility resident medication drawers and checked for accuracy of medication labels, and expired medications and had recommended the facility do audits of resident's medication drawers. PC-A indicated she would recommend dose change stickers to be used when an order for a medication was changed and would expect nurses to periodically look at resident medications and check for expiration dates.					

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		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245463	B. WING				C 22/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Continued From pa	.ge 19	F7	761			
	(DON) indicated sh check the medication She indicated if it do actual order in the of changed, she would sticker be used or a pharmacy. DON inde expired medications medication drawers expect licensed nur the medication's ex administering medication R37 R37's Diagnosis Re R37 had a diagnosi	cations. eport dated 3/22/18, indicated is of type 2 diabetes.					
	order for Novolog fl subcutaneously dai	ders dated 3/7/18, included an ex pen insulin, inject 24 units ly, 26 units subcutaneously subcutaneously daily and to below 150.					
	indicated R37 was of flex pen insulin, inje daily, 26 units subc	dated 3/1/18 - 3/31/18, currently receiving Novolog ect 24 units subcutaneously utaneously daily, and 36 units ly and to hold if blood sugar					
	LPN-A obtained R3 medication drawer plastic divider tray b LPN-A cleaned the	on 3/19/18 at 4:44 p.m. 7's Novolog flex pen from his which was laying in a white by itself inside the drawer. end of the insulin pen with ned a needle, primed the					

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		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		245463	B. WING			C 03/22/2018		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 761	needle with 2 units dial up 36 units of in The Novolog flex per opened, and had a pharmacy label whi Novolog flex pen ar plastic divider tray. R37 blood sugar via R37 would not get a below 150. R37's b LPN-A proceeded t bin. On 3/19/18 at 5:07 Novolog flex pen w and the pharmacy flex pen. LPN-A cor to be properly label R84 R84's Diagnosis Re R84 had a diagnosi R84's Physician Or an order for Novolo units subcutaneous subcutaneously one R84's current MAR indicated R84 was flex pen insulin, inje- two times a day and time per day. During observation LPN-A opened R84 R84's blood sugar was 32	of insulin and proceeded to nsulin in the Novolog flex pen. en was not dated when a date of 12/22/17 on the ich was detached from the nd was observed in the white LPN-A proceeded to check a finger stick and indicated any insulin if blood sugar was lood sugar reading was 147, o waste the dose into a waste p.m. LPN-A confirmed the as not dated when opened, label was detached from the nfirmed all medication needed ed and dated when in use.	F 7	761				

If continuation sheet Page 21 of 28

		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		245463	B. WING			C 03/22/2018		
NAME OF	PROVIDER OR SUPPLIER	•	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
PIONEE	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 761	flex pen, the flex per insulin per sliding se change order sticked LPN-A confirmed R orders in his paper glove, clean the end alcohol wipe, attach needle with 2 units dial up 10 units of in and administered 1 On 3/19/18 at 5:37 pharmacy label did dose of insulin and have been properly sticker. LPN-A verifi receiving sliding sca currently receiving for On 3/19/18 at 5:41 was currently not on insulin. She confirm attached to the insu- when opened and r staff were to place a refer to chart when were changed. CC- be labeled with a op on the pens. CC-B securely attached to labeled. Review of facility po Medications revised three: Drug contain incomplete, improp returned to the pha	ge 21 R84's pharmacy label on his en listed directions to inject cale and did not have a er on the pen. At 5:20 p.m. R4's current signed physician chart. LPN-A proceeded to d of the insulin pen with ned a needle, primed the of insulin and proceeded to nsulin in the Novolog flex pen 0 units of insulin to R84. p.m. LPN-A confirmed R84's not include R84's current indicated R84's insulin should labeled with change order ied R84 was no longer ale insulin injections and was 10 units of Novolog flex pen. p.m. CC-B confirmed R84 n a sliding scale dose of ned R37's label was not ulin pen, had not been dated nad expired. She indicated a medication change label and resident medication doses B indicated all insulins were to be the insulin pens and clearly blicy titled, Storage of d on 4/2007 indicated under ers that have missing, er or incorrect labels shall be rmacy for proper labeling bel refer to chart may be used.	F	761				

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
						0
		245463	B. WING		03/	22/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER			1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 761	Continued From pa	-	F 76 ⁻	1		
	Under number 4: indicated facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. all such drugs shall be returned to the dispensing pharmacy or destroyed.					
F 812 SS=F	812 Food Procurement, Store/Prepare/Serve-Sanitary		F 812	2		5/1/18
	§483.60(i) Food sat The facility must -	fety requirements.				
	approved or consid state or local autho (i) This may include from local producer and local laws or re (ii) This provision de facilities from using gardens, subject to safe growing and fo (iii) This provision de	e food items obtained directly s, subject to applicable State				
	serve food in accor standards for food a This REQUIREMEN by:	NT is not met as evidenced				
	review, the facility for sanitary equipment facility to prevent the organisms. This de potential to affect a facility. In addition to refrigerated food its expiration date and	tion, interview, and document ailed to maintain clean and in the main kitchen of the e spread of food borne ficent practice had the II 97 residents residing in the he facility failed to ensure ems were disposed of after were properly labeled and ginal packaging was opened in		1. The facility s white large stand Robot Coupe, Can Opener, and Bla Cooler were thoroughly cleaned on 3/19/2018. All undated, unlabeled, expired food was discarded on 3/19 from the following locations: Cherry kitchenette refrigerator inside the cupboard, Short Stay Kitchen Refri / Freezer, Apple Blossom Kitchen refrigerator, and Birch Lake Kitchen	ast or 9/2018 / Wood gerator	

Facility ID: 00443

If continuation sheet Page 23 of 28

		AND HUMAN SERVICES			FORM	: 04/26/2018 APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		245463	B. WING		03	C / 22/2018	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEI	R CARE CENTER		1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	Continued From pa 3 of 5 households.	-	F٤	312	refrigerator/ freezer.		
	Findings include:				2. All Residents in the facility have the potential to be affected by this practice.		
	main kitchen was c culinary services (D findings: The facility had multiple red, br across the back an Robot Coupe, used food splatters and metal attachment to had splattered and blade and metal tub blaster cooler had f buildup in the botto				 The Policy titled General Food Preparation and Handling was reviewed. Policy addresses all food service equipment will be cleaned, sanitized, dried and reassembled after each use. The policy titled Food Storage was reviewed. Policy addresses leftover food will be clearly labeled and dated. Leftover food is used within 3 days or discarded. Dietary staff, including Cooks, Homemakers, and Chef will be educated on these policies by April 27th, 2018. 	5	
	contained unlabeled On 3/19/18, at 1:13 refrigerator located Wood wing contain of 10 small carrots, appearance. Home confirmed the carro appeared old, and i be discarded. On 3/20/18 01:27 p the main kitchen, D facility practice was be cleaned every 2 blater cooler require facility's usual pract kitchenette refrigera	kitchenette refrigerator d and undated foods. p.m. the small compact inside the cupboard on Cherry ed an unmarked, undated bag dry and cracked in emaker (HM)-D was present, ots were undated and ndicated the carrots needed to 			4. Quality Audits monitoring cleanliness of kitchen equipment will be conducted by the Dietary Manager or his designee and will be completed weekly for 4 weeks, then every 2 weeks for 1 month, and monthly for 3 months. The results of the audits will be brought to the Quality Assurance meeting and recommendations from the Quality Team will be followed. Quality Audits monitoring for undated, unlabeled and expired foods of the household kitchenette and kitchen refrigerators will be conducted by the Dietary Manager or his designee and will be completed weekly for 4 weeks, then every 2 weeks for 1 month, and monthly for 3 months. The results of the audits wi be brought to the Quality Assurance meeting and recommendations from the		
		to the homemaker staff bods, dating and labeling of			meeting and recommendations from the team will be followed regarding continued		

Facility ID: 00443

		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED	
		245463	B. WING			C 03/22/2018		
NAME OF F	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PIONEEF	R CARE CENTER		1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537					
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 812	Continued From pa opened food.	lge 24	F٤	312	follow up.			
					5. The facility will have corrective a in place and be in substantial comp by May 1, 2018.			
	Short Term stay uni	ur of the kitchenette on the it on 3/19/18 at 12:35 p.m. with g areas of concern were noted:						
	was opened but did when the package -a plastic container opened but did not the container had b -a carton of heavy y full with expiration of -a plastic container which was opened	g of shredded cheese which hat have a date indicating had been opened. of coleslaw half full which was have a date indicating when been opened. whipping cream three quarters						
	bag containing stra carrots opened and containing frozen co opened and partiall containing biscuits, garlic bread, a zip lo and partial used. All been opened and p items were not in the have a date indication	ved to have: taining bread sticks, zip lock wberry's, 2 large bags of I partially used, zip lock bag ookie dough, a bag of waffles y used, a zip lock bag a zip lock bag containing ock bag of zucchini opened II the items listed above had partially used, however, the here original packages, did not ing when the packages had placed in the freezer.						
	On 3/19/18 at 12:44	4 p.m. HM-E confirmed the						

		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245463	B. WING				C 22/2018
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R CARE CENTER				131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	above finding, verifi dated when opened freezer. HM-E indic the frozen items ha not sure how long t freezer once opene be making sure the opening and storing HM-E indicated exp away and should no During the initial tou Apple Blossom unit HM-F, the following Fridge was observe -a large zip lock bag was opened but did when the packages -a carton of heavy v expiration date of 3 On 3/19/18 at 12:58 above findings and should be labeled a	ied all food items should be d and stored in the fridge and sted he was not sure how long id been in the freezer and was hey could be stored in the ed. HM-E indicated staff should a items are dated when g them in the fridge or freezer. Dired items should be thrown ot be in the fridge. ur of the kitchenette on the t on 3/19/18 at 12:51 p.m. with g areas of concern were noted: ed to have: g of shredded cheese which d not have a date indicating s had been opened. whipping cream half full with a/11/18. 8 p.m. HM-F confirmed the indicated items in the fridge and dated when opened. HM-F ems should be thrown away	Fε	312			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 04/26/2018 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245463	B. WING	i			C 22/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PIONEE	R CARE CENTER				1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	Birch Lake kitchene and expired food. On 3/19/18, at 3:40 refrigerator/freezer who identified herse The following items -14 shelled, hard bo substance, dated 3 -an open zip lock b turned brown, dated -1/2 quart contained expiration date of 3 -sliced deli style tur -package of sliced Freezer section -frozen bag of suga up of white frost on 2/7 -a quart size zip loc with a build up of w bread sticks was un The shelves and bo freezer sections we orange colored deb On 3/19/18, at 3:40 protocol of food item foods were opened refrigerator and free outdated and undat C-A identified staff food items and clear refrigerator/freezer supplies in order to prevent the use of of A facility form titled	ette refrigerator had undated 0 p.m. the Birch Lake was reviewed with cook (C)-A elf as the lead homemaker. s were noted: oiled eggs, in a wet slimy 3/4 rag of leaf lettuce which had d 3/14 r of chocolate TruMoo with an 3/17/18 rkey meat dated 3/6 ham dated 3/10 ar cookie dough, with a build the edges of the dough, dated ck bag with five bread sticks white frost on all edges of the ndated. ottom of the refrigerator and ere observed with green and oris of food . 0 p.m. C-A verified the facility ms labeled with the date the d. C-A verified the soiled ezer section, as well as the ted food items listed above. were expected to review the anliness of the daily while replenishing o maintain cleanliness and	F	812			

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		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245463	B. WING				C 22/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER	R CARE CENTER				131 SOUTH MABELLE AVENUE ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	Continued From pa	ige 27	F٤	312			
	completed in the kit for equipment clear	tchen, but lacked instruction ning.					
	and Handling, revis	tled General Food Preparation ed 4/1/09, indicated all food should be cleaned, sanitized, bled after each use.					
	undated, instructed	tled Kitchenettes and Pantries, the food service staff to ems. The policy lacked d undated items.					
	4/1/09, instructed le covered containers securely. Each iten dated before being	tled Food Storage, revised eftover food to be stored in or wrapped carefully and n to be clearly labeled, and refrigerated. Leftover food to tys or discarded. Frozen foods labeled and dated.					
	Family/Visitors, revi foods must be store with tightly fitting lid Containers will be la name, the item and nursing staff is resp	tled Foods Brought by ised 2/14, indicated perishable ed in re-sealable containers ls in the refrigerator. abeled with the resident's I the "use by" date. The ponsible for discarding in or before the "use by" date.					
	7/11/11, directed tin food which included - deli meat, seven d	days after opening 10 days after opening					

Facility ID: 00443

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		AND HUMAN SERVI & MEDICAID SERVI		FGU	163028	FORM	03/30/2018 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF			PLE CONSTRUCTION G 02 - MAIN BLDG TWO	(X3) DATE SU COMPLE	
		245463		B. WING		03/1	9/2018
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
PIONEE	R CARE CENTER				BELLE AVENUE MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE 7 BE PRECEDED BY FULL F INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs		K 000			
	5				1 0 ²		
	FIRE SAFETY						
	Building 02						
	Minnesota Departm time of this survey,	Survey was conduct nent of Public Safety. Pioneer Care Cente in compliance with t	. At the r 02 Main				
2 25	Medicare/Medicaid 483.70(a), Life Safe edition of National (NFPA) Standard 1	at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code g Health Care and th	e 2012 ciation (LSC),	8	6 5 2		
	The facility was sur Pioneer Care Cent Building 02 main bu basement and is Ty Building 03 is a 1-s	, Health Care Facilitie rveyed as two buildin er is two buildings bu uilding is a 2-story, w ype II (111) construct tory building without e V (111) constructio	gs. uilt in 2011. rithout a ion. a				
	accordance with N Installation of Sprin a complete fire alar detection in the con corridor and all cor accordance with N Alarm Code" . The automatic fire depa sleeping rooms hat and all hazardous a detection.	fully sprinkler protect FPA 13 Standard for ikler Systems. The farm system with smol ridors, spaces open nmon areas installed FPA 72 "The Nationa fire alarm is monitor artment notification. T ve smoke detection i areas have automati	the acility has ke to the d in al Fire red for The in them c fire 05 beds	K			
	and had a census	of 97 at the time of tl	ne survey.		>		
							(MO) D 200
LABORATC	DRY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRES	ENTATIVE'S SI	JNATURE	TITLE	8	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES ICES				FORM	03/30/2018 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			LE CONSTRUCTION	wo	(X3) DATE SU COMPLE	RVEY TED
		245463		B. WING			03/19/2018	
	ROVIDER OR SUPPLIER R CARE CENTER		1131 SC	OUTH MAE	TATE, ZIP CODE BELLE AVENUE 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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					ULD BE	(X5) COMPLETION DATE	
K 000		age 1 42 CFR, Subpart 48	3.70(a) is	K 000			c	
	v		•					
	8		42		2 U		×	
			2.					
5		1.						
	=		đ					
		a.	8 U 1			i)		1×
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FORM CMS-	-2567(02-99) Previous Ve	ersions Obsolete		c	EPDS21	×	If continuation	sheet Page 2 of 2

		AND HUMAN SERV & MEDICAID SERV		F546	3028	FORM	03/30/2018 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1	LE CONSTRUCTION 6 03 - SOUTH BLDG 3	(X3) DATE SU COMPLE	
		245463		B, WING		03/19	9/2018
	ROVIDER OR SUPPLIER R CARE CENTER		1131 SC	OUTH MAB	TATE, ZIP CODE BELLE AVENUE MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	Building 03						
	Minnesota Departm Fire Marshal Divisio Pioneer Care Cente with the requiremer Medicare/Medicaid 483.70(a), Life Safe edition of National H (NFPA) Standard 1 Chapter 19 Existing edition of NFPA 99, The facility was sur Pioneer Care Cente Building 02 main bu basement and is Ty	Survey was conduct nent of Public Safety. on. At the time of thi er was found in comp nts for participation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code g Health Care, and the Health Care Facilitie veyed as two buildin er is made up of two uilding is a 2-story, w ope II (111) construct tory building without (111).	State s survey, bliance 2012 ciation (LSC), ne 2012 es Code. gs. buildings. ithout a ion.				
	accordance with NI Installation of Sprin a complete fire alar detection in the cor corridor and all con accordance with NI Alarm Code". The automatic fire depa sleeping rooms hav and all hazardous a detection.	sprinkler protected i FPA 13 Standard for kler Systems. The fa m system with smok ridors, spaces open mon areas installed FPA 72 "The Nationa fire alarm is monitor rtment notification. T e smoke detection i areas have automation	the acility has to the in I Fire ed for The n them c fire				
	and had a census of	of 97 at the time of the 42 CFR, Subpart 48	ne survey.				
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	IMENT OF HEALTH					FORM	03/30/2018 APPROVED 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION 3 03 - SOUTH BLDG 3	(X3) DATE SU COMPLET	RVEY TED
		245463		B. WING		03/19	/2018
1	PROVIDER OR SUPPLIER		1131 SC	OUTH MAE	STATE, ZIP CODE BELLE AVENUE MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCII F BE PRECEDED BY FULL INTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
							E
FORM CMS	-2567(02-99) Previous Ve	ersions Obsolete			EPDS21	If continuation	sheet Page 2 of 2



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 4, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5463028

Dear Ms. Watkins:

The above facility was surveyed on March 19, 2018 through March 22, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5463024. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Pioneer Care Center April 4, 2018 Page 2 the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson, Unit Supervisor at (218) 332-5140 or gail.anderson@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00443	B. WING		03/2) 2/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PIONEEI	R CARE CENTER		TH MABELL FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 04/12/18

Electronically Signed

6899

If continuation sheet 1 of 26

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00443	B. WING			C 03/22/2018	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
PIONEE	R CARE CENTER		JTH MABELLE FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 000	Department of Hea you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, the corrected prior to el Minnesota Departm On 3/19/18 to 3/22/ Department's staff, the following correct Please indicate in y correction that you and identify the date At the time of the su complaint H546302 found to be substar substantiated at 19 Minnesota Departm the State Licensing federal software. Ta assigned to Minness Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Statement and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. (18, surveyors of this visited the above provider and tion orders are issued. our electronic plan of have reviewed these orders, e when they will be completed. (24 were completed and were ntiated. The complaint was 95. (25 ment of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for (26 ment of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and					

EPDS11

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00443	B. WING		C 03/22/2018	
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/	22/2010
			JTH MABELI			
PIONEEI	R CARE CENTER	FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
21100	MN Rule 4658.065 Storage of Perishal	0 Subp. 5 Food Supplies; ble food	21100			5/1/18
	perishable food mu washable, corrosion	of perishable food. All st be stored off the floor on n-resistant shelving under and at temperatures which spoilage.				
	by: Based on observative review, the facility for sanitary equipment facility to prevent the organisms. This depotential to affect a facility. In addition the refrigerated food its expiration date and dated when the origination of the origin	ent is not met as evidenced ion, interview, and document ailed to maintain clean and in the main kitchen of the spread of food borne ficient practice had the II 97 residents residing in the he facility failed to ensure ems were disposed of after were properly labeled and ginal packaging was opened in		Corrected		
	main kitchen was c culinary services (E	2 a.m. an initial tour of the ompleted with director of OCS)-A and confirmed the y's white large stand mixer,				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00443	B. WING			C 03/22/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
	R CARE CENTER		UTH MABELLE				
		FERGUS	FALLS, MN 5	6537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
21100	Continued From pa	age 3	21100				
	across the back an Robot Coupe, used food splatters and metal attachment to had splattered and blade and metal tul blaster cooler had f buildup in the botto Cherry Wood wing contained unlabele On 3/19/18, at 1:13 refrigerator located Wood wing contain of 10 small carrots, appearance. Home confirmed the carro	rown and white food splatters d the arm of the stand. The d for pureed foods, had some brown food buildup around the ube. The facility can opener crusted brown food on the o attached to the blade. The food particles and brown m of it. kitchenette refrigerator d and undated foods. g.p.m. the small compact inside the cupboard on Cherry ed an unmarked, undated bag dry and cracked in emaker (HM)-D was present, ots were undated and indicated the carrots needed to	/				
	the main kitchen, D facility practice was be cleaned every 2 blaster cooler requi facility's usual prac- kitchenette refrigers provided education regarding expired fo opened food. During the initial too Short Term stay un	b.m. during a follow up tour of DCS-A indicated the usual is for the kitchen can opener to 2-3 weeks, and confirmed the ired cleaning. He indicated the tice was monthly audits of the ators. He indicated he to the homemaker staff oods, dating and labeling of ur of the kitchenette on the it on 3/19/18 at 12:35 p.m. with	n				
	Fridge was observe -a large zip lock ba	g areas of concern were noted: ed to have: g of shredded cheese which d not have a date indicating					

STATE FORM

EPDS11
	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:				PLETED
			B. WING			C
		00443	B. WING		03/	22/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
PIONEE	R CARE CENTER		JTH MABELLE FALLS, MN 5			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		VMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21100	Continued From pa	ge 4	21100			
	opened but did not the container had b -a carton of heavy v full with expiration of -a plastic container which was opened indicating when the Freezer was observ -a zip lock bag cont bag containing stra carrots opened and containing frozen of	whipping cream three quarters late of 2/24/18. of cottage cheese half full but did not have a date package had been opened.				
	containing biscuits, garlic bread, a zip le and partial used. Al been opened and p items were not in th have a date indicati	a zip lock bag containing ock bag of zucchini opened I the items listed above had artially used, however, the here original packages, did not ng when the packages had laced in the freezer.				
	above finding, verifi dated when opened freezer. HM-E indic the frozen items ha not sure how long t freezer once opened be making sure the opening and storing	4 p.m. HM-E confirmed the led all food items should be d and stored in the fridge and ted he was not sure how long d been in the freezer and was hey could be stored in the id. HM-E indicated staff should items are dated when g them in the fridge or freezer. bired items should be thrown of be in the fridge.				
	Apple Blossom unit	ur of the kitchenette on the on 3/19/18 at 12:51 p.m. with areas of concern were noted:				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00443	B. WING			C 03/22/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	R CARE CENTER	1131 SO	UTH MABELLE	E AVENUE			
FIONEER	CARE CENTER	FERGUS	FALLS, MN 5	6537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21100	Continued From pa	ge 5	21100				
	was opened but did when the packages -a carton of heavy v expiration date of 3 On 3/19/18 at 12:58 above findings and should be labeled a indicated expired its and taken out of frid	g of shredded cheese which I not have a date indicating s had been opened. whipping cream half full with /11/18. B p.m. HM-F confirmed the indicated items in the fridge and dated when opened. HM-F ems should be thrown away					
	and expired food. On 3/19/18, at 3:40	p.m. the Birch Lake					
	who identified herse The following items -14 shelled, hard be substance, dated 3 -an open zip lock b turned brown, date -1/2 quart contained expiration date of 3	biled eggs, in a wet slimy /4 ag of leaf lettuce which had d 3/14 r of chocolate TruMoo with an B/17/18 key meat dated 3/6					
	up of white frost on 2/7 -a quart size zip loc	ar cookie dough, with a build the edges of the dough, dated of bag with five bread sticks hite frost on all edges of the ndated.	ł				
		ottom of the refrigerator and ere observed with green and oris of food .					

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If continuation sheet 6 of 26

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00443	B. WING			C 03/22/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE				
PIONEE	R CARE CENTER		FALLS, MN 5	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21100	Continued From pa	age 6	21100				
	foods were opened refrigerator and fre- outdated and unda C-A identified staff food items and clea refrigerator/freezer supplies in order to prevent the use of A facility form titled provided. The form completed in the ki for equipment clean The facility policy ti and Handling, revis service equipment dried and reassem The facility policy ti undated, instructed	daily while replenishing maintain cleanliness and outdated foods. Daily Checklist, undated, was n included multiple tasks to be tchen, but lacked instruction ning. tled General Food Preparation sed 4/1/09, indicated all food should be cleaned, sanitized, bled after each use. tled Kitchenettes and Pantries, I the food service staff to ems. The policy lacked					
	 4/1/09, instructed le covered containers securely. Each iter dated before being be used within 3 da should be covered, The facility policy ti Family/Visitors, rev foods must be store with tightly fitting lic Containers will be I 	tled Food Storage, revised eftover food to be stored in or wrapped carefully and m to be clearly labeled, and refrigerated. Leftover food to ays or discarded. Frozen foods labeled and dated. tled Foods Brought by ised 2/14, indicated perishable ed in re-sealable containers is in the refrigerator. abeled with the resident's if the "use by" date. The					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED	
		00443	B. WING			03/22/2018	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S				
PIONEE	R CARE CENTER		JTH MABELLE FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21100	Continued From pa	ge 7	21100				
	perishable foods or	n or before the "use by" date.					
	7/11/11, directed tin food which included - deli meat, seven o -shredded cheese, -leftovers, within the SUGGESTED MET The director of dieta development and in procedures to food cleaned and mainta store refrigerated for labeled, dated to er discard by the expin dietary services or o on those policies, a appropriate staff for procedures.	days after opening 10 days after opening ree days. THOD OF CORRECTION: ary services or designee could nplement policies and preparation equipment were ained regularly and ensure bod items were properly nsure they were used or ration date. The director of designee could educate staff ind then monitor the r adherence to the policies and					
21426	(21) days	R CORRECTION: Twenty one A.04 Subd. 3 Tuberculosis	21426			5/1/18	
	(a) A nursing home maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students,					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	СОМ	E SURVEY PLETED	
		00443	B. WING			C 03/22/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
PIONEE	R CARE CENTER		UTH MABEL FALLS, MN	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21426	Continued From pa	age 8	21426				
	Health shall provide regarding impleme	Inteers. The Department of e technical assistance Intation of the guidelines. ance with this subdivision musi he nursing home.	t				
	by: Based on documer facility failed to con	nent is not met as evidenced nt review and interview, the nplete a 2-step tuberculin skin of 5 newly hired employees		Corrected			
	Findings include:						
	position of a registe	was hired on 12/15/17 in the ered nurse. When reviewed, <i>r</i> idence that a Step 2 TST test ed.					
	position of a nursin	was hired on 1/29/18 in the ng assistant. When reviewed, vidence that a Step 2 TST test ed.					
	Testing (TST) Prote Workers (last revie "pre-employment s workers and correc	r entitled Tuberculin Skin ocol for Screening Health Care wed 8/28/13), indicated screening for healthcare ctional facility staff" had a " of Administer two-step TST.					
		ulosis (TB) Risk Assessment, 7, the facility was assessed to					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			С
		00443	B. WING		03/22/2018	
NAME OF F	PROVIDER OR SUPPLIER					
PIONEEF	R CARE CENTER		TH MABELL FALLS, MN 성			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
21426	Continued From pa	age 9	21426			
	baseline TB screer	ity, however, indicated a ning of all health care workers d at the time of hire.				
	infection control re- both of the employ TST which was ne- facilty practice was being given, Huma employees a posto Step must be comp felt the employees	on 3/22/18 at 10:15 a.m., the gistered nurse (ICRN) stated ees had received a 1st step gative. ICRN stated the usual within 48 hours of the 1st Step n Resources would send ard reminder of when the 2nd bleted by. The ICRN stated she had not returned for their 2nd anyone followed up with the e facility.				
	director of nursing employees were m did not receive their the postcard remin	8/22/18 at 10:35 a.m., the (DON) stated the two issed and/or over looked, and r 2nd Step TST. She stated ders for the 2nd Step TST was their employee contact				
	The director of nurreview the facility T on these policies a screening procedu	THOD OF CORRECTION: sing and/or designee could 'B policies, educate employees nd monitor to assure TB res were developed and sure staff were free of TB prior idents.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty one				
21530	MN Rule 4658.131	0 A.B.C Drug Regimen Review	21530			5/1/18
inesota De	epartment of Health					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	of connection	DENTITION NOMBER.	A. BUILDING: _		001		
		00443	B. WING			C 03/22/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
	R CARE CENTER		JTH MABELLE				
		FERGUS	FALLS, MN 5	6537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
21530	Continued From pa	ge 10	21530				
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Financ This standard is ind available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the ac report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct physician lf the me the attending physic justification for the o physician does not must be referred fo assessment and as by part 4658.0070. the medical director must refer the matter	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ing-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports to by the time of the next boner, if indicated by the rposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur 's recommendation, or does te justification, and the s the resident's quality of life is exted, the pharmacist must he medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter r review to the quality surance committee required If the attending physician is or, the consulting pharmacist er directly to the quality surance committee.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
			B. WING	•	С	
		00443	B. WING			22/2018
IAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
PIONEER	CARE CENTER		FALLS, MN	LE AVENUE 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21530	Continued From pa	ige 11	21530			
	by: Based on interview facility failed to ens been completed for	ent is not met as evidenced and document review the ure laboratory monitoring had 1 of 5 residents (R7) essary medications.		Corrected		
	Findings include:					
	physican on 2/20/1 included chronic kie (moderate), hyperte The report included and basic metabolii (August and Februa month related to ch moderate, weakness	eview Report, signed by the 8, listed diagnoses which dney disease stage 3 ension, and atrial fibrillation. I an order for a hemoglobin c panel 8 every six months in ary) the first Monday of the pronic kidney disease (stage 3) ss, hypertensive chronic n stage 1 through stage 4 and				
	3/22/18, and reveal hemoglobin (protein completed on 8/7/1 11.9, (reference ran recent basic metab 8/7/17, with abnorn /deciliter (mg/dl) b (reference range: 7 creatinine, (reference of 100 chloride (CL and low results of 3 (GFR) (reference ran used to assess kide	dical record was done on led the most recent n in red blood cells) was 7, with abnormal low results of nge: 12.0-16.0). The most olic panel 8 was completed on nal high results of 38 milligram blood urea nitrogen (BUN), 7-20), high results of 1.4 mg/dl ce range: 0.6-1.1), low results), (reference range: 101-109) 86 glomerular filtration rate ange: 60-250). These test are ney function. No further re documented as completed				

STATEMEN	a Department of H	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			PLETED
		00443	B. WING		C 03/22/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
PIONEER	CARE CENTER		ITH MABELLE FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 12	21530			
	through 3/19/18, re pharmacist (CP) h review was "ok." T comments which in reported, recent fa medication related did not identify R7' been completed as On 3/22/18 at 3:32 pharmacist confirm review notes, and been completed in primary physician. should of been dor expect them to foll CP indicated staff primary physician The CP indicated t	e p.m. the consulting ned R7's monthly pharmacy confirmed R7's labs had not February as ordered by her The CP indicated the labs ne by staff and she would ow the orders as written. The should of followed up with the when the labs were missed. they usually would of given 18 to complete labs before a				
	confirmed R7's had for a hemoglobin a ordered by the prin indicated she expe	p.m. director of nursing (DON) d not recently had labs drawn and basic metabolic panel 8 as nary physician. The DON also ected staff to make sure labs eted as ordered by the primary				
	Consultant Expect the policy of Pione pharmacy consulta	oolicy titled Pharmacy ations undated, indicated it is er Care that the services of a ant will be obtained to provide aspects of the provision of s in the facility.				
monoto Do		cy in regards to pharmacy sted, but not provided.				
ATE FORM			6899 EF	PDS11	If continuation	on sheet 13 o

Minneso	ta Department of He	ealth				-
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00443	B. WING		03/2) 2/2018
	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE		
			JTH MABELI			
PIONEER	R CARE CENTER		FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530		THOD OF CORRECTION: The	21530			
	review and revise p proper monitoring of Appropriate nursing these systems. The develop an auditing compliance. The au	(DON) or designee could policies and procedures for of medication usage and labs. g staff could be educated on e DON or designee, could g system to ensure ongoing udits could be reviewed with ce committee for further				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21620	MN Rule 4658.134	5 Labeling of Drugs	21620			5/1/18
	Drugs used in the r in accordance with	nursing home must be labeled part 6800.6300.				
	by: Based on observative review the facility farmedications were represented and the facility farmedication drawers (R59) during observed addition the facility were labeled accurrent facility facili	ent is not met as evidenced ion, interview and record ailed to ensure expired emoved from resident s for 2 of 4 residents (R23, rations of medication pass. In failed to ensure insulin pens ately, and not expired for 2 of R84) who received insulin		Corrected		
	R23					
	epartment of Health					
STATE FOR	N		6899	EPDS11	If continuatio	n sheet 14 of 26

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00443	B. WING			C 03/22/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
PIONEEI	R CARE CENTER		JTH MABELLE FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21620	Continued From pa	age 14	21620				
	included orders for	ician orders signed 2/21/18, simvastatin 20 mg give 1 e time a day related to					
	medication pass, a Simvastatin 20 mill observed in the me room. A bottle of Si an expiration date of in R23's medication supply of Simvasta LPN-B indicated he remove medication	8 a.m. during observations of partially used blister pack of igram (mg) tablets were edication box in the resident's invastatin 20 mg tablets, with of 2/23/17, was also observed n box. LPN-B confirmed R77's tin in the bottle was expired. er usual practice was to as when they were expired, and done that on a different wing					
	R59						
	did not include an o	ician orders signed 3/15/18, order for ProAir (an inhalation ent bronchospasms)					
	medication pass wi ProAir inhaler was of 7/17. LPN-B con indicated R58 was inhaler, and indicat	30 a.m. during observation of ith LPN-B in R58's room, a observed with expiration date firmed the finding and not currently receiving the ed the medication should of ot available to use for R58.					
	expected the licens resident medication medications and re CC-A confirmed the scheduled times to	p.m. CC-A indicated she sed nursing staff to go through n drawers when they gave move expired medications. e facility had no process or check medication drawers for indicated if an expired					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00443	B. WING	B. WING		C 03/22/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	·		
PIONEEF	R CARE CENTER		UTH MABELLE	-			
			FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21620	Continued From pa	age 15	21620				
	medication was giv as effective and co	ren it could potentially not be uld deteriorate.					
	(PC)-A indicated s the facility resident checked for accura expired medication facility do audits of PC-A indicated she change stickers to medication was cha	A4 p.m. pharmacy consultant he completed spot checks on medication drawers and acy of medication labels, and us and had recommended the resident's medication drawers. would recommend dose be used when an order for a anged and would expect anged and would expect anged and medications ration dates.					
	(DON) indicated sh check the medicati She indicated if it d actual order in the changed, she woul sticker be used or a pharmacy. DON ind expired medication medication drawers						
		eport dated 3/22/18, indicated is of type 2 diabetes.					
	order for Novolog f subcutaneously da	rders dated 3/7/18, included an lex pen insulin, inject 24 units ily, 26 units subcutaneously subcutaneously daily and to below 150.					
	B37's current MAB	a dated 3/1/18 - 3/31/18,					

STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00443	B. WING			C 22/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
PIONEEI	R CARE CENTER		JTH MABELLE FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
21620	flex pen insulin, inje daily, 26 units subc subcutaneously dai below 150. During observation LPN-A obtained R3 medication drawer plastic divider tray & LPN-A cleaned the alcohol wipe, attach needle with 2 units dial up 36 units of in The Novolog flex pen opened, and had a pharmacy label whi Novolog flex pen an plastic divider tray. R37 blood sugar via R37 would not get a below 150. R37's b LPN-A proceeded t bin. On 3/19/18 at 5:07 Novolog flex pen w and the pharmacy	ige 16 currently receiving Novolog ect 24 units subcutaneously utaneously daily, and 36 units ily and to hold if blood sugar on 3/19/18 at 4:44 p.m. 7's Novolog flex pen from his which was laying in a white by itself inside the drawer. end of the insulin pen with ned a needle, primed the of insulin and proceeded to nsulin in the Novolog flex pen. en was not dated when a date of 12/22/17 on the ch was detached from the nd was observed in the white LPN-A proceeded to check a finger stick and indicated any insulin if blood sugar was lood sugar reading was 147, o waste the dose into a waste p.m. LPN-A confirmed the as not dated when opened, label was detached from the nfirmed all medication needed	21620			
	R84 R84's Diagnosis Re R84 had a diagnos R84's Physician Or an order for Novolo	ed and dated when in use. eport dated 3/22/18, indicated is of type 2 diabetes. ders dated 1/25/18, included g flex pen insulin, inject 10 sly two times a day and 4 units e time per day.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00443	B. WING			C 22/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PIONEEI	R CARE CENTER		JTH MABELLI FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21620	Continued From pa	ige 17	21620			
	indicated R84 was flex pen insulin, inje	dated 3/1/18 - 3/31/18, currently receiving Novolog ect 10 units subcutaneously d 4 units subcutaneously one				
	LPN-A opened R84 R84's blood sugar blood sugar was 32 to receive 10 units pen. After review of flex pen, the flex per insulin per sliding s change order sticke LPN-A confirmed F orders in his paper glove, clean the en alcohol wipe, attach needle with 2 units dial up 10 units of i	on 3/19/18 at 5:09 p.m. I's medication drawer, checked via finger stick and R84's 24. LPN-A indicated R84 was of Novolog insulin from the flex f R84's pharmacy label on his en listed directions to inject cale and did not have a er on the pen. At 5:20 p.m. 184's current signed physician chart. LPN-A proceeded to d of the insulin pen with ned a needle, primed the of insulin and proceeded to nsulin in the Novolog flex pen 0 units of insulin to R84.				
	pharmacy label did dose of insulin and have been properly sticker. LPN-A verif receiving sliding sc	p.m. LPN-A confirmed R84's not include R84's current indicated R84's insulin should labeled with change order fied R84 was no longer ale insulin injections and was 10 units of Novolog flex pen.				
	was currently not o insulin. She confirm attached to the insu when opened and I staff were to place refer to chart when were changed. CC-	p.m. CC-B confirmed R84 n a sliding scale dose of ned R37's label was not ulin pen, had not been dated nad expired. She indicated a medication change label and resident medication doses B indicated all insulins were to pened date and expiration date				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00443 B. WING			C 03/22/201	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PIONEEI	R CARE CENTER		UTH MABELLE FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21620	Continued From pa	age 18	21620			
		confirmed the label should be to the insulin pens and clearly				
	Medications revise three: Drug contain incomplete, improp returned to the pha before storing. A la Under number 4: in discontinued, outda	olicy titled, Storage of d on 4/2007 indicated under hers that have missing, ber or incorrect labels shall be trmacy for proper labeling bel refer to chart may be used indicated facility shall not use ated, or deteriorated drugs or in drugs shall be returned to the acy or destroyed.				
	administrator, direc consulting pharma policies and proced medications and la educated as neces properly securing n DON or designee,	THOD OF CORRECTION: The ctor of nursing (DON) and cist could review and revise dures for proper storage of beling. Nursing staff could be sary to the importance of nedications and labeling. The along with the pharmacist, ts on a regular basis to ensure				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty one				
21995	MN St. Statute 626 Maltreatment of Vu	5.557 Subd. 4a Reporting - Inerable Adults	21995			5/1/18
	(a) Each facility sh ongoing written pro applicable licensing of suspected maltr	I reporting of maltreatment. I all establish and enforce an ocedure in compliance with g rules to ensure that all cases eatment are reported. If a nal reporting procedure, a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	COM	E SURVEY PLETED
		00443	B. WING			C 22/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
PIONEEF	R CARE CENTER		UTH MABEL FALLS, MN			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
21995	Continued From pa	age 19	21995			
	requirements of thi internally. Howeve responsible for cor	may meet the reporting is section by reporting er, the facility remains nplying with the immediate ents of this section.				
	by: Based on interview facility failed to imm agency (SA) allega abuse for 1 of 1 res allegations of misu addition the facility the SA, and condu- an injury of unknow	and document review, the mediately report to the state ations of mental/emotional sident (R49) reviewed use of cellular phone. In failed to immediately report to ct a thorough investigation of vn source for 1 of 1 (R77) for potential neglect of care.		Corrected		
	Findings include:					
	2/7/18, indicated R impaired with diagr failure, dementia a indicated R49 requ	nimum Data Set (MDS) dated 49 was severely cognitively noses which included heart nd depression. The MDS uired extensive assistance of ctivities of daily living (ADL's) ors.				
	various intervention provide consistent possible in order to confusion,encoura concerns, staff will	plan revised on 2/14/18, listed n which included to try to care givers as much as o decrease ge R49 to express any maintain safety, monitor and ed abuse or neglect following				
	dated 2/11/18, and	t Accident/Incident Report did not list a time the incident report indicated a nursing				

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00443	B. WING			C 22/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	R CARE CENTER		ITH MABELL			
FIONLE		FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21995	Continued From pa	ge 20	21995			
	assistant (NA)- B re to cause mental/em was no injury or cha listed on 2/13/18 sc an interview with Re the SW the nursing stated the nursing a her. The SW asked pictures of her, she perpetrator has lots "little boy." R49 stat show anyone those	eported a cell phone was used notion abuse to R49 and there ange in life style. The report ocial worker (SW) completed 49, and R49 was able to tell assistant's name and R49 assistant had been good to d if the perpetrator took stated "yes" and indicated the s of pictures of R49 and her ted she "hoped she doesn't pictures." When SW asked picture taken, R49 had stated				
	the SA on 2/13/18 a of emotional or men the incident had occ nursing assistant ha another nursing ass picture of R1 to her sexual, she was clo by the facility revea stated she did not li stated "I hope she o pictures." The invest	Report #310516, submitted to at 4:39 p.m. listed an allegation ntal abuse for R1, and listed curred on 2/12/18 at 1 p.m. A ad reported to her nurse that sistant had snap chatted the pictures of R1 were not othed. The investigation done led during an interview R1 had ike pictures taken of her and doesn't show anyone those stigation listed NA-B had eccived pictures of R1 from the				
linneceta D	(LPN)-D stated she and confirmed NA- another NA(perpetr R49 on her cell pho NA-B. LPN-D indica needed to report th NA-B was scared to	a.m. licensed practical nurse aware of the incident with R1 B came to her and reported rator) had taken pictures of one and snap chatting them to ated she told NA-B that she e incident right away, but o report the incident. LPN-D I reported the incident to her				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00443	B. WING			22/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PIONEE	R CARE CENTER		JTH MABELLE FALLS, MN 5	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	over the weekend a to the SW the next reported the incider confirmed staff wer immediately and co immediately. On 3/22/18 at 8:52 had reported the al (perpetrator) taking phone and sending her. The SW confii needed to be repor on weekends the co the report to the SA On 3/22/18 at 9:03 reported the allegat (perpetrator) taking them to her. The D incident over the we and LPN-D then rep confirmed the current the incident had no the SA. On 3/22/18 at 9:19 worked with the per and was not the first of R49. NA-B verifies she understood LP someone about it. I LPN-D on the week reported the incident to work on Monday the incident was no because there was	and she reported the incident day because NA-B had not int to anyone. The LPN-D re to report incidents of abuse onfirmed it was not reported a.m. SW confirmed the facility legations of abuse of a NA pictures of R49 with her cell the pictures on snap chat to rmed the allegations of abuse ted to the SA immediately and harge nurse should be making A. a.m. DON confirmed NA-B tion of another NA picture of R49 and sending ON verified NA-B reported the eekend to LPN-D right away ported it to the SW. The DON ent facility policy and confirmed t been reported immediately to a.m. NA-B stated she had rpetrator prior to the incident st time she had taken pictures ed she had told LPN-D and N-D was going to talk to NA-B indicated she had told kend and thought LPN-D int to the SW when she came or Tuesday. NA-B indicated the reported over the weekend not a SW available on the st it to and no one in the building		DEFICIENC		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.			С
		00443	B. WING			22/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PIONEEI	R CARE CENTER		UTH MABELLE FALLS, MN 5	-		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE
21995	Continued From pa	age 22	21995			
	confirmed the facili aware of the incide expected staff to re- immediately. The a would expect staff indicated she was allegation of abuse R77's annual MDS identified R77 had	assessment dated 2/21/18, diagnoses which included,				
	severe cognitive im identified she requi transfers and walki her room. R77's fall Care Are	and hypertension and had npairment. R77's MDS further ired extensive assistance with ing, but did not walk outside a Assessments (CAA) dated				
		she was at risk for falls related ns, use of antidepressant gnitive impairment.				
	was at high risk of with repair and liste included education caregivers for safe a fall occurred. The to ensure R77 word mobilizing in wheel remote to the back from accidentally s	-	F			
	12/11/19 identified:					
	Staff found R77 sitt bottom of her reclir	R77 was heard calling out. ting on the floor near the ner in her room.R77 in her left hip area and was				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00443	B. WING			C 22/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	R CARE CENTER	1131 SOI	JTH MABELL	E AVENUE		
FIUNEER		FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 23	21995			
	sent to the hospital	emergency department.				
	writer that the resid	-12/9/17, 10:30 a.m. the hospital updated the writer that the resident had a left hip fracture and would have surgery that day.				
	-12/11/17, 7:25 a.m. a fall follow up progress note written by CC-A indicated the care plan was reviewed and was appropriate prior to the fall. Fall intervention for staff to fasten the lift chair remote to the recliner so that R77 did not accidentally raise it up so high that she slid out of it again.					
	No further docume was provided by the	ntation of the incident for R77 e facility.				
	practice for reportir was for the nurse in nurse and either nu to the SA. She indic report to the SA has she did not see a re fracture to the SA,	6 p.m.CC-A indicated the usual ng to the state agency (SA) nvolved to report to the charge urse would complete the report cated she was not sure if a d been done, and indicated eason to report R77's fall with because it was just an id not suspect maltreatment.				
	facility process for a directed the floor na complete and subm could call the LSW they would report it would report major the care plan was n was notified of R77 it was not appropria DON indicated she	6 p.m. DON indicated the reporting to the state agency urse or the charge nurse to nit the report. If needed they , administrator or herself and . DON indicated the facility injuries for abuse, neglect or if not followed. She indicated she "s fall with major injury, but felt ate to make a report to the SA. did not feel there was a				
	reason to report R7	77's fall, since it was ure a hip if someone fell out of				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00443	B. WING			22/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PIONEEI	R CARE CENTER		JTH MABELLI FALLS, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21995	Continued From pa	ge 24	21995			
	accidental fall with	d she understood an injury would not be reportable, n was not followed or there esident altercation.				
	During a follow up interview on 3/22/18, at 1:15 p.m. DON indicated the facility would report serious injury if there was no reasonable explanation, such as a fracture after complaint of pain, or bruising with no reasonable explanation. DON indicated she would not consider R77's fall with fracture an injury of unknown origin.					
		p.m. administrator indicated s followed and addressed, and be reportable.				
	Mistreatment and M Property dated 11/2 Investigation, under suspected incident abuse, including inj misappropriation of IMMEDIATELY rep The Administrator of report of the inciden	blicy titled, Abuse, Neglect, Alisappropriation of Resident 28/16, indicated under r procedure 1) an incident or of mistreatment, neglect, or uries of unknown source, and property must be orted to the Administrator. 2) or designee will make an initial nt or suspected incident to the ediately in accordance with law.				
	The administrator of revise abuse/negle- or designee could e on the system for A administrator or des system to audit to e properly reported a	THOD OF CORRECTION: or designee could review and ct systems. The administrator ensure all staff are educated buse/Neglect reporting. The signee could establish a ensure all allegations are nd investigated. The signee could report audit				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CONTLETION	IDENTIFICATION NOMBER.	A. BUILDING: _			
		00443	B. WING			C 22/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PIONEEI	R CARE CENTER		UTH MABELLI 5 FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21995	Continued From pa	age 25	21995			
	results to the qualit improvement (QAF further recommend	ty assurance performance PI) committee for review and dations.				
	TIME PERIOD FO (21) days	R CORRECTION: Twenty-one)			