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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: EPDS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00443

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/03/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **105** (L18)
13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program
Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susan Bachleitner, HFE - NE II 08/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/01/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/03/2018
(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.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the 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

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

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

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

DEPARTMENT OF HEALTH

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 AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: EPDS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00443

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/19/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **105** (L18)
13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE - NE II 06/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/16/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/03/2018
(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.

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:

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

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

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

Substandard Quality of Care 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;

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

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

Informal Dispute Resolution - 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	R 06/19/2018

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments No deficiencies were noted at the time of the survey 06/19/2018	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post-certification revisit was conducted by the Minnesota Department of Health on June 18, and 19, 2018, to determine the status of Federal deficiencies issued during a recertification survey exited on March 22, 2018. The survey resulted in an Immediate Jeopardy (IJ) at F689 when a household stovetop burner was left on and unattended and unsecured by staff for a total of ten observed minutes with cognitively impaired residents in the vicinity of the stove and kitchen. The IJ began on June 18, 2018, at 9:25 a.m, and was removed on June 19, at 1:09 p.m.. As a result of identifying substandard quality of care, an extended survey was conducted on June 19, 2018. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. 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 000}		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		6/20/18

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

Electronically 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.

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F 689	Continued From page 1 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate supervision and accident prevention by facility staff when a stove top was left on and unattended for 4 of 21 residents (R1, R2, R3 and R4) who had severe cognitive impairment and were independent in mobility on the Deerwood unit and at risk for burn from the hot stove top. The deficient practice had the potential to affect all the cognitively impaired residents who were independent with mobility. This resulted in an immediate jeopardy (IJ) situation for R1, R2, R3, and R4. Findings include: The IJ began on 6/18/18, at 9:25 a.m. when upon entrance on the Deerwood neighborhoods kitchen, the stove top front right burner was observed to be turned on and left unattended posing a risk for serious injury for a burn. On 6/18/18, at 1:32 p.m. the facility administrator and the dietician were notified of the IJ for the identified residents at risk for possible injury R1, R2, R3,and R4. The IJ was removed on 6/19/18, at 1:09 p.m., however, non-compliance remained at a isolated score and severity which indicated no actual harm with potential for more than	F 689	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	

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F 689	Continued From page 2 minimal harm (Level D.) On 6/18/18, at 9:25 a.m. upon entrance to the Deerwood unit kitchen, a flat top stove and oven and four burners (a large burner in the front on the right and in the back on the left, two small burners, one on the left front and one in the back on the left) was present on the back wall of the kitchen adjacent to a steam table on the left side and a counter top on the right side. At that time the stove top right front burner was observed to be on as indicated by a red light on the right side of the stove top. The kitchen had two entrances, on either side of the kitchen area, yellow plastic chains were observed to be hanging from the walls on on both sides of the entrances, neither chain was across the entrances to the kitchen. No staff were present in the area, continuous observations began at that time. Residents were observed seated in wheelchairs in the dining room seated at the tables, the hallway of the unit and in the activity area behind the dining room. -At 9:28 a.m. the kitchen stove top, right front burner remained on, with no staff observed in the kitchen or dining area of the Deerwood neighborhood. The surveyor placed a hand over the right front burner, approximately 4 inches from the surface and heat could be felt radiating from the stove top. At that time R6 was observed seated in a wheelchair in the dining room, she wheeled herself towards the unchained kitchen entrance and stated she had been waiting for her breakfast. R6 propelled herself back to a table in front of the counter of the kitchen area. Residents were observed seated in wheelchairs in the dining room seated at the tables, the hallway of the unit and in the activity area behind the dining room.	F 689	have been conducted on random households, random meals daily for one week. These Audits will be conducted on random households, random meals 3 times a week for 3 weeks. Then these audits will be conducted on random households, random meals 1 time a week for 1 month. Then these audits will be conducted on random households, random meals monthly times 3 months. The results of these audits will be reviewed at Pioneers Quality Assurance Meeting, and recommendations for continued follow up will be followed.	

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F 689	Continued From page 3	F 689		

-At 9:31 a..m. the stove top burner remained on, with no staff observed in the kitchen or dining are of the Deerwood unit, and R6 remained seated in her wheelchair at the dining room table. Residents remained in various areas of the unit, including the dining room, seating area near adjacent to the kitchen and in the hallways.

-At 9:35 a.m. a staff member entered the kitchen from the hall adjacent to the outside of the neighborhood and held an english muffin in his gloved hand. He stated he was the homemaker (HM)-A for the Deerwood neighborhood, had left the Deerwood neighborhood and walked to the Cherrywood neighborhood for an english muffin. HM-A confirmed the front right burner of the stove was left on unattended and stated he thought he had only been gone a few seconds. He immediately shut the burner off and confirmed the burner was hot. HM-A stated he did not usually work on the Deerwood unit and was not aware of how many english muffins were needed, and had run out. He stated he usually would not leave the stove top on unattended and indicated he should have applied the yellow chains across both entrances to the kitchen area before leaving the kitchen.

On 6/18/18, from 9:25 a.m. to 9:35 a.m. the front right burner of the Deerwood neighborhoods stove top was observed to be on, unattended and hot for a total of ten minutes unsupervised by staff. No staff were observed to walk out or in the neighborhood during the entire ten minute duration. The hot stove top would have been accessible to residents on the unit posing a safety hazard, including cognitively impaired residents.

On 6/18/18, at 9:58 a.m. a tour of the Deerwood

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F 689	Continued From page 4 unit was conducted, one resident, R7 was observed lying in bed. No other residents were observed to be lying in bed. Residents were observed seated in wheelchairs in their rooms, seated in recliners in the common area and in the dining room seated at the tables. observed in various areas of the unit, seated in recliners in the seating area adjacent to the kitchen. On 6/18/18, at 10:00 a.m. during a follow up interview, HM-A stated he did not usually work on the Deerwood unit and stated he had not aware of any residents attempting to enter the kitchen. He indicated he thought several residents had dementia and were cognitively impaired and indicated he was unaware of any residents that wandered. On 6/18/18, at 10:07 a.m. licensed practical nurse (LPN)-A indicated she was the nurse on the Deerwood unit at that time. LPN-A stated most of the residents on the unit had diagnosis of dementia and had not seen any resident attempting to enter the kitchen. LPN-A stated she been unaware the HM had left the stovetop on and unattended. She stated she had not been asked to supervise the kitchen area prior to the interview. On 6/18/18, at 10:10 a.m. HM-B stated her usual practice would be to not leave the kitchen area during a meal service. She stated if she had to leave, she would shut the stove off, chain off the entrances of the kitchen with the two plastic yellow chains and she would let a staff member know she was leaving the area. HM-B indicated she would "never leave a burner on and walk away."	F 689		

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F 689	Continued From page 5 On 6/18/18, at 10:15 a.m. registered nurse manager (NM)-A for the Deerwood unit stated the current census on the unit was 21. NM-A stated two residents on the Deerwood unit wore wanderguards on their persons, due to a history of wandering. A list of residents which resided on the Deerwood unit was requested with the following information: resident name, cognition, mobility status and history of wandering. At that time, NM-A stated the stove top should "never" be left unattended when it was on. NM-A confirmed it was a safety concern for residents. Review of R1's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 5/28/18, identified R1 had severe cognitive impairment and had diagnoses which included, Alzheimer's disease, anxiety and depression. The MDS identified R1 did not use a mobility device and indicated staff had supervised R1 during ambulation and locomotion during the assessment period. R1's SCSA Care Area Assessment dated 5/28/18, identified R1 had cognitive impairment with periods of inattention, was hard of hearing and was able to stabilize himself during transition from a sitting to standing position. R1's CAAs lacked indication of R1's safety awareness and judgement. R1's current care plan revised 5/31/18, revealed R1 had impaired cognition and decision making, was independent with transfers and ambulation without an assistive device. The care plan revealed R1 was at high risk for wandering as he had left the unit and had a wanderguard on his left ankle. Further, R1's care plan revealed he was dependent on staff to maintain his safety.	F 689		

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F 689	Continued From page 6 R1's nursing assistant (NA) care guide printed on 6/18/18, revealed R1 was at high risk for wandering, had a wanderguard on his left ankle and was independent with transfers and ambulation. R2's SCSA MDS dated 5/3/18, identified R2 had severe cognitive impairment and had diagnoses which included dementia, Alzheimer's disease and seizure disorder. The MDS identified R2 had required extensive assistance with activities of daily living (ADL's) in areas of transfers, locomotion and limited assistance with ambulation. The MDS identified R2 had used a wheelchair and a walker. R2's SCSA CAA dated 5/3/18, identified R2 had disorganized thinking and had cognitive impairment. The CAA revealed R2 received extensive assistance with ADL's including transfers, locomotion and required limited assistance with ambulation. Further, the CAA identified R2 was at risk for falls due to impaired cognition. R2's CAAs lacked indication of R2's safety awareness and judgement. R2's current care plan revised 5/3/18, revealed R2 had impaired cognition and thought processes. R2's care plan revealed she required assistance of one staff with ambulation with a walker, transfers and locomotion with a wheelchair. R2's care plan revealed she would self transfer, was at a high risk for falls and required staff to anticipate her needs and maintain R2's safety. R2's NA care guide printed 6/18/18, revealed R2 was at high risk for falls, self transferred and	F 689		

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F 689	Continued From page 7 required assistance with transfers, ambulation and locomotion. R3's quarterly MDS dated 5/25/18, identified R3 had severe cognitive impairment and had diagnoses which included dementia, Parkinson's Disease, anxiety, irritability and anger. The MDS identified R3 had verbal behaviors, and identified R3 had required extensive assistance with transfers, walking and locomotion, and used a walker and a wheelchair for mobility devices. R3's annual CAA dated 11/24/17, identified R3 had disorganized thinking, inattention and cognitive loss. The CAA identified R3 had impaired memory, was impulsive and was at risk for falls. R3's care plan revised 5/29/18, revealed R3 had impaired cognition and communication related to Lewy body dementia and Parkinson's disease. R3's care plan revealed he required assistance with transfers, ambulation with a walker and locomotion with a wheelchair. The care plan revealed R3 was able to propel himself in a wheelchair with his feet around the household. R3's care plan revealed he was at high risk for falls and had various interventions in place, including bed and chair alarms, not to be left unattended in his room when restless or anxious, directed staff to use recliner in the day room, fall mat and staff notification when family leaves the household. Further, R3's care plan directed facility staff to maintain his safety. R3's NA care guide printed 6/18/18, revealed R3 was at high risk for falls, listed the aforementioned fall interventions and required assistance with transfers, ambulation with a	F 689		

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F 689	Continued From page 8	F 689		

walker and locomotion with a wheelchair. The care guide revealed R3 was able to propel himself in a wheelchair with his feet around the household.

R4's quarterly MDS dated 4/3/18, identified R4 had moderate cognitive impairment and had diagnoses including macular degeneration and hypertension. The MDS identified R4 had required extensive assistance with bed mobility, transfers and locomotion during the assessment period. The MDS identified R4 had received assistance with ambulation on two occasions during the assessment.

R4's annual CAA dated 10/13/17, identified R4 had memory impairment, needed cues, reminders and supervision daily. The CAA identified R4 had highly impaired vision, was hard of hearing, had impaired cognition and required assistance with ADL's of bed mobility, ambulation, transfers and locomotion. The CAA further revealed R4's confusion would worsen when she was fatigued. R4's CAA lacked indication of R4's safety awareness and judgement.

R4's care plan revised 4/11/18, revealed R4 had impaired thought processes, impaired vision and hearing and required staff assistance with transfers, bed mobility, ambulation with a walker, locomotion with a wheelchair. R4's care plan revealed staff were to maintain her safety.

R4's NA care guide printed 6/18/18, revealed R4's required assistance with transfers, ambulation and locomotion.

On 6/18/18, at 10:20 a.m. HM-C stated she would "never" leave the kitchen area during a meal

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F 689	Continued From page 9	F 689		

service, or when a cooking surface was hot. She stated if she had to leave she would shut the stove off, chain off the entrances of the kitchen with the two plastic yellow chains and she would let a staff member know she was leaving.

On 6/18/18, at 10:23 a.m. HM-D stated she used the kitchenette stove daily when preparing residents breakfast meals. She stated the stove had a locking mechanism which was to be locked with a key when the stove was not in use. HM-D stated she would "never" leave the stovetop burner on, unattended and indicated when staff were not present in the kitchen a plastic yellow chain would be applied across both entrances to the kitchen to detour wandering residents.

On 6/18/18, at 10:28 a.m. HM-E stated her usual process when leaving the kitchen area of a neighborhood was to shut off the stove, lock the stove with the key to ensure residents could not turn the stove back on. She stated she would also apply the yellow chains across both entrances to the kitchen area.

On 6/18/18, at 10:34 a.m. HM-F stated her usual process when preparing resident meals would be to remain in the near the cooking surfaces and indicated she would not leave the stove unattended. She stated if she needed an item outside of the neighborhood, she would ask another staff member to get it for her or she would have another staff member supervise the kitchen area while she obtained the item. Further, she stated if no staff were available, she would shut off the stovetop, lock the stove with a key and place the yellow plastic chains across both entrances to the kitchen to detour residents from entering.

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F 689	Continued From page 10 On 6/18/18, at 10:40 a.m. nursing assistant (NA)-A stated she felt most of the residents on the Deerwood unit were cognitively impaired and she felt no residents currently wandered off of the unit. She stated most of the cognitively impaired residents needed staff assistance with mobility, however, she indicated a few residents were able to freely move around the unit, such as R4, when she was in a wheelchair and R1 when he utilized a walker. NA-A stated she was unaware of any resident entering the kitchen area or attempting to enter the kitchen area in her memory. She indicated when the kitchen was not in use, plastic yellow chains were to be affixed across the entrances of the kitchen to detour residents from entering. Further, NA-A stated she had not been asked to supervise the kitchen area prior to interview and was unaware the stove had been left on without staff supervision. On 6/18/18, at 11:25 a.m. during a follow up interview, the Deerwood residents care guides were reviewed with NM-A. NM-A confirmed nine residents had diagnosis dementia and confirmed of the nine, four residents had the ability to independently move about the unit, whether by walking or wheelchair. NM-A confirmed the following: R1 had a diagnosis of dementia and was able to be independent with mobility and had a wanderguard in place due to a history of leaving the unit. R2 had a diagnosis of dementia and Alzheimer's disease and was able to self propel once she was up in a wheelchair. R3 had a diagnosis of Lewy body dementia (type of dementia that can have focal affects on behavior and communication,) and was able to move about the unit once he was up in a wheelchair. R4 had daily periods of confusion and was able	F 689		

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	245463	A. BUILDING _____ B. WING _____	R 06/19/2018

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F 689	Continued From page 11	F 689		

independently move about the unit once she was in a wheelchair.

On 6/18/18, at 11:55 a.m. registered dietician (RD)-A stated she expected stove surfaces to be off when the HM was not present. RD-A confirmed staff were expected to be present when the stove was in use in order to supervise residents. She stated dietary and HM staff had received orientation upon hire and annually on safe practices in neighborhood kitchens. RD-A stated if the HM assigned to the neighborhood needed to leave the stove or kitchen for any reason, the stove should be shut off and another staff member should supervise the area until the HM returned. Further, she indicated she would expect the yellow chains to be applied across both entrances to the kitchen to prevent residents from entering and indicated she would not necessarily expect staff to lock the stoves with the key if they were going to return.

On 6/18/18, at 12:06 p.m. the facility administrator stated he expected the neighborhood stove tops to be shut off when staff were not present in order to ensure residents were safe. The administrator stated if a staff member needed to leave the kitchen area during meal service, then another staff member needed to be informed in order to monitor the kitchen area. Further, the administrator confirmed "some" of the residents on the Deerwood unit were cognitively impaired.

On 6/18/18, at 2:48 p.m. during a group interview with the facility administrator and vice president, both confirmed they expected the kitchenette stove top to be shut off when staff were not present. The administrator and vice president

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F 689	Continued From page 12 confirmed multiple residents which resided on the Deerwood unit were cognitively impaired and required staff supervision. They both confirmed the hot burner left on and unattended was a significant safety concern and indicated they did not feel it was a continued immediate safety risk once the stove was turned off. Further, the administrator and vice president indicated they felt the issue was resolved when the HM shut the stove top off and indicated they did not feel residents on the unit would wander into the kitchen area. The IJ that began on 6/18/18, was removed on 6/19/18, at 1:09 p.m. when the facility completed the following: -policy and procedure for Safe Practives in the Household Kitchen was updated to reflect resident safety. -education was provided to staff on the updated policy and procedure and safety measures used in the neighborhood units to ensure resident safety. -auditing is in place for monitoring safe use of cooking services and resident safety. A facility policy titled, Safe Practices in the Household Kitchen, approved 1/2011, identified it was the facility's policy to have homemakers and team members who prepare food in the kitchen would follow safety precautions to protect staff and residents. The policy listed various procedures staff were to implement to ensure resident safety which included, to turn off all appliances when not in use, when leaving kitchen disconnect stovetop and unplug small appliances. Further the policy directed staff when a steam table was in use, the kitchen should not be	F 689		

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F 689	Continued From page 13 unattended.	F 689		

DEPARTMENT OF HEALTH

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

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	{2 000}		

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{2 000}	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On June 18, June 19, 2018. surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	{2 000}		

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{2 000}	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	{2 000}		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate supervision and accident prevention by facility staff when a stove top was left on and unattended for 4 of 21 residents (R1, R2, R3 and R4) who had severe cognitive impairment and were independent in mobility on the Deerwood unit and at risk for burn from the hot stove top. The deficient practice had the potential to affect all the cognitively impaired residents who were independent with mobility. This resulted in an immediate jeopardy (IJ) situation for R1, R2, R3, and R4.	2 830	Completed	6/20/18

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2 830	Continued From page 3 Findings include: The IJ began on 6/18/18, at 9:25 a.m. when upon entrance on the Deerwood neighborhoods kitchen, the stove top front right burner was observed to be turned on and left unattended posing a risk for serious injury for a burn. On 6/18/18, at 1:32 p.m. the facility administrator and the dietician were notified of the IJ for the identified residents at risk for possible injury R1, R2, R3,and R4. The IJ was removed on 6/19/18, at 1:09 p.m., however, non-compliance remained at a isolated score and severity which indicated no actual harm with potential for more than minimal harm (Level D.) On 6/18/18, at 9:25 a.m. upon entrance to the Deerwood unit kitchen, a flat top stove and oven and four burners (a large burner in the front on the right and in the back on the left, two small burners, one on the left front and one in the back on the left) was present on the back wall of the kitchen adjacent to a steam table on the left side and a counter top on the right side. At that time the stove top right front burner was observed to be on as indicated by a red light on the right side of the stove top. The kitchen had two entrances, on either side of the kitchen area, yellow plastic chains were observed to be hanging from the walls on on both sides of the entrances, neither chain was across the entrances to the kitchen. No staff were present in the area, continuous observations began at that time. Residents were observed seated in wheelchairs in the dining room seated at the tables, the hallway of the unit and in the activity area behind the dining room. -At 9:28 a.m. the kitchen stove top, right front burner remained on, with no staff observed in the kitchen or dining area of the Deerwood	2 830		

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2 830	Continued From page 4 neighborhood. The surveyor placed a hand over the right front burner, approximately 4 inches from the surface and heat could be felt radiating from the stove top. At that time R6 was observed seated in a wheelchair in the dining room, she wheeled herself towards the unchained kitchen entrance and stated she had been waiting for her breakfast. R6 propelled herself back to a table in front of the counter of the kitchen area. Residents were observed seated in wheelchairs in the dining room seated at the tables, the hallway of the unit and in the activity area behind the dining room. -At 9:31 a..m. the stove top burner remained on, with no staff observed in the kitchen or dining are of the Deerwood unit, and R6 remained seated in her wheelchair at the dining room table. Residents remained in various areas of the unit, including the dining room, seating area near adjacent to the kitchen and in the hallways. -At 9:35 a.m. a staff member entered the kitchen from the hall adjacent to the outside of the neighborhood and held an english muffin in his gloved hand. He stated he was the homemaker (HM)-A for the Deerwood neighborhood, had left the Deerwood neighborhood and walked to the Cherrywood neighborhood for an english muffin. HM-A confirmed the front right burner of the stove was left on unattended and stated he thought he had only been gone a few seconds. He immediately shut the burner off and confirmed the burner was hot. HM-A stated he did not usually work on the Deerwood unit and was not aware of how many english muffins were needed, and had run out. He stated he usually would not leave the stove top on unattended and indicated he should have applied the yellow chains across both entrances to the kitchen area before leaving the kitchen.	2 830		

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2 830	Continued From page 5 On 6/18/18, from 9:25 a.m. to 9:35 a.m. the front right burner of the Deerwood neighborhoods stove top was observed to be on, unattended and hot for a total of ten minutes unsupervised by staff. No staff were observed to walk out or in the neighborhood during the entire ten minute duration. The hot stove top would have been accessible to residents on the unit posing a safety hazard, including cognitively impaired residents. On 6/18/18, at 9:58 a.m. a tour of the Deerwood unit was conducted, one resident, R7 was observed lying in bed. No other residents were observed to be lying in bed. Residents were observed seated in wheelchairs in their rooms, seated in recliners in the common area and in the dining room seated at the tables. observed in various areas of the unit, seated in recliners in the seating area adjacent to the kitchen. On 6/18/18, at 10:00 a.m. during a follow up interview, HM-A stated he did not usually work on the Deerwood unit and stated he had not aware of any residents attempting to enter the kitchen. He indicated he thought several residents had dementia and were cognitively impaired and indicated he was unaware of any residents that wandered. On 6/18/18, at 10:07 a.m. licensed practical nurse (LPN)-A indicated she was the nurse on the Deerwood unit at that time. LPN-A stated most of the residents on the unit had diagnosis of dementia and had not seen any resident attempting to enter the kitchen. LPN-A stated she been unaware the HM had left the stovetop on and unattended. She stated she had not been asked to supervise the kitchen area prior to the interview.	2 830		

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2 830	Continued From page 6 On 6/18/18, at 10:10 a.m. HM-B stated her usual practice would be to not leave the kitchen area during a meal service. She stated if she had to leave, she would shut the stove off, chain off the entrances of the kitchen with the two plastic yellow chains and she would let a staff member know she was leaving the area. HM-B indicated she would "never leave a burner on and walk away." On 6/18/18, at 10:15 a.m. registered nurse manager (NM)-A for the Deerwood unit stated the current census on the unit was 21. NM-A stated two residents on the Deerwood unit wore wanderguards on their persons, due to a history of wandering. A list of residents which resided on the Deerwood unit was requested with the following information: resident name, cognition, mobility status and history of wandering. At that time, NM-A stated the stove top should "never" be left unattended when it was on. NM-A confirmed it was a safety concern for residents. Review of R1's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 5/28/18, identified R1 had severe cognitive impairment and had diagnoses which included, Alzheimer's disease, anxiety and depression. The MDS identified R1 did not use a mobility device and indicated staff had supervised R1 during ambulation and locomotion during the assessment period. R1's SCSA Care Area Assessment dated 5/28/18, identified R1 had cognitive impairment with periods of inattention, was hard of hearing and was able to stabilize himself during transition from a sitting to standing position. R1's CAAs lacked indication of R1's safety awareness and	2 830		

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2 830	Continued From page 7 judgement. R1's current care plan revised 5/31/18, revealed R1 had impaired cognition and decision making, was independent with transfers and ambulation without an assistive device. The care plan revealed R1 was at high risk for wandering as he had left the unit and had a wanderguard on his left ankle. Further, R1's care plan revealed he was dependent on staff to maintain his safety. R1's nursing assistant (NA) care guide printed on 6/18/18, revealed R1 was at high risk for wandering, had a wanderguard on his left ankle and was independent with transfers and ambulation. R2's SCSA MDS dated 5/3/18, identified R2 had severe cognitive impairment and had diagnoses which included dementia, Alzheimer's disease and seizure disorder. The MDS identified R2 had required extensive assistance with activities of daily living (ADL's) in areas of transfers, locomotion and limited assistance with ambulation. The MDS identified R2 had used a wheelchair and a walker. R2's SCSA CAA dated 5/3/18, identified R2 had disorganized thinking and had cognitive impairment. The CAA revealed R2 received extensive assistance with ADL's including transfers, locomotion and required limited assistance with ambulation. Further, the CAA identified R2 was at risk for falls due to impaired cognition. R2's CAAs lacked indication of R2's safety awareness and judgement. R2's current care plan revised 5/3/18, revealed R2 had impaired cognition and thought processes. R2's care plan revealed she required	2 830		

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2 830	Continued From page 8 assistance of one staff with ambulation with a walker, transfers and locomotion with a wheelchair. R2's care plan revealed she would self transfer, was at a high risk for falls and required staff to anticipate her needs and maintain R2's safety. R2's NA care guide printed 6/18/18, revealed R2 was at high risk for falls, self transferred and required assistance with transfers, ambulation and locomotion. R3's quarterly MDS dated 5/25/18, identified R3 had severe cognitive impairment and had diagnoses which included dementia, Parkinson's Disease, anxiety, irritability and anger. The MDS identified R3 had verbal behaviors, and identified R3 had required extensive assistance with transfers, walking and locomotion, and used a walker and a wheelchair for mobility devices. R3's annual CAA dated 11/24/17, identified R3 had disorganized thinking, inattention and cognitive loss. The CAA identified R3 had impaired memory, was impulsive and was at risk for falls. R3's care plan revised 5/29/18, revealed R3 had impaired cognition and communication related to Lewy body dementia and Parkinson's disease. R3's care plan revealed he required assistance with transfers, ambulation with a walker and locomotion with a wheelchair. The care plan revealed R3 was able to propel himself in a wheelchair with his feet around the household. R3's care plan revealed he was at high risk for falls and had various interventions in place, including bed and chair alarms, not to be left unattended in his room when restless or anxious, directed staff to use recliner in the day room, fall	2 830		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 mat and staff notification when family leaves the household. Further, R3's care plan directed facility staff to maintain his safety. R3's NA care guide printed 6/18/18, revealed R3 was at high risk for falls, listed the aforementioned fall interventions and required assistance with transfers, ambulation with a walker and locomotion with a wheelchair. The care guide revealed R3 was able to propel himself in a wheelchair with his feet around the household. R4's quarterly MDS dated 4/3/18, identified R4 had moderate cognitive impairment and had diagnoses including macular degeneration and hypertension. The MDS identified R4 had required extensive assistance with bed mobility, transfers and locomotion during the assessment period. The MDS identified R4 had received assistance with ambulation on two occasions during the assessment. R4's annual CAA dated 10/13/17, identified R4 had memory impairment, needed cues, reminders and supervision daily. The CAA identified R4 had highly impaired vision, was hard of hearing, had impaired cognition and required assistance with ADL's of bed mobility, ambulation, transfers and locomotion. The CAA further revealed R4's confusion would worsen when she was fatigued. R4's CAA lacked indication of R4's safety awareness and judgement. R4's care plan revised 4/11/18, revealed R4 had impaired thought processes, impaired vision and hearing and required staff assistance with transfers, bed mobility, ambulation with a walker, locomotion with a wheelchair. R4's care plan revealed staff were to maintain her safety.	2 830		

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2 830	Continued From page 10 R4's NA care guide printed 6/18/18, revealed R4's required assistance with transfers, ambulation and locomotion. On 6/18/18, at 10:20 a.m. HM-C stated she would "never" leave the kitchen area during a meal service, or when a cooking surface was hot. She stated if she had to leave she would shut the stove off, chain off the entrances of the kitchen with the two plastic yellow chains and she would let a staff member know she was leaving. On 6/18/18, at 10:23 a.m. HM-D stated she used the kitchenette stove daily when preparing residents breakfast meals. She stated the stove had a locking mechanism which was to be locked with a key when the stove was not in use. HM-D stated she would "never" leave the stovetop burner on, unattended and indicated when staff were not present in the kitchen a plastic yellow chain would be applied across both entrances to the kitchen to detour wandering residents. On 6/18/18, at 10:28 a.m. HM-E stated her usual process when leaving the kitchen area of a neighborhood was to shut off the stove, lock the stove with the key to ensure residents could not turn the stove back on. She stated she would also apply the yellow chains across both entrances to the kitchen area. On 6/18/18, at 10:34 a.m. HM-F stated her usual process when preparing resident meals would be to remain in the near the cooking surfaces and indicated she would not leave the stove unattended. She stated if she needed an item outside of the neighborhood, she would ask another staff member to get it for her or she would have another staff member supervise the	2 830		

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2 830	Continued From page 11 kitchen area while she obtained the item. Further, she stated if no staff were available, she would shut off the stovetop, lock the stove with a key and place the yellow plastic chains across both entrances to the kitchen to detour residents from entering. On 6/18/18, at 10:40 a.m. nursing assistant (NA)-A stated she felt most of the residents on the Deerwood unit were cognitively impaired and she felt no residents currently wandered off of the unit. She stated most of the cognitively impaired residents needed staff assistance with mobility, however, she indicated a few residents were able to freely move around the unit, such as R4, when she was in a wheelchair and R1 when he utilized a walker. NA-A stated she was unaware of any resident entering the kitchen area or attempting to enter the kitchen area in her memory. She indicated when the kitchen was not in use, plastic yellow chains were to be affixed across the entrances of the kitchen to detour residents from entering. Further, NA-A stated she had not been asked to supervise the kitchen area prior to interview and was unaware the stove had been left on without staff supervision. On 6/18/18, at 11:25 a.m. during a follow up interview, the Deerwood residents care guides were reviewed with NM-A. NM-A confirmed nine residents had diagnosis dementia and confirmed of the nine, four residents had the ability to independently move about the unit, whether by walking or wheelchair. NM-A confirmed the following: R1 had a diagnosis of dementia and was able to be independent with mobility and had a wanderguard in place due to a history of leaving the unit. R2 had a diagnosis of dementia and Alzheimer's disease and was able to self propel once she was up in a wheelchair. R3 had a	2 830		

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2 830	Continued From page 12 diagnosis of Lewy body dementia (type of dementia that can have focal affects on behavior and communication,) and was able to move about the unit once he was up in a wheelchair. R4 had daily periods of confusion and was able independently move about the unit once she was in a wheelchair. On 6/18/18, at 11:55 a.m. registered dietician (RD)-A stated she expected stove surfaces to be off when the HM was not present. RD-A confirmed staff were expected to be present when the stove was in use in order to supervise residents. She stated dietary and HM staff had received orientation upon hire and annually on safe practices in neighborhood kitchens. RD-A stated if the HM assigned to the neighborhood needed to leave the stove or kitchen for any reason, the stove should be shut off and another staff member should supervise the area until the HM returned. Further, she indicated she would expect the yellow chains to be applied across both entrances to the kitchen to prevent residents from entering and indicated she would not necessarily expect staff to lock the stoves with the key if they were going to return. On 6/18/18, at 12:06 p.m. the facility administrator stated he expected the neighborhood stove tops to be shut off when staff were not present in order to ensure residents were safe. The administrator stated if a staff member needed to leave the kitchen area during meal service, then another staff member needed to be informed in order to monitor the kitchen area. Further, the administrator confirmed "some" of the residents on the Deerwood unit were cognitively impaired. On 6/18/18, at 2:48 p.m. during a group interview	2 830		

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2 830	Continued From page 13 with the facility administrator and vice president, both confirmed they expected the kitchenette stove top to be shut off when staff were not present. The administrator and vice president confirmed multiple residents which resided on the Deerwood unit were cognitively impaired and required staff supervision. They both confirmed the hot burner left on and unattended was a significant safety concern and indicated they did not feel it was a continued immediate safety risk once the stove was turned off. Further, the administrator and vice president indicated they felt the issue was resolved when the HM shut the stove top off and indicated they did not feel residents on the unit would wander into the kitchen area. A facility policy titled, Safe Practices in the Household Kitchen, approved 1/2011, identified it was the facility's policy to have homemakers and team members who prepare food in the kitchen would follow safety precautions to protect staff and residents. The policy listed various procedures staff were to implement to ensure resident safety which included, to turn off all appliances when not in use, when leaving kitchen disconnect stovetop and unplug small appliances. Further the policy directed staff when a steam table was in use, the kitchen should not be unattended. SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) and Dietician could provide inservice training to homemaking and nursing staff on the importance of kitchen safety. An audit could be developed to ensure stoves or cooking equipment are not left on and unsupervised. The results could be reported to the quality assurance committee.	2 830		

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2 830	Continued From page 14 TIME PERIOD FOR CORRECTION: Seven (7) days.	2 830		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: EPDS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00443

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/17/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **105** (L18)
13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE - NE II 05/31/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/13/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/03/2018
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 245463

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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))

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 https://dab.efile.hhs.gov 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 Tamika.Brown@cms.hhs.gov .

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;

- 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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	R 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	INITIAL COMMENTS A recertification survey was conducted 5/17/18. During this visit it was determined that the following citations were 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. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	{F 000}		
{F 812} SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	{F 812}		6/7/18

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

Electronically Signed | 06/04/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	R 05/17/2018

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 812}	Continued From page 1 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure refrigerated food items were disposed of after expiration date and were properly stored, labeled and dated when the original packaging was opened in 3 of 5 households. Findings include: On 5/17/18, at 10:37 a.m. a tour of the 5 unit kitchenettes was conducted with the facility dietitian. During this tour the following was noted. The Short Stay unit kitchenette refrigerator contained the following: -An undated and unlabeled 1 pound zip lock bag of shredded Mozzarella cheese. The shredded cheese had green spots of mold ranging in size from 0.5 c.m. (centimeters) to 1 c.m. in diameter. - One fourth of an angel food cake in an undated, unlabeled and unsealed plastic bag. The Cherry Wood unit kitchenette refrigerator contained the following: -A small zip lock baggie dated 5/9/18, contained expired single serve packets of sour cream. 1 packet expired April 18, 2018, 5 packets expired April 26, 2018. The Deer Wood unit kitchenette refrigerator contained the following: -An undated small zip lock baggie contained 4 single serve packets of sour cream which expired on April 26, 2018. -An undated zip lock package of turkey meat with	{F 812}	1) On 5/17/2018 the following actions were taken: The Short Stay Unit Kitchenette Refrigerator- the Zip Lock bag of Mozzarella cheese and Angel Food Cake was discarded. The Cherry Wood Unit Kitchenette refrigerator- the Single serve packets of sour cream were discarded. The Deerwood Kitchenette refrigerator – sour cream packets, turkey and ham was discarded. 2) All residents in the facility have the potential to be affected by this practice. 3) The policy Food Storage was reviewed and updated. Dietary Staff will be educated on this policy. Education will take place on June 6th and 7th, 2018. 4) Audits of household Refrigerators, and freezers, to ensure food is properly packaged and dated will be conducted daily for 1 week, 2 times a week for a month, and weekly for a month. Results of Audits will be brought to the Quality Assurance Committee and will follow further recommendations from this committee. 5) The facility will have corrective actions in place and be in substantial compliance by June 7th, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 812}	Continued From page 2 four slices remaining. -A package of three Ham slices dated 5/7/18. On 5/17/18, at 11:03 a.m. the dietitian verified the above findings and indicated opened packages of deli meat should be discarded after seven days. The dietitian indicated the expectation that staff label foods, keep them in sealed containers and do not keep food items in refrigerators after the expiration date. The dietitian indicated the food storage problem in the refrigerators had not been corrected. On 5/17/18, at 2:15 p.m. the administrator agreed the facility had not corrected the problem with food storage in the unit kitchenette refrigerators. The facility policy titled Food Storage, revised 4/1/09, instructed leftover food to be stored in covered containers or wrapped carefully and securely. Each item to be clearly labeled, and dated before being refrigerated. Leftover food to be used within 3 days or discarded. Frozen foods should be covered, labeled and dated. A facility form titled Food Storage Guide revised 7/11/11, directed time frames for use of opened food which included: - deli meat, seven days after opening -shredded cheese, 10 days after opening -leftovers, within three days.	{F 812}		

DEPARTMENT OF HEALTH

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00443	A. BUILDING: _____ B. WING _____	R 05/17/2018

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on May 17, 2018. During this visit it was determined that the following correction order, #0812, was NOT corrected. The uncorrected order will remain in effect and will be reviewed at the next onsite visit. To be	{2 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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{2 000}	Continued From page 1 reviewed for possible penalty assessment.	{2 000}		
{21100}	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 3/22/18 will remain in effect. Penalty assessment issued. Based on observation, interview, and document review, the facility failed to ensure refrigerated food items were disposed of after expiration date and were properly stored, labeled and dated when the original packaging was opened in 3 of 5 households. Findings include: On 5/17/18, at 10:37 a.m. a tour of the 5 unit kitchenettes was conducted with the facility dietitian. During this tour the following was noted. The Short Stay unit kitchenette refrigerator contained the following: -An undated and unlabeled 1 pound zip lock bag of shredded Mozzarella cheese. The shredded cheese had green spots of mold ranging in size from 0.5 c.m. (centimeters) to 1 c.m. in diameter. - One fourth of an angel food cake in an undated, unlabeled and unsealed plastic bag.	{21100}	Corrected	6/7/18

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{21100}	Continued From page 2 The Cherry Wood unit kitchenette refrigerator contained the following: -A small zip lock baggie dated 5/9/18, contained expired single serve packets of sour cream. 1 packet expired April 18, 2018, 5 packets expired April 26, 2018. The Deer Wood unit kitchenette refrigerator contained the following: -An undated small zip lock baggie contained 4 single serve packets of sour cream which expired on April 26, 2018. -An undated zip lock package of turkey meat with four slices remaining. -A package of three Ham slices dated 5/7/18. On 5/17/18, at 11:03 a.m. the dietitian verified the above findings and indicated opened packages of deli meat should be discarded after seven days. The dietitian indicated the expectation that staff label foods, keep them in sealed containers and do not keep food items in refrigerators after the expiration date. The dietitian indicated the food storage problem in the refrigerators had not been corrected. On 5/17/18, at 2:15 p.m. the administrator agreed the facility had not corrected the problem with food storage in the unit kitchenette refrigerators. The facility policy titled Food Storage, revised 4/1/09, instructed leftover food to be stored in covered containers or wrapped carefully and securely. Each item to be clearly labeled, and dated before being refrigerated. Leftover food to be used within 3 days or discarded. Frozen foods should be covered, labeled and dated. A facility form titled Food Storage Guide revised 7/11/11, directed time frames for use of opened	{21100}		

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

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{21100}	Continued From page 3 food which included: - deli meat, seven days after opening -shredded cheese, 10 days after opening -leftovers, within three days. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	{21100}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EPDS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00443

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/22/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **105** (L18)
13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program
Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NE-II 04/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 04/30/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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: 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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - 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;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

Informal Dispute Resolution - 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/19/18, to 3/22/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 3/19/18 through 3/22/18, and complaint investigations were also completed at the time of the standard survey. At the time of the survey, an investigation of complaint H5463024 were completed and were found to be substantiated. The complaint was substantiated at F607 and F609. 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. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607		5/1/18

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

Electronically 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.

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F 607	Continued From page 1 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement policies and procedures to ensure the State agency (SA) was immediately notified for mental/emotional abuse for 1 of 1 resident (R49) reviewed for allegations of abuse. In addition the facility failed to report to the SA an incident of injury of unknown source 1 of 1 (R77) resident reviewed for potential neglect of care. Findings include: R49's quarterly Minimum Data Set (MDS) dated 2/7/18, indicated R49 was severely cognitively impaired with diagnoses which included heart failure, dementia and depression. The MDS indicated R49 required extensive assistance of two staff with all activities of daily living (ADL's) and had no behaviors. R49's current care plan revised on 2/14/18, listed various intervention which included to try to provide consistent care givers as much as possible in order to decrease confusion,encourage R49 to express any concerns, staff will maintain safety, monitor and report any suspected abuse or neglect following policy. Review of Resident Accident/Incident Report	F 607	1. It is the practice of this facility to develop and implement policies for abuse/neglect. LPN-D will be educated on the Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy, including timely reporting of potential abuse/neglect by April 18, 2018. On April 6, 2018 a report was submitted to OHFC for potential neglect for R77. 2. All current residents have the potential to be affected. 3. Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy includes immediately reporting suspected/alleged abuse, neglect, and injuries of unknown origin to the designated state agency/common entry point. Re-Education has been conducted by the Administrator on April 17, 2018, on immediate reporting to the State Agency of all incidents of suspected/ alleged abuse, neglect, and injuries of unknown origin - Education was provided for all care center staff. Staff will be educated during orientation and will also be educated yearly on this topic. 4. Progress notes will be reviewed daily	

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F 607	Continued From page 2 dated 2/11/18, and did not list a time the incident had occurred. The report indicated a nursing assistant (NA)- B reported a cell phone was used to cause mental/emotion abuse to R49 and there was no injury or change in life style. The report listed on 2/13/18 social worker (SW) completed an interview with R49, and R49 was able to tell the SW the nursing assistant's name and R49 stated the nursing assistant had been good to her. The SW asked if the perpetrator took pictures of her, she stated "yes" and indicated the perpetrator has lots of pictures of R49 and her "little boy." R49 stated she "hoped she doesn't show anyone those pictures." When SW asked R49 if she liked her picture taken, R49 had stated "no." Review of Incident Report #310516, submitted to the SA on 2/13/18 at 4:39 p.m. listed an allegation of emotional or mental abuse for R1, and listed the incident had occurred on 2/12/18 at 1 p.m. A nursing assistant had reported to her nurse that another nursing assistant had snap chatted picture of R1 to her. The pictures of R1 were not sexual, she was clothed. The investigation done by the facility revealed during an interview R1 had stated she did not like pictures taken of her and stated "I hope she doesn't show anyone those pictures." The investigation listed NA-B had reported she had received pictures of R1 from the alleged perpetrator. On 3/22/18 at 8:38 a.m. licensed practical nurse (LPN)-D stated she aware of the incident with R1 and confirmed NA-B came to her and reported another NA(perpetrator) had taken pictures of R49 on her cell phone and snap chatting them to NA-B. LPN-D indicated she told NA-B that she	F 607	by the DON or her designee, to assure immediate reporting of suspected/ alleged abuse, neglect, and injuries of unknown origin are properly reported for until May 31st, following this the progress notes will be reviewed randomly to assure immediate reporting of suspected/ alleged abuse, neglect, and injuries of unknown origin are properly reported. Results will be brought to the QA meeting and recommendations will be followed. 5. The facility will have corrective actions in place and be in substantial compliance by May 1, 2018.	

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F 607	Continued From page 3	F 607		

needed to report the incident right away, but NA-B was scared to report the incident. LPN-D indicated NA-B had reported the incident to her over the weekend and she reported the incident to the SW the next day because NA-B had not reported the incident to anyone. The LPN-D confirmed staff were to report incidents of abuse immediately and confirmed it was not reported immediately.

On 3/22/18 at 8:52 a.m. SW confirmed the facility had reported the allegations of abuse of a NA (perpetrator) taking pictures of R49 with her cell phone and sending the pictures on snap chat to her. The SW confirmed the allegations of abuse needed to be reported to the SA immediately and on weekends the charge nurse should be making the report to the SA.

On 3/22/18 at 9:03 a.m. DON confirmed NA-B reported the allegation of another NA (perpetrator) taking picture of R49 and sending them to her. The DON verified NA-B reported the incident over the weekend to LPN-D right away and LPN-D then reported it to the SW. The DON confirmed the current facility policy and confirmed the incident had not been reported immediately to the SA.

On 3/22/18 at 9:19 a.m. NA-B stated she had worked with the perpetrator prior to the incident and was not the first time she had taken pictures of R49. NA-B verified she had told LPN-D and she understood LPN-D was going to talk to someone about it. NA-B indicated she had told LPN-D on the weekend and thought LPN-D reported the incident to the SW when she came to work on Monday or Tuesday. NA-B indicated the incident was not reported over the weekend

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F 607	Continued From page 4 because there was not a SW available on the weekends to report it to and no one in the building to report to on the weekends. On 3/22/18 at 10:18 a.m. The administrator confirmed the facility policy, confirmed she was aware of the incident with R1 and indicated she expected staff to report the allegation of abuse immediately. The administrator indicated she would expect staff to follow the policy and indicated she was aware staff did not report the allegation of abuse right away. R77's annual MDS assessment dated 2/21/18, identified R77 had diagnoses which included, dementia, arthritis and hypertension and had severe cognitive impairment. R77's MDS further identified she required extensive assistance with transfers and walking, but did not walk outside her room. R77's fall Care Area Assessments (CAA) dated 2/27/18, identified she was at risk for falls related to balance problems, use of antidepressant medication and cognitive impairment. R77's care plan, revised 2/22/18, indicated R77 was at high risk of falls, history of left hip fracture with repair and listed various interventions which	F 607		

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F 607	Continued From page 5	F 607		

included education to the resident, family and caregivers for safety reminders and what to do if a fall occurred. The care plan also instructed staff to ensure R77 wore appropriate footwear mobilizing in wheelchair and for staff to move the remote to the back of her recliner to prevent her from accidentally sitting on it.

Review of R77's progress notes from 12/9/17 to 12/11/19 identified:

-12/9/17, 8:00 a.m. R77 was heard calling out. Staff found R77 sitting on the floor near the bottom of her recliner in her room. R77 complained of pain in her left hip area and was sent to the hospital emergency department.

-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 clinical coordinator (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 documentation of the incident for R77 was provided by the facility.

On 3/21/18, at 2:26 p.m.CC-A indicated the usual practice for reporting to the state agency (SA) was for the nurse involved to report to the charge nurse and either nurse would complete the report to the SA. She indicated she was not sure if a report to the SA had been done, and indicated she did not see a reason to report R77's fall with

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F 607	Continued From page 6 fracture to the SA, because it was just an accident and she did not suspect maltreatment. On 3/22/18, at 12:46 p.m. DON indicated the facility process for reporting to the state agency directed the floor nurse or the charge nurse to complete and submit the report. If needed they could call the LSW, administrator or herself and they would report it. DON indicated the facility would report major injuries for abuse, neglect or if the care plan was not followed. She indicated she was notified of R77's fall with major injury, but felt it was not appropriate to make a report to the SA. DON indicated she did not feel there was a reason to report R77's fall, since it was reasonable to fracture a hip if someone fell out of a chair. DON stated she understood an accidental fall with injury would not be reportable, unless the care plan was not followed or there was a resident to resident 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. On 3/22/18, at 1:24 p.m. administrator indicated R77's care plan was followed and addressed, and she felt it would not be reportable.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		5/1/18

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F 609	Continued From page 7 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the state agency (SA) allegations of mental/emotional abuse for 1 of 1 resident (R49) reviewed allegations of misuse of cellular phone. In addition the facility failed to immediately report to the SA, and conduct a thorough investigation of an injury of unknown source for 1 of 1 (R77) resident reviewed for potential neglect of care. Findings include:	F 609	1. It is the practice of this facility to report alleged violations of abuse/neglect. LPN-D will be educated on the Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy, including timely reporting of potential abuse/neglect by April 18, 2018. On April 6, 2018 a report was submitted to OHFC for potential neglect for R77. 2. All current residents have the potential to be affected.	

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F 609	Continued From page 8 R49's quarterly Minimum Data Set (MDS) dated 2/7/18, indicated R49 was severely cognitively impaired with diagnoses which included heart failure, dementia and depression. The MDS indicated R49 required extensive assistance of two staff with all activities of daily living (ADL's) and had no behaviors. R49's current care plan revised on 2/14/18, listed various intervention which included to try to provide consistent care givers as much as possible in order to decrease confusion,encourage R49 to express any concerns, staff will maintain safety, monitor and report any suspected abuse or neglect following policy. Review of Resident Accident/Incident Report dated 2/11/18, and did not list a time the incident had occurred. The report indicated a nursing assistant (NA)- B reported a cell phone was used to cause mental/emotion abuse to R49 and there was no injury or change in life style. The report listed on 2/13/18 social worker (SW) completed an interview with R49, and R49 was able to tell the SW the nursing assistant's name and R49 stated the nursing assistant had been good to her. The SW asked if the perpetrator took pictures of her, she stated "yes" and indicated the perpetrator has lots of pictures of R49 and her "little boy." R49 stated she "hoped she doesn't show anyone those pictures." When SW asked R49 if she liked her picture taken, R49 had stated "no." Review of Incident Report #310516, submitted to the SA on 2/13/18 at 4:39 p.m. listed an allegation of emotional or mental abuse for R1, and listed	F 609	3. Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy includes immediately reporting suspected/alleged abuse, neglect, and injuries of unknown origin to the designated state agency/common entry point. Re-Education has been conducted by the Administrator on April 17, 2018, on immediate reporting to the State Agency of all incidents of suspected/ alleged abuse, neglect, and injuries of unknown origin - Education was provided for all care center staff. Staff will be educated during orientation and will also be educated yearly on this topic. 4. Progress notes will be reviewed daily by the DON or her designee, to assure immediate reporting of suspected/ alleged abuse, neglect, and injuries of unknown origin are properly reported for until May 31st, following this the progress notes will be reviewed randomly to assure immediate reporting of suspected/ alleged abuse, neglect, and injuries of unknown origin are properly reported. Results will be brought to the Quality Assurance Performance Improvement committee for further recommendations 5. The facility will have corrective actions in place and be in substantial compliance by May 1, 2018.	

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F 609	Continued From page 9	F 609		

the incident had occurred on 2/12/18 at 1 p.m. A nursing assistant had reported to her nurse that another nursing assistant had snap chatted picture of R1 to her. The pictures of R1 were not sexual, she was clothed. The investigation done by the facility revealed during an interview R1 had stated she did not like pictures taken of her and stated "I hope she doesn't show anyone those pictures." The investigation listed NA-B had reported she had received pictures of R1 from the alleged perpetrator.

On 3/22/18 at 8:38 a.m. licensed practical nurse (LPN)-D stated she aware of the incident with R1 and confirmed NA-B came to her and reported another NA(perpetrator) had taken pictures of R49 on her cell phone and snap chatting them to NA-B. LPN-D indicated she told NA-B that she needed to report the incident right away, but NA-B was scared to report the incident. LPN-D indicated NA-B had reported the incident to her over the weekend and she reported the incident to the SW the next day because NA-B had not reported the incident to anyone. The LPN-D confirmed staff were to report incidents of abuse immediately and confirmed it was not reported immediately.

On 3/22/18 at 8:52 a.m. SW confirmed the facility had reported the allegations of abuse of a NA (perpetrator) taking pictures of R49 with her cell phone and sending the pictures on snap chat to her. The SW confirmed the allegations of abuse needed to be reported to the SA immediately and on weekends the charge nurse should be making the report to the SA.

On 3/22/18 at 9:03 a.m. DON confirmed NA-B reported the allegation of another NA

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F 609	Continued From page 10 (perpetrator) taking picture of R49 and sending them to her. The DON verified NA-B reported the incident over the weekend to LPN-D right away and LPN-D then reported it to the SW. The DON confirmed the current facility policy and confirmed the incident had not been reported immediately to the SA. On 3/22/18 at 9:19 a.m. NA-B stated she had worked with the perpetrator prior to the incident and was not the first time she had taken pictures of R49. NA-B verified she had told LPN-D and she understood LPN-D was going to talk to someone about it. NA-B indicated she had told LPN-D on the weekend and thought LPN-D reported the incident to the SW when she came to work on Monday or Tuesday. NA-B indicated the incident was not reported over the weekend because there was not a SW available on the weekends to report it to and no one in the building to report to on the weekends. On 3/22/18 at 10:18 a.m. The administrator confirmed the facility policy, confirmed she was aware of the incident with R1 and indicated she expected staff to report the allegation of abuse immediately. The administrator indicated she would expect staff to follow the policy and indicated she was aware staff did not report the allegation of abuse right away. R77's annual MDS assessment dated 2/21/18, identified R77 had diagnoses which included, dementia, arthritis and hypertension and had severe cognitive impairment. R77's MDS further identified she required extensive assistance with transfers and walking, but did not walk outside	F 609		

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her room.

R77's fall Care Area Assessments (CAA) dated 2/27/18, identified she was at risk for falls related to balance problems, use of antidepressant medication and cognitive impairment.

R77's care plan, revised 2/22/18, indicated R77 was at high risk of falls, history of left hip fracture with repair and listed various interventions which included education to the resident, family and caregivers for safety reminders and what to do if a fall occurred. The care plan also instructed staff to ensure R77 wore appropriate footwear mobilizing in wheelchair and for staff to move the remote to the back of her recliner to prevent her from accidentally sitting on it.

Review of R77's progress notes from 12/9/17 to 12/11/19 identified:

-12/9/17, 8:00 a.m. R77 was heard calling out. Staff found R77 sitting on the floor near the bottom of her recliner in her room. R77 complained of pain in her left hip area and was sent to the hospital emergency department.

-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 clinical coordinator (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.

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No further documentation of the incident for R77 was provided by the facility.

On 3/21/18, at 2:26 p.m.CC-A indicated the usual practice for reporting to the state agency (SA) was for the nurse involved to report to the charge nurse and either nurse would complete the report to the SA. She indicated she was not sure if a report to the SA had been done, and indicated she did not see a reason to report R77's fall with fracture to the SA, because it was just an accident and she did not suspect maltreatment.

On 3/22/18, at 12:46 p.m. DON indicated the facility process for reporting to the state agency directed the floor nurse or the charge nurse to complete and submit the report. If needed they could call the LSW, administrator or herself and they would report it. DON indicated the facility would report major injuries for abuse, neglect or if the care plan was not followed. She indicated she was notified of R77's fall with major injury, but felt it was not appropriate to make a report to the SA. DON indicated she did not feel there was a reason to report R77's fall, since it was reasonable to fracture a hip if someone fell out of a chair. DON stated she understood an accidental fall with injury would not be reportable, unless the care plan was not followed or there was a resident to resident 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.

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F 609	Continued From page 13 On 3/22/18, at 1:24 p.m. administrator indicated R77's care plan was followed and addressed, and she felt it would not be reportable. Review of facility policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 11/28/16, indicated under Investigation, under procedure 1) an incident or suspected incident of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property must be IMMEDIATELY reported to the Administrator. 2) The Administrator or designee will make an initial report of the incident or suspected incident to the State Agency immediately in accordance with law.	F 609		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		5/1/18

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F 756	Continued From page 14 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure laboratory monitoring had been completed for 1 of 5 residents (R7) reviewed for unnecessary medications. Findings include: R7's Medication Review Report, signed by the physican on 2/20/18, listed diagnoses which included chronic kidney disease stage 3 (moderate), hypertension, and atrial fibrillation. The report included an order for a hemoglobin and basic metabolic panel 8 every six months in (August and February) the first Monday of the month related to chronic kidney disease (stage 3) moderate, weakness, hypertensive chronic kidney disease with stage 1 through stage 4 and fatigue. Review of R7's medical record was done on	F 756	1. 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. 2. All current residents have the potential to be affected. 3. Policy titled Medication Regimen Review was reviewed and copy was provided to consulting pharmacist on April 10, 2018. 4. Quality audits on the completion of ordered labs will be completed weekly for four weeks, then monthly for two months,	

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F 756	Continued From page 15 3/22/18, and revealed the most recent hemoglobin (protein in red blood cells) was completed on 8/7/17, with abnormal low results of 11.9, (reference range: 12.0-16.0). The most recent basic metabolic panel 8 was completed on 8/7/17, with abnormal high results of 38 milligram /deciliter (mg/dl) blood urea nitrogen (BUN), (reference range: 7-20), high results of 1.4 mg/dl creatinine, (reference range: 0.6-1.1), low results of 100 chloride (CL), (reference range: 101-109) and low results of 36 glomerular filtration rate (GFR) (reference range: 60-250). These test are used to assess kidney function. No further laboratory tests were documented as completed after 8/7/17. Review of R7's Pharmacist Medication Regimen Review form completed monthly from 9/14/17 through 3/19/18, revealed monthly the consulting pharmacist (CP) had documented the monthly review was "ok." The notes listed various comments which included no recent fatigue reported, recent fall does not appear to be medication related, however; the monthly reviews did not identify R7's laboratory testing had not been completed as ordered. On 3/22/18 at 3:32 p.m. the consulting pharmacist confirmed R7's monthly pharmacy review notes, and confirmed R7's labs had not been completed in February as ordered by her primary physician. The CP indicated the labs should of been done by staff and she would expect them to follow the orders as written. The CP indicated staff should of followed up with the primary physician when the labs were missed. The CP indicated they usually would of given them until April 2018 to complete labs before a reminder was given.	F 756	and then PRN. The audit reports will be reviewed at the Quarterly Quality Assurance meetings and recommendations from the Quality Team will be followed. 5. The facility will have corrective actions in place and be in substantial compliance by May 1, 2018.	

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F 756	Continued From page 16 On 3/22/18 at 4:25 p.m. director of nursing (DON) confirmed R7's had not recently had labs drawn for a hemoglobin and basic metabolic panel 8 as ordered by the primary physician. The DON also indicated she expected staff to make sure labs were being completed as ordered by the primary physician. Review of facility policy titled Pharmacy Consultant Expectations undated, indicated it is the policy of Pioneer Care that the services of a pharmacy consultant will be obtained to provide consultation on all aspects of the provision of pharmacy services in the facility. On 3/22/18, a policy in regards to pharmacy reviews was requested, but not provided.	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		5/1/18

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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 medications were removed from resident medication drawers for 2 of 4 residents (R23, R59) during observations of medication pass. In addition the facility failed to ensure insulin pens were labeled accurately, and not expired for 2 of 2 residents (R37, R84) who received insulin injections. Findings include: R23 R23's current physician orders signed 2/21/18, included orders for simvastatin 20 mg give 1 tablet by mouth one time a day related to hyperlipidemia. On 3/20/18, at 10:18 a.m. during observations of medication pass, a partially used blister pack of Simvastatin 20 milligram (mg) tablets were observed in the medication box in the resident's room. A bottle of Simvastatin 20 mg tablets, with an expiration date of 2/23/17, was also observed in R23's medication box. LPN-B confirmed R77's supply of Simvastatin in the bottle was expired. LPN-B indicated her usual practice was to remove medications when they were expired, and	F 761	1. It is the practice of this facility to ensure medications are labeled properly and are not outdated. On March 20, 2018, outdated medications were removed from R23□s and R58□s drawers. On March 19, 2018 a refer to chart sticker was placed on R84□s insulin pen and R37□s unlabeled insulin pen was replaced. 2. All residents receiving medications have the potential to be affected by outdated medications. All residents receiving insulin via insulin pen have the potential to be affected by improper labeling. All insulin pens in facility were reviewed to assure appropriate labeling. All medications in facility were reviewed to assure they were not expired. 3. Policy titled Storage of Medications was reviewed. Nursing staff will receive re education that all insulin pens must have their own label on each pen, if a pen is found not to have a proper label on it, nursing staff will sendback to pharmacy for proper labeling, or apply sticker indicating to refer to residents medical record for current order. RE Education will also include the need to destroy expired	

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F 761	Continued From page 18 indicated she had done that on a different wing recently. R59 R59's current physician orders signed 3/15/18, did not include an order for ProAir (an inhalation medication to prevent bronchospasms) medication. On 3/20/18, at 10:30 a.m. during observation of medication pass with LPN-B in R58's room, a ProAir inhaler was observed with expiration date of 7/17. LPN-B confirmed the finding and indicated R58 was not currently receiving the inhaler, and indicated the medication should of been destroyed, not available to use for R58. On 3/20/18, at 1:21 p.m. CC-A indicated she expected the licensed nursing staff to go through resident medication drawers when they gave medications and remove expired medications. CC-A confirmed the facility had no process or scheduled times to check medication drawers for medications. CC-A indicated if an expired medication was given it could potentially not be as effective and could deteriorate. 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.	F 761	medications. Licensed nurses and trained medication aides (TMAs) will be educated on current policy by April 30, 2018. 4. Quality audits of medications in resident drawers will be completed weekly x4, monthly x2, and quarterly PRN. These audits will monitor for appropriate labeling of insulin pens, and monitoring for expired medications. The audit reports will be reviewed at the Quarterly Quality Assurance meetings and recommendations from the Quality Team will be followed. 5. The facility will have corrective actions in place and be in substantial compliance by May 1, 2018.	

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On 3/22/18, at 1:09 p.m. director of nursing (DON) indicated she would expect nursing staff to check the medication label with the MAR order. She indicated if it does not match, to check the actual order in the chart. If an order was changed, she would expect an order change sticker be used or a new label from the pharmacy. DON indicated she would expect expired medications be removed from resident medication drawers. DON indicated she would expect licensed nursing staff to routinely check the medication's expiration date when administering medications.

R37
R37's Diagnosis Report dated 3/22/18, indicated R37 had a diagnosis of type 2 diabetes.

R37's Physician Orders dated 3/7/18, included an order for Novolog flex pen insulin, inject 24 units subcutaneously daily, 26 units subcutaneously daily, and 36 units subcutaneously daily and to hold if blood sugar below 150.

R37's current MAR dated 3/1/18 - 3/31/18, indicated R37 was currently receiving Novolog flex pen insulin, inject 24 units subcutaneously daily, 26 units subcutaneously daily, and 36 units subcutaneously daily and to hold if blood sugar below 150.

During observation on 3/19/18 at 4:44 p.m. LPN-A obtained R37's Novolog flex pen from his medication drawer which was laying in a white plastic divider tray by itself inside the drawer. LPN-A cleaned the end of the insulin pen with alcohol wipe, attached a needle, primed the

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F 761	Continued From page 20	F 761		

needle with 2 units of insulin and proceeded to dial up 36 units of insulin in the Novolog flex pen. The Novolog flex pen was not dated when opened, and had a date of 12/22/17 on the pharmacy label which was detached from the Novolog flex pen and was observed in the white plastic divider tray. LPN-A proceeded to check R37 blood sugar via finger stick and indicated R37 would not get any insulin if blood sugar was below 150. R37's blood sugar reading was 147, LPN-A proceeded to waste the dose into a waste bin.

On 3/19/18 at 5:07 p.m. LPN-A confirmed the Novolog flex pen was not dated when opened, and the pharmacy label was detached from the flex pen. LPN-A confirmed all medication needed to be properly labeled and dated when in use.

R84
R84's Diagnosis Report dated 3/22/18, indicated R84 had a diagnosis of type 2 diabetes.

R84's Physician Orders dated 1/25/18, included an order for Novolog flex pen insulin, inject 10 units subcutaneously two times a day and 4 units subcutaneously one time per day.

R84's current MAR dated 3/1/18 - 3/31/18, indicated R84 was currently receiving Novolog flex pen insulin, inject 10 units subcutaneously two times a day and 4 units subcutaneously one time per day.

During observation on 3/19/18 at 5:09 p.m. LPN-A opened R84's medication drawer, checked R84's blood sugar via finger stick and R84's blood sugar was 324. LPN-A indicated R84 was to receive 10 units of Novolog insulin from the flex

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F 761	Continued From page 21 pen. After review of R84's pharmacy label on his flex pen, the flex pen listed directions to inject insulin per sliding scale and did not have a change order sticker on the pen. At 5:20 p.m. LPN-A confirmed R84's current signed physician orders in his paper chart. LPN-A proceeded to glove, clean the end of the insulin pen with alcohol wipe, attached a needle, primed the needle with 2 units of insulin and proceeded to dial up 10 units of insulin in the Novolog flex pen and administered 10 units of insulin to R84. On 3/19/18 at 5:37 p.m. LPN-A confirmed R84's pharmacy label did not include R84's current dose of insulin and indicated R84's insulin should have been properly labeled with change order sticker. LPN-A verified R84 was no longer receiving sliding scale insulin injections and was currently receiving 10 units of Novolog flex pen. On 3/19/18 at 5:41 p.m. CC-B confirmed R84 was currently not on a sliding scale dose of insulin. She confirmed R37's label was not attached to the insulin pen, had not been dated when opened and had expired. She indicated staff were to place a medication change label and refer to chart when resident medication doses were changed. CC-B indicated all insulins were to be labeled with a opened date and expiration date on the pens. CC-B confirmed the label should be securely attached to the insulin pens and clearly labeled. Review of facility policy titled, Storage of Medications revised on 4/2007 indicated under three: Drug containers that have missing, incomplete, improper or incorrect labels shall be returned to the pharmacy for proper labeling before storing. A label refer to chart may be used.	F 761		

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F 761	Continued From page 22 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 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain clean and sanitary equipment in the main kitchen of the facility to prevent the spread of food borne organisms. This deficent practice had the potential to affect all 97 residents residing in the facility. In addition the facility failed to ensure refrigerated food items were disposed of after expiration date and were properly labeled and dated when the original packaging was opened in	F 812	1. The facility□s white large stand mixer, Robot Coupe, Can Opener, and Blast Cooler were thoroughly cleaned on 3/19/2018. All undated, unlabeled, or expired food was discarded on 3/19/2018 from the following locations: Cherry Wood kitchenette refrigerator inside the cupboard, Short Stay Kitchen Refrigerator / Freezer, Apple Blossom Kitchen refrigerator, and Birch Lake Kitchen	5/1/18

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F 812	Continued From page 23 3 of 5 households. Findings include: On 3/19/18, at 11:42 a.m. an initial tour of the main kitchen was completed with director of culinary services (DCS)-A and confirmed the findings: The facility's white large stand mixer, had multiple red, brown and white food splatters across the back and the arm of the stand. The Robot Coupe, used for pureed foods, had some food splatters and brown food buildup around the metal attachment tube.The facility can opener had splattered and crusted brown food on the blade and metal tub attached to the blade. The blaster cooler had food particles and brown buildup in the bottom of it. Cherry Wood wing kitchenette refrigerator contained unlabeled and undated foods. On 3/19/18, at 1:13 p.m. the small compact refrigerator located inside the cupboard on Cherry Wood wing contained an unmarked, undated bag of 10 small carrots, dry and cracked in appearance. Homemaker (HM)-D was present, confirmed the carrots were undated and appeared old, and indicated the carrots needed to be discarded. On 3/20/18 01:27 p.m. during a follow up tour of the main kitchen, DCS-A indicated the usual facility practice was for the kitchen can opener to be cleaned every 2-3 weeks, and confirmed the blater cooler required cleaning. He indicated the facility's usual practice was monthly audits of the kitchenette refrigerators. He indicated he provided education to the homemaker staff regarding expired foods, dating and labeling of	F 812	refrigerator/ freezer. 2. All Residents in the facility have the potential to be affected by this practice. 3. 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. 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 will be brought to the Quality Assurance meeting and recommendations from the team will be followed regarding continued	

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

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F 812	Continued From page 24 opened food. During the initial tour of the kitchenette on the Short Term stay unit on 3/19/18 at 12:35 p.m. with HM-E, the following areas of concern were noted: Fridge was observed to have: -a large zip lock bag of shredded cheese which was opened but did not have a date indicating when the package had been opened. -a plastic container of coleslaw half full which was opened but did not have a date indicating when the container had been opened. -a carton of heavy whipping cream three quarters full with expiration date of 2/24/18. -a plastic container of cottage cheese half full which was opened but did not have a date indicating when the package had been opened. Freezer was observed to have: -a zip lock bag containing bread sticks, zip lock bag containing strawberry's, 2 large bags of carrots opened and partially used, zip lock bag containing frozen cookie dough, a bag of waffles opened and partially used, a zip lock bag containing biscuits, a zip lock bag containing garlic bread, a zip lock bag of zucchini opened and partial used. All the items listed above had been opened and partially used, however, the items were not in there original packages, did not have a date indicating when the packages had been opened and placed in the freezer. On 3/19/18 at 12:44 p.m. HM-E confirmed the	F 812	follow up. 5. The facility will have corrective actions in place and be in substantial compliance by May 1, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 25 above finding, verified all food items should be dated when opened and stored in the fridge and freezer. HM-E indicted he was not sure how long the frozen items had been in the freezer and was not sure how long they could be stored in the freezer once opened. HM-E indicated staff should be making sure the items are dated when opening and storing them in the fridge or freezer. HM-E indicated expired items should be thrown away and should not be in the fridge. During the initial tour of the kitchenette on the Apple Blossom unit on 3/19/18 at 12:51 p.m. with HM-F, the following areas of concern were noted: Fridge was observed to have: -a large zip lock bag of shredded cheese which was opened but did not have a date indicating when the packages had been opened. -a carton of heavy whipping cream half full with expiration date of 3/11/18. On 3/19/18 at 12:58 p.m. HM-F confirmed the above findings and indicated items in the fridge should be labeled and dated when opened. HM-F indicated expired items should be thrown away and taken out of fridge.	F 812		

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F 812	Continued From page 26 Birch Lake kitchenette refrigerator had undated and expired food. On 3/19/18, at 3:40 p.m. the Birch Lake refrigerator/freezer was reviewed with cook (C)-A who identified herself as the lead homemaker. The following items were noted: -14 shelled, hard boiled eggs, in a wet slimy substance, dated 3/4 -an open zip lock bag of leaf lettuce which had turned brown, dated 3/14 -1/2 quart container of chocolate TruMoo with an expiration date of 3/17/18 -sliced deli style turkey meat dated 3/6 -package of sliced ham dated 3/10 Freezer section -frozen bag of sugar cookie dough, with a build up of white frost on the edges of the dough, dated 2/7 -a quart size zip lock bag with five bread sticks with a build up of white frost on all edges of the bread sticks was undated. The shelves and bottom of the refrigerator and freezer sections were observed with green and orange colored debris of food . On 3/19/18, at 3:40 p.m. C-A verified the facility protocol of food items labeled with the date the foods were opened. C-A verified the soiled refrigerator and freezer section, as well as the outdated and undated food items listed above. C-A identified staff were expected to review the food items and cleanliness of the refrigerator/freezer daily while replenishing supplies in order to maintain cleanliness and prevent the use of outdated foods. A facility form titled Daily Checklist, undated, was provided. The form included multiple tasks to be	F 812		

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F 812	Continued From page 27	F 812		

completed in the kitchen, but lacked instruction for equipment cleaning.

The facility policy titled General Food Preparation and Handling, revised 4/1/09, indicated all food service equipment should be cleaned, sanitized, dried and reassembled after each use.

The facility policy titled Kitchenettes and Pantries, undated, instructed the food service staff to remove outdated items. The policy lacked direction for opened undated items.

The facility policy titled Food Storage, revised 4/1/09, instructed leftover food to be stored in covered containers or wrapped carefully and securely. Each item to be clearly labeled, and dated before being refrigerated. Leftover food to be used within 3 days or discarded. Frozen foods should be covered, labeled and dated.

The facility policy titled Foods Brought by Family/Visitors, revised 2/14, indicated perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date. The nursing staff is responsible for discarding perishable foods on or before the "use by" date.

A facility form titled Food Storage Guide revised 7/11/11, directed time frames for use of opened food which included:
- deli meat, seven days after opening
-shredded cheese, 10 days after opening
-leftovers, within three days.

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	245463	A. BUILDING **02 - MAIN BLDG TWO** B. WING _____	**03/19/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY Building 02 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Pioneer Care Center 02 Main Building was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19, Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. The facility was surveyed as two buildings. Pioneer Care Center is two buildings built in 2011. Building 02 main building is a 2-story, without a basement and is Type II (111) construction. Building 03 is a 1-story building without a basement and Type V (111) construction. Both buildings are fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" . The fire alarm is monitored for automatic fire department notification. The sleeping rooms have smoke detection in them and all hazardous areas have automatic fire detection. The facility has a licensed capacity of 105 beds and had a census of 97 at the time of the survey.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **02 - MAIN BLDG TWO** B. WING _____	**03/19/2018**

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **03 - SOUTH BLDG 3** B. WING _____	**03/19/2018**

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K 000	INITIAL COMMENTS Building 03 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care, and the 2012 edition of NFPA 99, Health Care Facilities Code. The facility was surveyed as two buildings. Pioneer Care Center is made up of two buildings. Building 02 main building is a 2-story, without a basement and is Type II (111) construction. Building 03 is a 1-story building without a basement, Type V (111). The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code". The fire alarm is monitored for automatic fire department notification. The sleeping rooms have smoke detection in them and all hazardous areas have automatic fire detection. The facility has a licensed capacity of 105 beds and had a census of 97 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

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

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

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

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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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00443	A. BUILDING: _____ B. WING _____	C 03/22/2018

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 3/19/18 to 3/22/18, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. At the time of the survey, an investigation of complaint H5463024 were completed and were found to be substantiated. The complaint was substantiated at 1995. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain clean and sanitary equipment in the main kitchen of the facility to prevent the spread of food borne organisms. This deficient practice had the potential to affect all 97 residents residing in the facility. In addition the facility failed to ensure refrigerated food items were disposed of after expiration date and were properly labeled and dated when the original packaging was opened in 3 of 5 households. Findings include: On 3/19/18, at 11:42 a.m. an initial tour of the main kitchen was completed with director of culinary services (DCS)-A and confirmed the findings: The facility's white large stand mixer,	21100	Corrected	5/1/18

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21100	Continued From page 3	21100		

had multiple red, brown and white food splatters across the back and the arm of the stand. The Robot Coupe, used for pureed foods, had some food splatters and brown food buildup around the metal attachment tube. The facility can opener had splattered and crusted brown food on the blade and metal tub attached to the blade. The blaster cooler had food particles and brown buildup in the bottom of it.

Cherry Wood wing kitchenette refrigerator contained unlabeled and undated foods.

On 3/19/18, at 1:13 p.m. the small compact refrigerator located inside the cupboard on Cherry Wood wing contained an unmarked, undated bag of 10 small carrots, dry and cracked in appearance. Homemaker (HM)-D was present, confirmed the carrots were undated and appeared old, and indicated the carrots needed to be discarded.

On 3/20/18 01:27 p.m. during a follow up tour of the main kitchen, DCS-A indicated the usual facility practice was for the kitchen can opener to be cleaned every 2-3 weeks, and confirmed the blaster cooler required cleaning. He indicated the facility's usual practice was monthly audits of the kitchenette refrigerators. He indicated he provided education to the homemaker staff regarding expired foods, dating and labeling of opened food.

During the initial tour of the kitchenette on the Short Term stay unit on 3/19/18 at 12:35 p.m. with HM-E, the following areas of concern were noted:

Fridge was observed to have:
-a large zip lock bag of shredded cheese which was opened but did not have a date indicating

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21100	Continued From page 4 when the package had been opened. -a plastic container of coleslaw half full which was opened but did not have a date indicating when the container had been opened. -a carton of heavy whipping cream three quarters full with expiration date of 2/24/18. -a plastic container of cottage cheese half full which was opened but did not have a date indicating when the package had been opened. Freezer was observed to have: -a zip lock bag containing bread sticks, zip lock bag containing strawberry's, 2 large bags of carrots opened and partially used, zip lock bag containing frozen cookie dough, a bag of waffles opened and partially used, a zip lock bag containing biscuits, a zip lock bag containing garlic bread, a zip lock bag of zucchini opened and partial used. All the items listed above had been opened and partially used, however, the items were not in there original packages, did not have a date indicating when the packages had been opened and placed in the freezer. On 3/19/18 at 12:44 p.m. HM-E confirmed the above finding, verified all food items should be dated when opened and stored in the fridge and freezer. HM-E indicted he was not sure how long the frozen items had been in the freezer and was not sure how long they could be stored in the freezer once opened. HM-E indicated staff should be making sure the items are dated when opening and storing them in the fridge or freezer. HM-E indicated expired items should be thrown away and should not be in the fridge. During the initial tour of the kitchenette on the Apple Blossom unit on 3/19/18 at 12:51 p.m. with HM-F, the following areas of concern were noted:	21100		

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21100	Continued From page 5 Fridge was observed to have: -a large zip lock bag of shredded cheese which was opened but did not have a date indicating when the packages had been opened. -a carton of heavy whipping cream half full with expiration date of 3/11/18. On 3/19/18 at 12:58 p.m. HM-F confirmed the above findings and indicated items in the fridge should be labeled and dated when opened. HM-F indicated expired items should be thrown away and taken out of fridge. Birch Lake kitchenette refrigerator had undated and expired food. On 3/19/18, at 3:40 p.m. the Birch Lake refrigerator/freezer was reviewed with cook (C)-A who identified herself as the lead homemaker. The following items were noted: -14 shelled, hard boiled eggs, in a wet slimy substance, dated 3/4 -an open zip lock bag of leaf lettuce which had turned brown, dated 3/14 -1/2 quart container of chocolate TruMoo with an expiration date of 3/17/18 -sliced deli style turkey meat dated 3/6 -package of sliced ham dated 3/10 Freezer section -frozen bag of sugar cookie dough, with a build up of white frost on the edges of the dough, dated 2/7 -a quart size zip lock bag with five bread sticks with a build up of white frost on all edges of the bread sticks was undated. The shelves and bottom of the refrigerator and freezer sections were observed with green and orange colored debris of food . On 3/19/18, at 3:40 p.m. C-A verified the facility	21100		

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21100	Continued From page 6	21100		

protocol of food items labeled with the date the foods were opened. C-A verified the soiled refrigerator and freezer section, as well as the outdated and undated food items listed above. C-A identified staff were expected to review the food items and cleanliness of the refrigerator/freezer daily while replenishing supplies in order to maintain cleanliness and prevent the use of outdated foods.

A facility form titled Daily Checklist, undated, was provided. The form included multiple tasks to be completed in the kitchen, but lacked instruction for equipment cleaning.

The facility policy titled General Food Preparation and Handling, revised 4/1/09, indicated all food service equipment should be cleaned, sanitized, dried and reassembled after each use.

The facility policy titled Kitchenettes and Pantries, undated, instructed the food service staff to remove outdated items. The policy lacked direction for opened undated items.

The facility policy titled Food Storage, revised 4/1/09, instructed leftover food to be stored in covered containers or wrapped carefully and securely. Each item to be clearly labeled, and dated before being refrigerated. Leftover food to be used within 3 days or discarded. Frozen foods should be covered, labeled and dated.

The facility policy titled Foods Brought by Family/Visitors, revised 2/14, indicated perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date. The nursing staff is responsible for discarding

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21100	Continued From page 7 perishable foods on or before the "use by" date. A facility form titled Food Storage Guide revised 7/11/11, directed time frames for use of opened food which included: - deli meat, seven days after opening -shredded cheese, 10 days after opening -leftovers, within three days. SUGGESTED METHOD OF CORRECTION: The director of dietary services or designee could development and implement policies and procedures to food preparation equipment were cleaned and maintained regularly and ensure store refrigerated food items were properly labeled, dated to ensure they were used or discard by the expiration date. The director of dietary services or designee could educate staff on those policies, and then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21100		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students,	21426		5/1/18

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21426	Continued From page 8 residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to complete a 2-step tuberculin skin testing (TST) for 2 of 5 newly hired employees (E-A & E-B). Findings include: Employee-A (E-A) was hired on 12/15/17 in the position of a registered nurse. When reviewed, E-A's file lacked evidence that a Step 2 TST test had been completed. Employee-B (E-B) was hired on 1/29/18 in the position of a nursing assistant. When reviewed, E-B's file lacked evidence that a Step 2 TST test had been completed. The facility's policy entitled Tuberculin Skin Testing (TST) Protocol for Screening Health Care Workers (last reviewed 8/28/13), indicated "pre-employment screening for healthcare workers and correctional facility staff" had a "Prescribed Action" of Administer two-step TST. The facility Tuberculosis (TB) Risk Assessment, last revised 5/24/17, the facility was assessed to	21426	Corrected	

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21426	Continued From page 9 be a "low risk" facility, however, indicated a baseline TB screening of all health care workers would be performed at the time of hire. When interviewed on 3/22/18 at 10:15 a.m., the infection control registered nurse (ICRN) stated both of the employees had received a 1st step TST which was negative. ICRN stated the usual facilty practice was within 48 hours of the 1st Step being given, Human Resources would send employees a postcard reminder of when the 2nd Step must be completed by. The ICRN stated she felt the employees had not returned for their 2nd Step TST, nor had anyone followed up with the employees from the facility. In an interview on 3/22/18 at 10:35 a.m., the director of nursing (DON) stated the two employees were missed and/or over looked, and did not receive their 2nd Step TST. She stated the postcard reminders for the 2nd Step TST was a recent change in their employee contact system. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review the facility TB policies, educate employees on these policies and monitor to assure TB screening procedures were developed and implemented to ensure staff were free of TB prior to working with residents. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review	21530		5/1/18

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21530	Continued From page 10 A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure laboratory monitoring had been completed for 1 of 5 residents (R7) reviewed for unnecessary medications. Findings include: R7's Medication Review Report, signed by the physican on 2/20/18, listed diagnoses which included chronic kidney disease stage 3 (moderate), hypertension, and atrial fibrillation. The report included an order for a hemoglobin and basic metabolic panel 8 every six months in (August and February) the first Monday of the month related to chronic kidney disease (stage 3) moderate, weakness, hypertensive chronic kidney disease with stage 1 through stage 4 and fatigue. Review of R7's medical record was done on 3/22/18, and revealed the most recent hemoglobin (protein in red blood cells) was completed on 8/7/17, with abnormal low results of 11.9, (reference range: 12.0-16.0). The most recent basic metabolic panel 8 was completed on 8/7/17, with abnormal high results of 38 milligram /deciliter (mg/dl) blood urea nitrogen (BUN), (reference range: 7-20), high results of 1.4 mg/dl creatinine, (reference range: 0.6-1.1), low results of 100 chloride (CL), (reference range: 101-109) and low results of 36 glomerular filtration rate (GFR) (reference range: 60-250). These test are used to assess kidney function. No further laboratory tests were documented as completed after 8/7/17. Review of R7's Pharmacist Medication Regimen	21530	Corrected	

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21530	Continued From page 12 Review form completed monthly from 9/14/17 through 3/19/18, revealed monthly the consulting pharmacist (CP) had documented the monthly review was "ok." The notes listed various comments which included no recent fatigue reported, recent fall does not appear to be medication related, however; the monthly reviews did not identify R7's laboratory testing had not been completed as ordered. On 3/22/18 at 3:32 p.m. the consulting pharmacist confirmed R7's monthly pharmacy review notes, and confirmed R7's labs had not been completed in February as ordered by her primary physician. The CP indicated the labs should of been done by staff and she would expect them to follow the orders as written. The CP indicated staff should of followed up with the primary physician when the labs were missed. The CP indicated they usually would of given them until April 2018 to complete labs before a reminder was given. On 3/22/18 at 4:25 p.m. director of nursing (DON) confirmed R7's had not recently had labs drawn for a hemoglobin and basic metabolic panel 8 as ordered by the primary physician. The DON also indicated she expected staff to make sure labs were being completed as ordered by the primary physician. Review of facility policy titled Pharmacy Consultant Expectations undated, indicated it is the policy of Pioneer Care that the services of a pharmacy consultant will be obtained to provide consultation on all aspects of the provision of pharmacy services in the facility. On 3/22/18, a policy in regards to pharmacy reviews was requested, but not provided.	21530		

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21530	Continued From page 13 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for proper monitoring of medication usage and labs. Appropriate nursing staff could be educated on these systems. The DON or designee, could develop an auditing system to ensure ongoing compliance. The audits could be reviewed with the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure expired medications were removed from resident medication drawers for 2 of 4 residents (R23, R59) during observations of medication pass. In addition the facility failed to ensure insulin pens were labeled accurately, and not expired for 2 of 2 residents (R37, R84) who received insulin injections. Findings include: R23	21620	Corrected	5/1/18

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21620	Continued From page 14 R23's current physician orders signed 2/21/18, included orders for simvastatin 20 mg give 1 tablet by mouth one time a day related to hyperlipidemia. On 3/20/18, at 10:18 a.m. during observations of medication pass, a partially used blister pack of Simvastatin 20 milligram (mg) tablets were observed in the medication box in the resident's room. A bottle of Simvastatin 20 mg tablets, with an expiration date of 2/23/17, was also observed in R23's medication box. LPN-B confirmed R77's supply of Simvastatin in the bottle was expired. LPN-B indicated her usual practice was to remove medications when they were expired, and indicated she had done that on a different wing recently. R59 R59's current physician orders signed 3/15/18, did not include an order for ProAir (an inhalation medication to prevent bronchospasms) medication. On 3/20/18, at 10:30 a.m. during observation of medication pass with LPN-B in R58's room, a ProAir inhaler was observed with expiration date of 7/17. LPN-B confirmed the finding and indicated R58 was not currently receiving the inhaler, and indicated the medication should of been destroyed, not available to use for R58. On 3/20/18, at 1:21 p.m. CC-A indicated she expected the licensed nursing staff to go through resident medication drawers when they gave medications and remove expired medications. CC-A confirmed the facility had no process or scheduled times to check medication drawers for medications. CC-A indicated if an expired	21620		

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21620	Continued From page 15 medication was given it could potentially not be as effective and could deteriorate. 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. On 3/22/18, at 1:09 p.m. director of nursing (DON) indicated she would expect nursing staff to check the medication label with the MAR order. She indicated if it does not match, to check the actual order in the chart. If an order was changed, she would expect an order change sticker be used or a new label from the pharmacy. DON indicated she would expect expired medications be removed from resident medication drawers. DON indicated she would expect licensed nursing staff to routinely check the medication's expiration date when administering medications. R37 R37's Diagnosis Report dated 3/22/18, indicated R37 had a diagnosis of type 2 diabetes. R37's Physician Orders dated 3/7/18, included an order for Novolog flex pen insulin, inject 24 units subcutaneously daily, 26 units subcutaneously daily, and 36 units subcutaneously daily and to hold if blood sugar below 150. R37's current MAR dated 3/1/18 - 3/31/18,	21620		

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21620	Continued From page 16	21620		

indicated R37 was currently receiving Novolog flex pen insulin, inject 24 units subcutaneously daily, 26 units subcutaneously daily, and 36 units subcutaneously daily and to hold if blood sugar below 150.

During observation on 3/19/18 at 4:44 p.m. LPN-A obtained R37's Novolog flex pen from his medication drawer which was laying in a white plastic divider tray by itself inside the drawer. LPN-A cleaned the end of the insulin pen with alcohol wipe, attached a needle, primed the needle with 2 units of insulin and proceeded to dial up 36 units of insulin in the Novolog flex pen. The Novolog flex pen was not dated when opened, and had a date of 12/22/17 on the pharmacy label which was detached from the Novolog flex pen and was observed in the white plastic divider tray. LPN-A proceeded to check R37 blood sugar via finger stick and indicated R37 would not get any insulin if blood sugar was below 150. R37's blood sugar reading was 147, LPN-A proceeded to waste the dose into a waste bin.

On 3/19/18 at 5:07 p.m. LPN-A confirmed the Novolog flex pen was not dated when opened, and the pharmacy label was detached from the flex pen. LPN-A confirmed all medication needed to be properly labeled and dated when in use.

R84
R84's Diagnosis Report dated 3/22/18, indicated R84 had a diagnosis of type 2 diabetes.

R84's Physician Orders dated 1/25/18, included an order for Novolog flex pen insulin, inject 10 units subcutaneously two times a day and 4 units subcutaneously one time per day.

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21620	Continued From page 17 R84's current MAR dated 3/1/18 - 3/31/18, indicated R84 was currently receiving Novolog flex pen insulin, inject 10 units subcutaneously two times a day and 4 units subcutaneously one time per day. During observation on 3/19/18 at 5:09 p.m. LPN-A opened R84's medication drawer, checked R84's blood sugar via finger stick and R84's blood sugar was 324. LPN-A indicated R84 was to receive 10 units of Novolog insulin from the flex pen. After review of R84's pharmacy label on his flex pen, the flex pen listed directions to inject insulin per sliding scale and did not have a change order sticker on the pen. At 5:20 p.m. LPN-A confirmed R84's current signed physician orders in his paper chart. LPN-A proceeded to glove, clean the end of the insulin pen with alcohol wipe, attached a needle, primed the needle with 2 units of insulin and proceeded to dial up 10 units of insulin in the Novolog flex pen and administered 10 units of insulin to R84. On 3/19/18 at 5:37 p.m. LPN-A confirmed R84's pharmacy label did not include R84's current dose of insulin and indicated R84's insulin should have been properly labeled with change order sticker. LPN-A verified R84 was no longer receiving sliding scale insulin injections and was currently receiving 10 units of Novolog flex pen. On 3/19/18 at 5:41 p.m. CC-B confirmed R84 was currently not on a sliding scale dose of insulin. She confirmed R37's label was not attached to the insulin pen, had not been dated when opened and had expired. She indicated staff were to place a medication change label and refer to chart when resident medication doses were changed. CC-B indicated all insulins were to be labeled with a opened date and expiration date	21620		

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21620	Continued From page 18 on the pens. CC-B confirmed the label should be securely attached to the insulin pens and clearly labeled. Review of facility policy titled, Storage of Medications revised on 4/2007 indicated under three: Drug containers that have missing, incomplete, improper or incorrect labels shall be returned to the pharmacy for proper labeling before storing. A label refer to chart may be used. 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. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications and labeling. Nursing staff could be educated as necessary to the importance of properly securing medications and labeling. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a	21995		5/1/18

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21995	Continued From page 19 mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the state agency (SA) allegations of mental/emotional abuse for 1 of 1 resident (R49) reviewed allegations of misuse of cellular phone. In addition the facility failed to immediately report to the SA, and conduct a thorough investigation of an injury of unknown source for 1 of 1 (R77) resident reviewed for potential neglect of care. Findings include: R49's quarterly Minimum Data Set (MDS) dated 2/7/18, indicated R49 was severely cognitively impaired with diagnoses which included heart failure, dementia and depression. The MDS indicated R49 required extensive assistance of two staff with all activities of daily living (ADL's) and had no behaviors. R49's current care plan revised on 2/14/18, listed various intervention which included to try to provide consistent care givers as much as possible in order to decrease confusion,encourage R49 to express any concerns, staff will maintain safety, monitor and report any suspected abuse or neglect following policy. Review of Resident Accident/Incident Report dated 2/11/18, and did not list a time the incident had occurred. The report indicated a nursing	21995	Corrected	

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21995	Continued From page 20 assistant (NA)- B reported a cell phone was used to cause mental/emotion abuse to R49 and there was no injury or change in life style. The report listed on 2/13/18 social worker (SW) completed an interview with R49, and R49 was able to tell the SW the nursing assistant's name and R49 stated the nursing assistant had been good to her. The SW asked if the perpetrator took pictures of her, she stated "yes" and indicated the perpetrator has lots of pictures of R49 and her "little boy." R49 stated she "hoped she doesn't show anyone those pictures." When SW asked R49 if she liked her picture taken, R49 had stated "no." Review of Incident Report #310516, submitted to the SA on 2/13/18 at 4:39 p.m. listed an allegation of emotional or mental abuse for R1, and listed the incident had occurred on 2/12/18 at 1 p.m. A nursing assistant had reported to her nurse that another nursing assistant had snap chatted picture of R1 to her. The pictures of R1 were not sexual, she was clothed. The investigation done by the facility revealed during an interview R1 had stated she did not like pictures taken of her and stated "I hope she doesn't show anyone those pictures." The investigation listed NA-B had reported she had received pictures of R1 from the alleged perpetrator. On 3/22/18 at 8:38 a.m. licensed practical nurse (LPN)-D stated she aware of the incident with R1 and confirmed NA-B came to her and reported another NA(perpetrator) had taken pictures of R49 on her cell phone and snap chatting them to NA-B. LPN-D indicated she told NA-B that she needed to report the incident right away, but NA-B was scared to report the incident. LPN-D indicated NA-B had reported the incident to her	21995		

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21995	Continued From page 21 over the weekend and she reported the incident to the SW the next day because NA-B had not reported the incident to anyone. The LPN-D confirmed staff were to report incidents of abuse immediately and confirmed it was not reported immediately. On 3/22/18 at 8:52 a.m. SW confirmed the facility had reported the allegations of abuse of a NA (perpetrator) taking pictures of R49 with her cell phone and sending the pictures on snap chat to her. The SW confirmed the allegations of abuse needed to be reported to the SA immediately and on weekends the charge nurse should be making the report to the SA. On 3/22/18 at 9:03 a.m. DON confirmed NA-B reported the allegation of another NA (perpetrator) taking picture of R49 and sending them to her. The DON verified NA-B reported the incident over the weekend to LPN-D right away and LPN-D then reported it to the SW. The DON confirmed the current facility policy and confirmed the incident had not been reported immediately to the SA. On 3/22/18 at 9:19 a.m. NA-B stated she had worked with the perpetrator prior to the incident and was not the first time she had taken pictures of R49. NA-B verified she had told LPN-D and she understood LPN-D was going to talk to someone about it. NA-B indicated she had told LPN-D on the weekend and thought LPN-D reported the incident to the SW when she came to work on Monday or Tuesday. NA-B indicated the incident was not reported over the weekend because there was not a SW available on the weekends to report it to and no one in the building to report to on the weekends.	21995		

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21995	Continued From page 22 On 3/22/18 at 10:18 a.m. The administrator confirmed the facility policy, confirmed she was aware of the incident with R1 and indicated she expected staff to report the allegation of abuse immediately. The administrator indicated she would expect staff to follow the policy and indicated she was aware staff did not report the allegation of abuse right away. R77's annual MDS assessment dated 2/21/18, identified R77 had diagnoses which included, dementia, arthritis and hypertension and had severe cognitive impairment. R77's MDS further identified she required extensive assistance with transfers and walking, but did not walk outside her room. R77's fall Care Area Assessments (CAA) dated 2/27/18, identified she was at risk for falls related to balance problems, use of antidepressant medication and cognitive impairment. R77's care plan, revised 2/22/18, indicated R77 was at high risk of falls, history of left hip fracture with repair and listed various interventions which included education to the resident, family and caregivers for safety reminders and what to do if a fall occurred. The care plan also instructed staff to ensure R77 wore appropriate footwear mobilizing in wheelchair and for staff to move the remote to the back of her recliner to prevent her from accidentally sitting on it. Review of R77's progress notes from 12/9/17 to 12/11/19 identified: -12/9/17, 8:00 a.m. R77 was heard calling out. Staff found R77 sitting on the floor near the bottom of her recliner in her room. R77 complained of pain in her left hip area and was	21995		

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21995	Continued From page 23 sent to the hospital emergency department. -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 documentation of the incident for R77 was provided by the facility. On 3/21/18, at 2:26 p.m.CC-A indicated the usual practice for reporting to the state agency (SA) was for the nurse involved to report to the charge nurse and either nurse would complete the report to the SA. She indicated she was not sure if a report to the SA had been done, and indicated she did not see a reason to report R77's fall with fracture to the SA, because it was just an accident and she did not suspect maltreatment. On 3/22/18, at 12:46 p.m. DON indicated the facility process for reporting to the state agency directed the floor nurse or the charge nurse to complete and submit the report. If needed they could call the LSW, administrator or herself and they would report it. DON indicated the facility would report major injuries for abuse, neglect or if the care plan was not followed. She indicated she was notified of R77's fall with major injury, but felt it was not appropriate to make a report to the SA. DON indicated she did not feel there was a reason to report R77's fall, since it was reasonable to fracture a hip if someone fell out of	21995		

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21995	Continued From page 24 a chair. DON stated she understood an accidental fall with injury would not be reportable, unless the care plan was not followed or there was a resident to resident 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. On 3/22/18, at 1:24 p.m. administrator indicated R77's care plan was followed and addressed, and she felt it would not be reportable. Review of facility policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 11/28/16, indicated under Investigation, under procedure 1) an incident or suspected incident of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property must be IMMEDIATELY reported to the Administrator. 2) The Administrator or designee will make an initial report of the incident or suspected incident to the State Agency immediately in accordance with law. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise abuse/neglect systems. The administrator or designee could ensure all staff are educated on the system for Abuse/Neglect reporting. The administrator or designee could establish a system to audit to ensure all allegations are properly reported and investigated. The administrator or designee could report audit	21995		

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21995	Continued From page 25 results to the quality assurance performance improvement (QAPI) committee for review and further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21995		