DEPARTMENT OF HEALT	TH AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAL	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: F849
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00469
1. MEDICARE/MEDICAID PROVID (L1) 245301	DER NO.	3. NAME AND AI (L3) PIONEER N			TER	4. TYPE OF ACTION: 7 (L8)
2.STATE VENDOR OR MEDICAID (L2) 358342200	NO.	(L4) 23028 - 347 (L5) ERSKINE, 1		OUTHEAS	ST (L6) 56535	1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
	4/2017 (L34)(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR ENDING DATE: (L35) 03/31
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	68 (L18) 68 (L17)	Compliance			And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
		Requirements	and/or Applied V	Vaivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
68 (L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REN	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):		
See Attached Remarks	():		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Theresa Guillingsrud,	HFE NEII	1	0/05/2017	(L19)	Mark Meath,	Enforcement Specialist 10/05/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	LOFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBI <u>X</u> 1. Facility is Eligible to <u>2</u>. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) : :
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 12/01/1985	BEGINNINC	G DATE	ENDING DAT	ΓE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	č
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active
(L27)	B. Rescind St	spension Date:	(=)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	DATE		
	(L32)	06/06/2017		(L33)	DETERMINATION APPE	ROVAL

CCN: 24 5301

On July 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that the facility had achieved full compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 6, 2017 and a PCR completed on May 30, 2017. We presumed, based on their plan of correction, that your facility had corrected these deficiencies as of May 9, 2017. Based on our PCR, we have determined the facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 6, 2017 and PCR completed on May 30, 2017, effective May 9, 2017 and therefore remedies outlined in our letter to you dated April 11, 2017 and June 28, 2017, will not be imposed.

Effective May 9, 2017, the facility is certified for 68 skilled nursing facility beds.



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 245301

October 5, 2017

Mr. Gary Hjelmstad, Administrator Pioneer Memorial Care Center 23028 - 347th Street Southeast Erskine, MN 56535-9466

Dear Mr. Hjelmstad:

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 May 9, 2017 the above facility is certified for:

68 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 68 skilled nursing facility beds.

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

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

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

Sincerely,

Mark meath

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



Electronically delivered October 5, 2017

Mr. Gary Hjelmstad, Administrator Pioneer Memorial Care Center 23028 - 347th Street Southeast Erskine, MN 56535-9466

RE: Project Number S5301026

Dear Mr. Hjelmstad:

On April 11, 2017 and June 28, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 6, 2017 and not achieving full compliance at the post certification revisit on May 30, 2017. The survey found the most serious deficiency to be a pattern deficiency that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) and the revisit found the most serious deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), whereby corrections were required.

On July 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved full compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 6, 2017 and a PCR completed on May 30, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 9, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 6, 2017 and PCR completed on May 30, 2017, effective May 9, 2017 and therefore remedies outlined in our letter to you dated April 11, 2017 and June 28, 2017, will not be imposed.

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

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

Sincerely,

Mark meath

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 5, 2017

Mr. Gary Hjelmstad, Administrator Pioneer Memorial Care Center 23028 - 347th Street Southeast Erskine, MN 56535-9466

Re: Reinspection Results - Project Number S5301026

Dear Mr. Hjelmstad:

On July 24, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 6, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form delivered to you electronically.

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

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

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES
	MEDIC	ARE/MEDICAL	D CERTIFIC.	ATION A	AND TRANSMITTAL	ID: F849
	PART I -	TO BE COMPI	LETED BY TI	HE STAT	TE SURVEY AGENCY	Facility ID: 00469
1. MEDICARE/MEDICAID PROVID (L1) 245301	ER NO.	3. NAME AND AI (L3) PIONEER N			TER	 TYPE OF ACTION: <u>7</u>(L8) Initial 2. Recertification
2.STATE VENDOR OR MEDICAID 1 (L2) 358342200	NO.	(L4) 23028 - 3471 (L5) ERSKINE, N		DUTHEAS	ST (L6) 56535	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEGO 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint
	0/2017 (L34)	02 SNF/NF/Dual	05 HHA 06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	03/31
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED A	AS:		
From (a):		XA. In Complia	ince With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
		1			3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	68 (L18)	<u></u> 1. A	cceptable POC		4. 7-Day RN (Rural SN	· <u> </u>
13.Total Certified Beds	68 (L17)	B. Not in Comp	liance with Program	m	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied W	aivers:	* Code: A,1	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF 68	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION D	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	
Jana Bromenshenkel, H	IFE NEII	0	07/07/2017	(L19)	Mark Meath,	Enforcement Specialist 09/12/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBII	LITY	20. COM	IPLIANCE WITH	CIVIL	21. 1. Statement of Finan	icial Solvency (HCFA-2572)
X 1. Facility is Eligible to I	Participate	RIGH	ITS ACT:			l Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	-				5. Both of the Above	
<u></u> 2. Tuonky is not English	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DAT	Е	VOLUNTARY 00	INVOLUNTARY
12/01/1985					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	6
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	n <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B Rescind St	uspension Date:	(L44)			00-Active
	D. Reselled 5	uspension Date.	(L45)			
28. TERMINATION DATE:	20	. INTERMEDIARY			30. REMARKS	
20. TERRITATION DATE.	23		entrality into:		50. REMARKS	
	(L28)	03001		(L31)		
	(120)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)	06/06/2017		(L33)	DETERMINATION APPE	ROVAL
	()			(200)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: F849

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5301

On May 19, 2017 and May 30, 2017, Department's of Health and Public Safetya completed a Post Certification Revisit (PCR) to verify the facility achieved and maintained coimpliance with federal certification regulations. Based on our revisits we have deteremined life safety code deficiencies were found corrected. However, the health deficiency was not corrected. The facility submitted a plan of correction that was deteremined acceptable. Refer to the CMS 2567 along with the facility's plan of correction for the health deficiency. Post Certification Revisit (PCR) to follow.

Facility ID: 00469



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 28, 2017

Mr. Delbert Clark, Administrator Pioneer Memorial Care Center 23028 - 347th Street Southeast Erskine, MN 56535-9466

RE: Project Number S5301026

Dear Mr. Clark:

On April 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 6, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On May 30, 2017, the Minnesota Department of Health and on May 19, 2017, the Minnesota Department of Public Safety 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 April 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 9, 2017. Based on our visit, we have determined that your facility has obtained substantial compliance with, but has not totally corrected, the deficiencies issued pursuant to our standard survey, completed on April 6, 2017, effective May 9, 2017. The deficiency not corrected is as follows:

F0226 - S/S: C - 483.12(b)(1)-(3), 483.95(c)(1)-(3) - Develop/implment Abuse/neglect, Etc Policies

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Since these deficiencies are considered to be in substantial compliance, remedies outlined in our letter to you dated April 11, 2017 will not be imposed.

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

Pioneer Memorial Care Center June 28, 2017 Page 2

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:

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: Lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

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,

Pioneer Memorial Care Center June 28, 2017 Page 3

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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:

Pioneer Memorial Care Center June 28, 2017 Page 4 <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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

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

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	`´co⊮	E SURVEY IPLETED
		245301	B. WING	i			R / 30/2017
NAME OF F	PROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PIONEE	R MEMORIAL CARE (CENTER			23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	rs	{F 0	00}			
	of this department compliance with Fe during a recertificat	was conducted by surveyors on May 30, 2017, to determine ederal deficiencies issued tion survey exited on April 6, visit the following regulations be not corrected.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.					
{F 226} SS=C	on-site revisit of you validate that substa regulations has bee your verification. 483.12(b)(1)-(3), 48	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with 33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC	{F 2	26}			7/5/17
	483.12 (b) The facility mus written policies and	t develop and implement procedures that:					
		event abuse, neglect, and lents and misappropriation of					
	(2) Establish policie investigate any suc	es and procedures to hallegations, and					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						07/05/2017

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

PRINTED: 07/07/2017

		AND HUMAN SERVICES			F	FORM A	07/07/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	COMP	SURVEY LETED
		245301	B. WING	÷		R 05/3	0/2017
NAME OF F	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	R MEMORIAL CARE O	ENTER			3028 - 347TH STREET SOUTHEAST RSKINE, MN 56535		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 226}	 (3) Include training §483.95, 483.95 (c) Abuse, neglect, the freedom from a requirements in § 4 provide training to t educates staff on- (c)(1) Activities that exploitation, and miproperty as set forth (c)(2) Procedures for neglect, exploitation resident property (c)(3) Dementia maprevention. This REQUIREMENT by: Based on interview facility failed to impreducated on a polic protecting resident abuse related to phone. 	as required at paragraph and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum constitute abuse, neglect, isappropriation of resident in at § 483.12. For reporting incidents of abuse, n, or the misappropriation of anagement and resident abuse NT is not met as evidenced <i>y</i> and document review, the lement and ensure staff were ey and procedure related to privacy and prohibiting mental otographs and audio/video ad the potential to affect all 63	{F 2	226}	Social Media Policy was reviewed an updated to include not only video but audio as well on 6/1/17. Staff were trained by LSW at an All Si Meeting on Wednesday June 7th. Acknowledgement forms were compli by those in attendance and Policy was	taff leted is	
	Findings include:				reviewed with those that were not and forms completed. Policy and Acknowledgment Form was added to new hire packets it will be reviewed a	our	
	(DON) stated the fa media policy on 4/2 to all 116 employee	p.m. director of nursing acility developed a social 017, which had been sent out s for them to review and then			completed at that time. No further residents should have potential to be affected by deficient practice.		
	sign an Acknowled	gement Of Receipt Of Notice			Policy will be reviewed annually to en	sure	

Facility ID: 00469

If continuation sheet Page 2 of 3

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/07/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245301	B. WING				२ 30/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PIONEE	R MEMORIAL CARE O	SENTER			3028 - 347TH STREET SOUTHEAST RSKINE, MN 56535		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 226}	form which verified	age 2 the employee had been the new social media policy.	{F 2:	26}	compliance.		
	of who the policy ha mark in the last colu- Form" which indicate employees had ack received and under Media/Electronic Co- confirmed that only	7 p.m. DON provided the roster ad been sent to and a check umn labeled "Returned signed ted 19 out of the 116 knowledged that they had rstood the new Social ommunications Policy. DON of the employees had of had received and understood					
	[undated] indicated from posting or disp of residents without authorized form and facility managemen displaying commen vulgar, obscene, th intimidating was also	Electric Communication Policy employees where prohibited playing photographs or videos t first obtained a signed d written permission from the nt. In addition, posting or nts about residents that was reatening, un-dignified, or so prohibited. However, the ion of prohibiting audio					

Facility ID: 00469

If continuation sheet Page 3 of 3



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 28, 2017

Mr. Delbert Clark, Administrator Pioneer Memorial Care Center 23028 - 347th Street Southeast Erskine, MN 56535-9466

Re: Reinspection Results - Project Number S5301026

Dear Mr. Clark:

On May 30, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 6, 2017. Based on our visit we deteremined you had not corrected the orders. The correction orders are listed on the State form delivered to you electronically. Only the ID Prefix Tag in the left hand column with brackets will identify these reissued licensing orders.

You are not required to submit a plan of correction. However, when the orders have been corrected, please submit electronically, your acknowledgement, that the orders have been corrected. If you have questions regarding the orders, **please contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us**.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

Minnesc	ota Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00469	B. WING		F 05/3	₹ 0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PIONEE	R MEMORIAL CARE (:ENTER	47TH STREE , MN 56535	T SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	30, 2017, to verify this onsite visit it wa following correction NOT corrected. Thi remain in effect and onsite visit.	FS: visit was completed on May correction of orders. During as determined that the s orders # 0302, #1426 were s uncorrected order/s will d will be reviewed at the next				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 07/05/17

Electronically Signed

STATE FORM

If continuation sheet 1 of 8

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _	·····		R
		00469	B. WING			n 30/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PIONEEF	R MEMORIAL CARE	CENTER	847TH STREET E, MN 56535	SOUTHEAST		
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{2 000}	Continued From pa	age 1	{2 000}			
	electronic receipt of consistent with the Health Informationa http://www.health.s obul.htm The Stat delineated on the M Health orders being Although no plan of State Statutes/Rule "corrected" in the b indicate in the elect under the heading orders will be corrected	reed to participate in the of State licensure orders Minnesota Department of al Bulletin 14-01, available at state.mn.us/divs/fpc/profinfo/inf te licensing orders are Minnesota Department of g submitted electronically. f correction is necessary for es, please enter the word box available for text. Then tronic State licensure process, completion date, the date your ected prior to electronically linnesota Department of				
	the State Licensing federal software. T	nent of Health is documenting g Correction Orders using ag numbers have been esota state statutes/rules for				
	column entitled "IC statute/rule number the state statute/rul in the "Summary S column and replace the correction order the findings which	number appears in the far left D Prefix Tag." The state r and the corresponding text of le out of compliance is listed tatement of Deficiencies" es the "To Comply" portion of er. This column also includes are in violation of the state atement, "This Rule is not met	ŗ			
	PLEASE DISREGA	ARD THE HEADING OF THE				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
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{2 000}	Continued From pa	ge 2	{2 000}			
	APPLIES TO FEDE	I WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
{2 302}	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	{2 302}			7/7/17
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related or segregated or gene care staff	ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia	ı			
	related disorders; (2) assistance with (3) problem solving and (4) communication	of Alzheimer's disease and activities of daily living; with challenging behaviors; skills.				
	written or electronic training program, th trained, the frequen topics covered.	provide to consumers in form a description of the le categories of employees loy of training, and the basic document compliance with				

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Minneso	ta Department of He	alth			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00469	B. WING		R 05/30/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	
PIONEE	R MEMORIAL CARE C	ENTER	47TH STREE , MN 56535	ET SOUTHEAST	
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{2 302}	Continued From pa	ge 3	{2 302}		
	by: Uncorrected based	ent is not met as evidenced on the following findings. The der issued on 5/30/17, will		CORRECTED	
	facility failed to ensu	and document review, the ure 3 of 3 newly hired , NA-A, NA-C) had completed y upon hire.			
	Findings include:				
	2/8/16. LPN-A's trai	nurse (LPN)-A was hired on ining record lacked indication the Alzheimer's training			
	NA-A's training reco	NA)-A was hired on 7/21/16. ord lacked indication she had eimer's training requirements.			
		5/1/17. NA-C's training record he had completed the requirements.			
		7 p.m. registered nurse NA-C had not completed the s training.			
Ainnesota D	(DON) confirmed N and NA-C started to on 5/26/17. DON c	p.m. director of nursing A-C's hire date was 5/1/17, provide direct resident care onfirmed LPN-A, NA-A and due for completing the			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY
	OF CONTLECTION	IDENTIFICATION NOMBER.	A. BUILDING:	·		
		00469	B. WING			R 30/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PIONEEF	R MEMORIAL CARE	CENTER	47TH STREE , MN 56535	ET SOUTHEAST		
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{2 302}	Continued From pa	age 4	{2 302}			
	should have compl	's training. DON stated all staff leted the Alzheimer's training re they started to work on the				
{21426}	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	{21426}			7/7/17
	maintain a compre- infection control pre- current tuberculosi- issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must he nursing home.				
	by: Uncorrected based	ent is not met as evidenced on the following findings. The rder issued on 5/30/17, will		CORRECTED		
	Based on interview	and document review, the				

STATE FORM

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If continuation sheet 5 of 8

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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IAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, S ⁻ 347TH STREE			
PIONEE	R MEMORIAL CARE	CENTER	E, MN 56535	JOUTHLAST		
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{21426}	Continued From pa	age 5	{21426}			
L t ii	LPN-A, LPN-B, NA timely tuberculin sł	sure 5 of 6 employees (RN-A, A-A and NA-B) had received kin test (TST) and the results o both the interpretation and the ST site.	of			
	Findings include:					
	The New Employe Documentation Fo first step TST on 8 The TST was read TST was documen The interpretation RN-A received a so was read on 8/17/1	RN)-A was hired on 6/16/16. e Tuberculin Skin Test rm indicated RN-A received a /1/16 (1.5 months after hire.) on 8/4/16. The results of the ted as zero millimeters (mm). of the TST was not identified. econd step TST on 8/14/16. It 16, as 0 mm. The e TST was not identified.				
	2/8/16. The New E Documentation Fo first step TST on 2 was read on 2/19/- identified as 0 mm was not identified. TST on 2/26/16. T	nurse (LPN)-A was hired on Employee Tuberculin Skin Test rm indicated LPN-A received a /17/16 (9 days after hire) and 17. The induration was however, the interpretation LPN-A received a second ste The TST was read on 2/29/16, nduration as 0 mm however was not identified.	a			
	Tuberculin Skin Te indicated LPN-B re 5/16/16 (1.5 month 5/18/16, and was in	on 3/30/16. The New Employe st Documentation From eceived a first step TST on is after hire). It was read on dentified as 0 mm however, th not identified. LPN-B received	e			

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STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
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	a second step TST day later) the secor	nge 6 on 5/26/17. On 5/27/17, (one nd step TST was identified as pretation of the TST was not	{21426}			
	Tuberculin Skin Tes indicated NA-A reco 8/8/16 (19 days afte was identified as ne induration of the TS NA-A received a se The second step TS	7/21/16. The New Employee at Documentation Form eived a first step TST on er hire.) On 8/11/16, the TST egative, however, the ST site was not identified. econd step TST on 8/18/16. ST was read on 8/20/16 and e 0 mm. However, the not identified.				
	Tuberculin Skin Tes indicated NA-B rec 11/4/16, the TST w however, the interp NA-B received a se		3			
	(DON) confirmed th the TST was admir should be 48-72 ho second TST was re after it had been ac TST results when r induration and inter RN-A, LPN-A, LPN received repeat a T	p.m. director of nursing the time frame between when histered and the time was read burs. DON confirmed LPN-B's ead one day (not 48-72 hours) Iministered. DON stated the ead should have included the rpretation. DON confirmed -B, NA-A, and NA-B had not 'ST. The DON stated no mpleted with regards to				

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Iinnesota Department of He TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
ND FLAN OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _			
	00469	B. WING			R 30/2017
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IONEER MEMORIAL CARE		347TH STREET E, MN 56535	SOUTHEAST		
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21426} Continued From pa	age 7	{21426}			
compliance with er screening.	nployee tuberculosis				
[undated], indicate initiated prior to em direct the staff to d	perculosis Screening policy d a two-step TST was to be ployment. The policy did not ocument the interpretation and e results of the TST.				

DEPARTMENT OF HEALT	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC.	ATION A	AND TRANSMITTAL	ID: F849
	PART I -	TO BE COMPI	LETED BY TI	HE STAT	TE SURVEY AGENCY	Facility ID: 00469
1. MEDICARE/MEDICAID PROVI NO.(L1) 245301	DER	3. NAME AND AI (L3) PIONEER N			TER	 TYPE OF ACTION: <u>2(L8)</u> Initial Recertification
2. STATE VENDOR OR MEDICAI (L2) 358342200	D NO.	(L4) 23028 - 347 (L5) ERSKINE, N		DUTHEAS	ST (L6) 56535	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEGO 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 6. DATE OF SURVEY ()4/ 8. ACCREDITATION STATUS: 	/06/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	()	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	03/31
11LTC PERIOD OF CERTIFICATIO	ON	10.THE FACILITY	IS CERTIFIED A	S:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		U U	equirements		2. Technical Personnel	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	68 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size
13.Total Certified Beds	68 (L17)	X B. Not in Con	anlianaa with Decor		5. Life Safety Code	9. Beds/Room
15. Total Certified Beds	00 (E17)		and/or Applied W		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	5 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
68					(-)(-)(),(-).	
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	MARKS (IF APPI IC A	BLE SHOW LTC CA	NCELLATION D	ATE).		
				/ II <i>L</i>).		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Rebecca Haberle, HF	E NE II	0	5/09/2017	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 06/06/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	STATE AGENCY
19. DETERMINATION OF ELIGIBLE	ILITY	20. COM	IPLIANCE WITH	CIVIL		ncial Solvency (HCFA-2572)
 Facility is Eligible to 	Participate	RIGH	ITS ACT:		 Ownership/Contr Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligib	-					
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	ENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Е	VOLUNTARY 00	<u>INVOLUNTARY</u>
12/01/1985					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
(L2T)	B. Rescind Su	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL I	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 11, 2017

Mr. Tyler Champ, Administrator Pioneer Memorial Care Center 23028 - 347th Street Southeast Erskine, Minnesota 56535-9466

RE: Project Number S5301026 and H5301015

Dear Mr. Champ:

On April 6, 2017, 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 April 6, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5301015. This survey found the most serious deficiencies in your facility 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. A copy of the Statement of Deficiencies (CMS-2567), has been electronically delivered. In addition, at the time of the April 6, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5301015 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: Lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

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 16, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 July 6, 2017 (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 October 6, 2017 (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

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

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

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

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

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

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

Sincerely,

mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

							APPROVED
		& MEDICAID SERVICES					. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			CON	E SURVEY IPLETED
		245301	B. WING				C / 06/2017
NAME OF F	PROVIDER OR SUPPLIER		L I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				23	3028 - 347TH STREET SOUTHEAST		
PIONEER	R MEMORIAL CARE C	ENTER		Ε	RSKINE, MN 56535		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	00			
	signature is not req						
	revisit of your facilit validate that substa	acceptable POC an on-site y may be conducted to Intial compliance with the en attained in accordance with					
F 226 SS=C	complaint H530101 found to be unsubs 483.12(b)(1)-(3), 48		F 2	26			4/13/17
	483.12 (b) The facility musi written policies and	t develop and implement procedures that:					
		vent abuse, neglect, and lents and misappropriation of					
	(2) Establish policie investigate any suc	es and procedures to hallegations, and					
	(3) Include training §483.95,	as required at paragraph					
		and exploitation. In addition to buse, neglect, and exploitation					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						04/20/2017

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

PRINTED: 05/30/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/30/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245301	B. WING	i) 06/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEEF	MEMORIAL CARE C	ENTER	23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	provide training to t educates staff on- (c)(1) Activities that exploitation, and mi property as set forth (c)(2) Procedures for neglect, exploitation resident property (c)(3) Dementia map prevention. This REQUIREMEN by: Based on interview facility failed to deve and procedure relat privacy and prohibit photographs and at practice had the por residing at the facilit Findings include: During the entrance 4/3/17, at 1:00 p.m. facility had not deve to protecting the res meal abuse related and audio recording it may be included i	 83.12, facilities must also heir staff that at a minimum constitute abuse, neglect, sappropriation of resident in at § 483.12. by reporting incidents of abuse, h, or the misappropriation of nagement and resident abuse NT is not met as evidenced and document review, the elop and implement a policy ed to protecting resident ing mental abuse related to udio/video recordings. This tential to affect all 63 residents ty. e conference conducted on the administrator stated the eloped a written policy related sidents privacy and prohibiting to photographs and/or video ys. The administrator thought in the employee handbook. 	F	226	A written policy for audio/video reco has been added as an addendum to current vulnerable adult policy. The addendum includes prohibition of a of our residents using and device w audio/video capabilities, regardless intent. Our current policy already has policies/procedures to investigate s abuse and/or allegations, as well as training procedure. All staff will be passed out addendu sign stating they understand policy/procedure. Addendum will als added to new hire packets. Policy was added 4/13/17, and will 1 in compliance with regulation by 5/1	o our new buse rith of uch s our m, and so be be fully //17.	
	The undated emplo	n the employee handbook. yee handbook section 6.11 rees not to use personal cell				l/17. ential	

Facility ID: 00469

If continuation sheet Page 2 of 3

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245301	B. WING				C 06/2017
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		50/2011
PIONEE	R MEMORIAL CARE	CENTER			3028 - 347TH STREET SOUTHEAST RSKINE, MN 56535		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 226	226 Continued From page 2 phones and other mobile devices while working to ensure the devices did not interfere with their job duties or impact the workplace safety and health. An employee with devices equipped with cameras and/or audio/video recording capability were to be restricted from using those functions while on company property unless authorized in advance by management.		F 2	226	Policy will be reviewed annually to compliance.	ensure	
	stated the employed from the facility to the while working at the considered a format confirmed the facil	On 4/6/16, at 10:20 a.m. the director of nurses stated the employee handbook was notification from the facility to the employee of expectations while working at the facility, however, was not considered a formal policy of the facility. She confirmed the facility had not developed a policy related to the use of photographs and audio/vide recordings.					
	confirmed the facil	censed social worker ity did not have a policy related graphs and/or audio/video					
	At 10:30 a.m. the administrator confirmed the facility had not developed a policy.						

Facility ID: 00469

If continuation sheet Page 3 of 3

The REGULATORY OR LSC IDENTIFYING INFORMATION TAGE CROSS REFERENCE TO THE APPROPRIATE DATE K 000 INITIAL COMMENTS K 000 FIRE SAFETY Building 01 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2560 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE. SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEED ANTAINED IN ACCORDANCE WITH YOUR VERIFICATION. ALife Safety Code Survey was conducted by the Minnesota Department of Public Safety, State FIR Marshal Division. At the the of this survey, Pioneer Memorial Care Center was not found in complance with the requirements for participation In Medicare/Medicaid at 42 CFR, Subpart 435 37(a), Life Safety Code (LSC), Chapter 19 Existing Healt Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division Attes After to State Fire Marshal Division Attes State Fire Marshal Division Attes The Masto Division Health Care Fire Inspections State Fire Marshal Division State Fi			AND HUMAN SERVICES	11	FS	371226	FORM	: 05/09/2017 APPROVED . 0938-0391
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2020 - 347TH STREET SOUTHART PONEER MEMORIAL CARE CENTER SURMARY STATEMENT OF DEFICIENCIES 2020 - 347TH STREET SOUTHART PARTY SURMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S ILAN OF CORRECTION PREFIX SURMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S ILAN OF CORRECTION TAG SURMARY STATEMENT OF DEFICIENCIES PROVIDER'S ILAN OF CORRECTION CROSSREETENCED TO THE ADDROPHIATE DEFICIENCY BUILDING REGULATORY OR LSC DENTFYING INFORMATION) ID PROVIDER'S ILAN OF CORRECTION K 000 INITIAL COMMENTS K 000 CROSSREETENCED TO THE APPROPHIATE COMPLANCE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CONPLIANCE. K 000 K 000 UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSTRET REVISITO FY YOUR RACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTATURIAL COMPLIANCE CROSSREETING UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSTRET REVISITO FY OUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTATURIAL COMPLIANCE CROSSRATICE UPON RECEIPT OF ANA ACCEPTABLE POC. AN ONSTRET REVISITO CARE CARE WAS NOT IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Memorial Tire Protection Association (NFPA) Standard 101, LIFE Safety Code (LSC), Chapter 19 Existing Health Care.				L` ′				
IMME OF PROVIDER OR SUIPILIER SITHEIT ADDRESS, CTY, STATE, PRODE 2002 32028-347H STREET SOUTHEAST PONDEER MEMORIAL CARE CENTER 20028-347H STREET SOUTHEAST (M) D SUMMARY STATEMENT OF DEFICIENCIES PREINX REQUIATORY OR LSC.DENTFYING INFORMATION) PREINX REQUIATORY OR LSC.DENTFYING INFORMATION) K 000 INITIAL COMMENTS FIRE SAFETY Building 01 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATUREA THE BOTTOM OF THE FIRST PAGE OF THE CMS-2667 WILL BE USED AS VERIFICATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATUREA THE BOTTOM OF THE FIRST PAGE OF THE CMS-2667 WILL BE USED AS VERIFICATION OF COMPLIANCE UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FABLES AND YOUR VERIFICATION. ALLE Safety Code Survey was conducted by the Minesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Memorial Care Center was not found in CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (KTAGS) TO. Health Care Fire Inspections State Fire Marshal Division State Fire Marshal Division Sta			245301	B:WING			04/	04/2017
Priegry TAG (EACH DEPICIENCY MILE DEPICIENCY MILE PROTECTION SPECUL TAG PREFX (EACH CORRECTED COTIN DATA CEACH CORRECTED COTIN DATA COMMENTS K 000 INITIAL COMMENTS K 000 FIRE SAFETY Building 01 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGMATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2657 WILL BE USED AS VERIFICATION OF COMPLIANCE. K 000 UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE. WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. Alfe Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Memorial Care Center was not found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.7(0). Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN S5101 EVENT			CENTER		2302	8 - 347TH STREET SOUTHEAST		
FIRE SAFETY Building 01 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE RECORDANCE WITH YOUR VERIFICATION. ALife Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Memorial Care Center was not found in Complication IF ire Protection Association (NFPA) Standard 101. Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division Ats Minnesota Street, Suite 145 St. Paul, MN 55101	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
Building 01 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2667 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, At the time of this survey, Pioneer Memorial Care Center was not 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 483.70(a), Life Safety from Fire, and the 2012 CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division Att S Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	INITIAL COMMEN	ГS	кc	000			
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ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Memorial Care Center was not found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpat 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101		ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS					
Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Memorial Care Center was not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ITLE (40) DATE		ONSITE REVISIT (CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN	_				
CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Image: Comparison of the fire inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Image: Comparison of the fire inspection of the fire inspecting defined of the fire inspection of the fir		Minnesota Departm Fire Marshal Divisio Pioneer Memorial C compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) Standard 1	nent of Public Safety, State on. At the time of this survey, Care Center was not found in a requirements for participation and at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC),				1	
445 Minnesota Street, Suite 145 St. Paul, MN 55101 ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		CORRECTION FO DEFICIENCIES (K Health Care Fire In:	R THE FIRE SAFETY TAGS) TO: spections			EPOC		
		445 Minnesota Stre	et, Suite 145					
Electronically Signed 04/20/20			ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 04/20/2017

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

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245301	B, WING			04/	04/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER	R MEMORIAL CARE O	ENTER			3028 - 347TH STREET SOUTHEAST RSKINE, MN 56535		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	ка	000			
	Or by e-mail to both Marian.Whitney@s and Angela.Kappenmar	tate.mn.us					
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	vhat has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	Pioneer Memorial C is one story with a p determined to be T 1997 a 1-story addi east of the original was determined to and which is separa In 2005 an 1-story a south of the original	pected as one building. Care Center was built in 1985, partial basement and was ype V(111) construction. In tion was constructed to the building with out a basement, be Type V (111) construction ated with a 2-hour fire barrier. addition was constructed to the I building that has a full determined to be a Type V			÷		
	sprinkler system an corridor smoke dete all common areas, smoke detectors ar	cted with a complete automatic d has a fire alarm system with ection and smoke detectors in installed. Additional single e in all sleeping rooms of the emodeled east wing and					

If continuation sheet Page 2 of 7

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
				UT - MAIN BUILDING UT	
		245301	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	04/04/2017
	PROVIDER OR SUPPLIER		2	23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
K 000	Continued From p hazardous areas h	age 2 ave automatic fire detection.	K 000		
		apacity of 68 beds and had a e time of the survey.			
K 211 SS=E	NOT MET.	t 42 CFR, Subpart 483.70(a) is of Egress - General	K 211		5/9/17
30-L	exit locations, and with Chapter 7, an continuously main full use in case of 18/19.2.2 through 18.2.1, 19.2.1, 7.1 This STANDARD Based on observa had 1 of several ex requirements of N Code" 2012 edition 19.2.1. This deficie	accesses are in accordance d the means of egress is tained free of all obstructions to emergency, unless modified by 18/19.2.11. .10.1 is not met as evidenced by: ation and interview, the facility kit doors that did not meet the IFPA 101 "The Life Safety n, sections 7.2.1.1.2 and ent practice could affect 20 of ell as an undetermined number		Removal of the entire mural on the door was completed on 5/9/2017.	exit
		ween 1:00 p.m. to 5:00 p.m. on vations revealed that a set of			
	exit doors located had a plastic stick barn scene to the	in the memory care unit have on style door coverings of a exit doors that have made them the event of and emergency.			

Facility ID: 00469

If continuation sheet Page 3 of 7

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		. 0938-039 E SURVEY IPLETED
		245301	B. WING		04	04/2017
NAME OF I	PROVIDER OR SUPPLIER	240301		STREET ADDRESS, CITY, STATE,		04/2017
	R MEMORIAL CARE (-ENTED		23028 - 347TH STREET SOUTH	IEAST	
				ERSKINE, MN 56535		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
K 211	Continued From pa	age 3	K 2	:11		
	This deficient cond Maintenance Super	ition was verified by a rvisor.				
K 346 SS=D		m System - Out of Service	K 3	46		4/14/17
	services for more the period, the authority notified, and the but approved fire watch parties left unprotect fire alarm system he 9.6.1.6 This STANDARD is Based on a record facility has failed to acceptable written to be followed in the en- system has to be point more hours in a 24 practice could affect response and notifing affect the safety of an undetermined me- the facility.	e alarm system is out of han 4 hours in a 24-hour y having jurisdiction shall be ilding shall be evacuated or an n shall be provided for all cted by the shutdown until the as been returned to service. s not met as evidenced by: review and staff interview, the provide a complete and policy containing procedures to event that the Fire Alarm laced out-of-service for four or hour period. This deficient of the facility's ability for early cation of a fire and would 63 of 63 residents as well as umber of staff, and visitors to		Current policy/procedu updated by our Mainter to include all current co Policy will be reviewed change of Administrato supervisor. No residents can furthe this deficient practice.	nance Supervisor ntact information. annually, and with r/Maintenance	
	04/05/2017, during interview with the M facility did not have system out of servic current Deputy Stat information in the e	veen 1:00 p.m. to 5:00 p.m. on a records review and an faintenance Supervisor, the an acceptable fire alarm ce policy that included the te Fire Marshal's contact vent of the fire alarm being out need for a fire watch to be				

If continuation sheet Page 4 of 7

PRINTED: 05/09/2017

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION (X3)	DATE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01	OMPLETED
		245301	B. WING		04/04/2017
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ONEEF		CENTER		23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 346	Continued From pa	age 4	K 346		
	Maintenance Supe				
K 354 SS=D	Sprinkler System - Where the sprinkle extent and duration determined, areas inspected and risks recommendations or designated repre- department and oth jurisdiction have be sprinkler system is hours in a 24-hour of the building affec approved fire watcl system has been re 18.3.5.1, 19.3.5.1, This STANDARD is Based on a record facility has failed to acceptable written be followed in the e sprinkler system has for four or more ho deficient practice c for early response would affect the sa	r system is impaired, the of the impairment has been or buildings involved are s are determined, are submitted to management esentative, and the fire her authorities having been notified. Where the out of service for more than 10 period, the building or portion of service for more than 10 period, the building or portion of are evacuated or an is provided until the sprinkler eturned to service. 9.7.5, 15.5.2 (NFPA 25) is not met as evidenced by: I review and staff interview, the provide a complete and policy containing procedures to event that the automatic fire as to be placed out-of-service urs in a 24 hour period. This ould affect the facility's ability and notification of a fire and fety of 63 of 63 residents as mined number of staff, and	K 354	Current policy/procedure has been updated by our Maintenance Supervisc to include all current contact informatio Policy will be reviewed annually, and wi change of Administrator/Maintenance supervisor. No residents can further be affected by this deficient practice.	n. th
	Findings include:				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/09/201 APPROVE 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01	(X3) DATI	E SURVEY PLETED
		245301	B. WING			04/	04/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PIONEE	R MEMORIAL CARE O	ENTER			28 - 347TH STREET SOUTHEAST SKINE, MN 56535		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
	interview with the M facility did not have system out of servic current Deputy Stat information in the e out of service and ti initiated. This deficient condi Maintenance Super NFPA 101 Corridor Corridor - Doors 2012 EXISTING Doors protecting correquired enclosures hazardous areas sh as those constructed core wood, or capa 20 minutes. Doors in compartments are of passage of smoke. means suitable for There is no impedin doors. Clearance be floor covering is not latches are prohibite corridor doors and no or combustible mat complying with 7.2. devices that release pulled are permitted	a records review and an laintenance Supervisor, the an acceptable fire sprinkler ce policy that included the e Fire Marshal's contact vent of the fire sprinkler being he need for a fire watch to be tion was verified by a visor. - Doors prridor openings in other than s of vertical openings, exits, or hall be substantial doors, such ed of 1-3/4 inch solid-bonded ble of resisting fire for at least in fully sprinklered smoke conly required to resist the Doors shall be provided with a keeping the door closed. ment to the closing of the etween bottom of door and t exceeding 1 inch. Roller ed by CMS regulations on rooms containing flammable erials. Powered doors 1.9 are permissible. Hold open e when the door is pushed or d. Nonrated protective plates are permitted. Dutch doors	K3				4/5/17

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY PLETED
		245301	B. WING		04/04/2017	
	PROVIDER OR SUPPLIER	243301		STREET ADDRESS, CITY, STATE, ZIP CODE	04/	04/2017
	R MEMORIAL CARE (CENTER		23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETIO DATE
K 363	window assemblies sprinklered compar- restrictions in area frames in window a 19.3.6.3, 42 CFR F and 485 Show in REMARKS protection ratings, a etc. This STANDARD i Based on observa had 2 of several co the requirements o Code" 2012 edition affect 10 of 63 resi undetermined num smoke from a fire v access corridors m Findings include: On facility tour betw 04/05/2017, observ laundry room locate holes both measur around the lockset.	tment is sprinklered. Fixed fire s are allowed per 8.3. In rtments there are no or fire resistance of glass or assemblies. Parts 403, 418, 460, 482, 483, S details of doors such as fire automatics closing devices, is not met as evidenced by: tion and interview, the facility prridor doors that did not meet of NFPA 101 "The Life Safety the This deficient practice could dents, as well as an ber of staff, and visitors if were allowed to enter the exit making it untenable. ween 1:00 p.m. to 5:00 p.m. on vations revealed that the ed in the oak wing that had two ing 1/4 of an inch in diameter	K 36	 Maintenance team fixed door withours. Contacted door company, and hadordered, holes filled, and plate insover old locking mechanism. Door is now in compliance with L Doors on each wing will be audited once/month for 3 months to ensurongoing compliance. No other residents will be affected deficient practice. 	ad plate stalled SC. ed ire	

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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 11, 2017

Mr. Tyler Champ, Administrator Pioneer Memorial Care Center 23028 - 347th Street Southeast Erskine, Minnesota 56535-9466

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5301026 and H5301015

Dear Mr. Champ:

The above facility was surveyed on April 3, 2017 through April 6, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5301015. that was found to be unsubstantiated. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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 Lyla Burkman at (218) 308-2104 or email: lyla.burkman@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.

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

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00469	B. WING		04/0	C)6/2017
NAME OF PROVIDER OR SUPPLIER STREET ADD				STATE, ZIP CODE		
PIONEER MEMORIAL CARE CENTER 23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535						
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMPLETE	
2 000	00 Initial Comments		2 000			
	*****ATTENTION******					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
Innesota Department of Health ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Electronically Signed						(X6) DATE 04/20/17

Electronically Signed

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