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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GMSC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00469

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245301**
2.STATE VENDOR OR MEDICAID NO.
(L2) **358342200**

3. NAME AND ADDRESS OF FACILITY
(L3) **PIONEER MEMORIAL CARE CENTER**
(L4) **23028 - 347TH STREET SOUTHEAST**
(L5) **ERSKINE, MN** (L6) **56535**

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 **04/05/2015** (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)
03/31

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

12.Total Facility Beds **68** (L18)

13.Total Certified Beds **68** (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
	68			
(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 :
Lyla Burkman, Unit Supervisor — 04/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 05/01/2015 (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
12/01/1985
(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
Posted 05/01/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/25/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245301

April 29, 2015

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

Dear Mr. Champ:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective February 24, 2015 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
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 8, 2015

Ms. Marlene McGuire, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, Minnesota 56535-9466

RE: Project Number S5301024

Dear Ms. McGuire:

On February 24, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 11, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On April 5, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 11, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 24, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 11, 2015, effective February 24, 2015 and therefore remedies outlined in our letter to you dated February 24, 2015, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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: mark.meath@state.mn.us

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

Enclosure 5301r15

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245301	A. Building B. Wing	4/5/2015

Name of Facility	Street Address, City, State, Zip Code
PIONEER MEMORIAL CARE CENTER	23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0221 Reg. # 483.13(a) LSC	02/24/2015	ID Prefix F0356 Reg. # 483.30(e) LSC	02/24/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By LB/mm	Date: 04/07/2015	Signature of Surveyor: 00469	Date: 04/05/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/11/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GMSC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00469

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245301**
2.STATE VENDOR OR MEDICAID NO.
(L2) **358342200**

3. NAME AND ADDRESS OF FACILITY
(L3) **PIONEER MEMORIAL CARE CENTER**
(L4) **23028 - 347TH STREET SOUTHEAST**
(L5) **ERSKINE, MN** (L6) **56535**

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 **02/11/2015** (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)
03/31

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

12.Total Facility Beds **68** (L18)

13.Total Certified Beds **68** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	68			
(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 :
Rebecca Haberle, HFE NEII 03/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/25/2015 (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
12/01/1985
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6749

February 24, 2015

Ms. Marlene McGuire, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, Minnesota 56535-9466

RE: Project Number S5301024

Dear Ms. McGuire:

On February 11, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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>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;

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 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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 23, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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 form will be used as verification of compliance. 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 May 11, 2015 (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 August 11, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

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
mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File 5301s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 form will be used as verification of compliance. Upon receipt of an acceptable 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	Pioneer Memorial Care Center wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is February 24th 2015. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies sanctioned by the Department of Health and Human Services. The plan of correction is prepared and/or executed solely as a requirement by the provisions of Federal and State law.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure physical restraints were used only to treat a medical symptom and failed to ensure the least restrictive device was used for the least amount of time as necessary for 1 of 1 resident (R12 in the sample who utilized wheelchair breaks at the dining room table. Findings include: R12's quarterly Minimum Data Set (MDS) dated 1/20/15, identified R12 was diagnosed with Alzheimer dementia and peripheral vascular disease. The MDS indicated R12 had severe	F 221	Resident #12 was comprehensively assessed for physical restraints on February 12th 2015 and it was determined that no physical restraints be implemented. Intervention put in place to put one brake on one side of the wheelchair PRN while at the dining room table as resident will jut feet out at times causing her to push herself away from the table, which leads to frustration due to not being able to reach her food and dropping	POC approved addendum 3/9/15 SB

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

Melissa Gross RN | Director of Nursing / Acting Admin. 3-6-15

/ deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 cognitive impairment and required extensive assistance with all activities of daily living. The MDS also indicated R12 did not utilize restraints. R12's significant change MDS dated 8/7/14, identified R12 had severe cognitive impairment, required extensive assistance with all activities of daily living and did not utilize restraints. A restraint care area assessment was not completed at the time of the significant change MDS. R12's care plan dated 2/9/15, did not identify R12 utilized restraints nor directed the staff the apply any type of restraint. On 2/8/15, at 6:30 p.m. R12 was observed seated in a wheelchair at the dining room table. R12 was observed to attempt to push back from the table, however, both wheelchair brakes were engaged and locked and the chair did not move. When R12 pushed on the table, the table moved and nursing assistant (NA)-A was observed to place his hand on the table to prevent the table from being pushed into R30 who was seated across from R12. NA-A and licensed practical nurse (LPN)-B were observed to sit at R12's table assisting other residents with their meals. At no time were the staff members observed to release R12's wheelchair brakes. On 2/9/15, at 12:22 p.m. R12 was observed seated at the dining room table with both wheelchair lock brakes engaged. At 1:10 p.m. licensed practical nurse (LPN)-A was observed to unlock the brakes and wheel R12 away from the table. R12 was not observed to attempt to wheel away from the table during the noon meal. LPN-A was observed to sit with other residents at	F 221	food in her lap. Director of Nursing/Acting Administrator held an all staff meeting on February 24th 2015 at which time updated Physical Restraints Policy and Procedure for facility and F221 Regulation were reviewed. Director of Nursing or designee will perform random audits of all units for potential restraint use. If potential restraint use is identified Director of Nursing or designee will do a comprehensive assessment of those residents that are utilizing potential restraints and the information obtained will be brought to the Interdisciplinary Team Meeting to ensure that the least restrictive environment is used for each individual resident. Policy and Procedure for Physical Restraints was updated on 2-16-15. Random Audits started week of 3/2/15 and will be performed 1x/week for 1 month, 2x/month for 2 months, and 1x/month for 3 months. All direct care staff were assigned an education training "Creating a Restraint Free Environment".	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 2 the table during the entire meal assisting other residents. At no time were R12's brakes released during the meal. On 2/10/15, at 7:15 a.m. R12 was observed seated at the breakfast table with both wheelchair brakes locked. R12 was not observed to attempt to leave the table during the meal. At 8:40 a.m. activity aide (AA)-A sat with R12 and provided a one to one activity with R12. At 8:45 a.m. AA-A released the brakes and wheeled R12 to an activity area. At no time during the meal or activity, were R12's brakes released. Staff members NA-B and NA-C were observed to sit at R12's table and assist other residents with the breakfast meals. R12's clinical record lacked documentation related to the use of R12's wheelchair brakes. On 2/10/15, at 9:00 a.m. NA-B and NA-C stated R12's brakes were locked at the meal to ensure she did not leave the table during the meals. The NA's stated they were used to prevent R12 from pushing herself away from the table. On 2/10/15, at 9:10 a.m. registered nurse (RN)-B stated R12 did not utilize a restraint. She stated R12 did not have the ability to unlock the brakes on her own. She confirmed the facility did not use restraints, but since R12 was unable to unlock the breaks on her own, it would be considered a restraint. She stated the use of the wheelchair brakes needed to be looked into. On 2/10/15, at 11:10 a.m. RN-A/unit manager, stated none of the residents were to have both wheelchair brakes locked while at the table. She stated the brakes would be a restraint for the	F 221	The audit information, compliance of training and Policy and Procedure update will be with the Quality Assessment and Assurance Committee. Completion date: 2-24-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 3 residents and the facility was restraint free. She confirmed R12 had not been assessed for the ability to release the wheelchair breaks and if the brakes were on, then R12 would be considered restrained. Review of the Physical Restraint policy dated 2/16/10, did not address locking wheelchair brakes at a table.	F 221	Director of Nursing/Acting Administrator updated Daily Staffing Hours and Census that is required to be posted on a daily basis to include facility name, the current date, total number and the actual hours worked by RN's, LPN's, TMA's and NAR's, and resident census for each shift. This is updated throughout the day as changes are made and located in the main hallway by Director of Nursing office. Quality Assessment and Assurance Committee will review to ensure proper documentation is followed through. An all staff meeting was held on February 24th 2015 to review the changes that were made to the Daily Staffing Posting. Completion date: 2-24-15	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 4 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the nurse posting was accurate regarding the actual hours worked per shift for nursing staff directly responsible for resident care. This had the potential to effect all 59 residents who resided in the facility and any visitors who chose to view this information. Findings include: On 2/8/15, at 1:36 p.m. during the initial tour of the facility, registered nurse (RN)-A was observed to post the Daily Staff Form dated 2/8/15, on a clip outside the director of nursing (DON) office. RN-A stated she completed the form when she realized it had not yet been done that day. Review of the form revealed AM shift to be 6:00 a.m. to 2:30 p.m., PM shift to be 2:00 p.m. to 10:30 p.m. and NOC shift to be 10:00 p.m. to 6:30 a.m. The PM shift indicated seven nursing assistants (NAs) worked a total of 50 hours. Additional shift times were not identified. On 2/9/15, at 8:20 a.m. there were two RNs listed for 15 hours on the day shift and two trained medication assistants (TMA) listed for 17 hours on the PM shift. Additional shift times were not identified On 2/10/15, at 7:05 a.m. there were four RNs listed for ten hours and seven NAs listed for 51 hours on the PM shift. Additional shift times were not identified.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 5 On 2/11/15, at 8:10 a.m. there were five RNs listed for 29 hours on the day shift, four RNs listed for 10 hours and seven NAs listed for 48.5 hours on the PM shift. Additional shift times were not identified. On 2/11/15, at 10:29 a.m. DON stated the night shift on the Evergreen unit completed the posting form and it was updated as changes occurred. The DON stated the form should have been posted prior the start of the day shift on 2/8/15. The DON also confirmed there were additional shift start and end times not reflected on the Daily Staffing form for RNs and NAs for 2/8, 2/9 2/10 and 2/11. The Daily Staffing Form Assignment policy dated 12/15/11 did not provide direction regarding the posting of actual shift hours worked.	F 356		

Addendum
March 09, 2015

Pioneer Memorial Care Center
23028 347th ST SE
Erskine, MN 56535
(218)687-2365

In regard to restraint tag 2510: Staff has done pre-restraint assessment. It will be noted on Care Plan why regular chair does not work for her. Her behaviors regarding pushing her table away and how she becomes frustrated with food dropping on lap and floor when she is allowed to drift away from table. Placing one brake on her wheelchair is the least restrictive environment.

M. Johnson RN
3/9/15

Rec'd
Approved
3/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Pioneer Memorial Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. . Pioneer Memorial Care Center was built in 1985, is one story with a partial basement and was determined to be Type V(111) construction. In 1997 a 1-story addition was constructed to the east of the original building with out a basement, was determined to be Type V (111) construction and which is separated with a 2-hour fire barrier. In 2005 an 1-story addition was constructed to the south of the original building that has a full basement and was determined to be a Type V (111) construction. The facility is protected with a complete automatic sprinkler system and has a fire alarm system with corridor smoke detection and smoke detectors in all common areas, installed. Additional single smoke detectors are in all sleeping rooms of the 2005 addition, the remodeled east wing and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 68 beds and had a census of 60 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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
	245301	A. BUILDING **02 - 2005 ADDITION 02** B. WING _____	**02/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL CARE CENTER	**23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Pioneer Memorial Care Center - 2005 Addition was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Pioneer Memorial Care Center was built in 1985, is one story with a partial basement and was determined to be Type V(111) construction. In 1997 a 1-story addition was constructed to the east of the original building with out a basement, was determined to be Type V (111) construction and which is separated with a 2-hour fire barrier. In 2005 an 1-story addition was constructed to the south of the original building that has a full basement and was determined to be a Type V (111) construction. The facility is protected with a complete automatic sprinkler system and has a fire alarm system with corridor smoke detection and smoke detectors in all common areas, installed. Additional single smoke detectors are in all sleeping rooms of the 2005 addition, the remodeled east wing and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 68 beds and had a census of 60 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING **02 - 2005 ADDITION 02** B. WING _____	**02/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6749

February 24, 2015

Ms. Marlene McGuire, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, Minnesota 56535-9466

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5301024

Dear Ms. McGuire:

The above facility was surveyed on February 8, 2015 through February 11, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at:

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

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 the phone number of email listed above.

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 letter.

Sincerely,

Mark Meath

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

Enclosure(s) 5301s15lic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00469	A. BUILDING: _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 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: On February 8, 9th, 10th, and 11th, 2015, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's	2 000	Pioneer Memorial Care Center wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is February 24th 2015. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies sanctioned by the Department of Health and Human Services. The plan of correction is prepared and/or executed solely as a requirement by the provisions of Federal and State law. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00469	A. BUILDING: _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL CARE CENTER	23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535

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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: On February 8, 9th, 10th, and 11th, 2015, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00469	A. BUILDING: _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 signature." Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health 705 Fifth Street NW, Suite A, Bemidji, MN 56601-2933 c/o Lyla Burkman, Unit Supervisor	2 000	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 which 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.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct	2 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00469	A. BUILDING: _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 302	Continued From page 2 care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided in written or electronic form, a description of facility staff training for the care of residents with dementia/Alzheimer's, categories of staff trained, frequency of training and topics covered in the training. This had the potential to affect all 59 residents residing in the facility and / or resident representatives/families. Findings include: On 2/11/15, at 8:50 a.m. the social service designee (SSD) stated the facility did have dementia / Alzheimer's related information for family members to receive if an admission was going to be the special care unit. However, The	2 302		

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2 302	Continued From page 3 SSD stated there was no documentation to show that the consumers were actually provided the required information. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to ensure the required information for consumers regarding dementia training in the facility was provided. The quality assessment and assurance committee could review the revised document to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure physical restraints were used only to treat a medical symptom and failed to ensure the least restrictive device was used for the least amount of time as necessary for 1 of 1 resident (R12 in the sample who utilized wheelchair breaks at the dining room table. Findings include:	2 510		

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2 510	Continued From page 4 R12's quarterly Minimum Data Set (MDS) dated 1/20/15, identified R12 was diagnosed with Alzheimer dementia and peripheral vascular disease. The MDS indicated R12 had severe cognitive impairment and required extensive assistance with all activities of daily living. The MDS also indicated R12 did not utilize restraints. R12's significant change MDS dated 8/7/14, identified R12 had severe cognitive impairment, required extensive assistance with all activities of daily living and did not utilize restraints. A restraint care area assessment was not completed at the time of the significant change MDS. R12's care plan dated 2/9/15, did not identify R12 utilized restraints nor directed the staff the apply any type of restraint. On 2/8/15, at 6:30 p.m. R12 was observed seated in a wheelchair at the dining room table. R12 was observed to attempt to push back from the table, however, both wheelchair brakes were engaged and locked and the chair did not move. When R12 pushed on the table, the table moved and nursing assistant (NA)-A was observed to place his hand on the table to prevent the table from being pushed into R30 who was seated across from R12. NA-A and licensed practical nurse (LPN)-B were observed to sit at R12's table assisting other residents with their meals. At no time were the staff members observed to release R12's wheelchair brakes. On 2/9/15, at 12:22 p.m. R12 was observed seated at the dining room table with both wheelchair lock brakes engaged. At 1:10 p.m. licensed practical nurse (LPN)-A was observed to	2 510		

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2 510	Continued From page 5	2 510		

unlock the brakes and wheel R12 away from the table. R12 was not observed to attempt to wheel away from the table during the noon meal. LPN-A was observed to sit with other residents at the table during the entire meal assisting other residents. At no time were R12's brakes released during the meal.

On 2/10/15, at 7:15 a.m. R12 was observed seated at the breakfast table with both wheelchair brakes locked. R12 was not observed to attempt to leave the table during the meal. At 8:40 a.m. activity aide (AA)-A sat with R12 and provided a one to one activity with R12. At 8:45 a.m. AA-A released the brakes and wheeled R12 to an activity area. At no time during the meal or activity, were R12's brakes released. Staff members NA-B and NA-C were observed to sit at R12's table and assist other residents with the breakfast meals.

R12's clinical record lacked documentation related to the use of R12's wheelchair brakes.

On 2/10/15, at 9:00 a.m. NA-B and NA-C stated R12's brakes were locked at the meal to ensure she did not leave the table during the meals. The NA's stated they were used to prevent R12 from pushing herself away from the table.

On 2/10/15, at 9:10 a.m. registered nurse (RN)-B stated R12 did not utilize a restraint. She stated R12 did not have the ability to unlock the brakes on her own. She confirmed the facility did not use restraints, but since R12 was unable to unlock the breaks on her own, it would be considered a restraint. She stated the use of the wheelchair brakes needed to be looked into.

On 2/10/15, at 11:10 a.m. RN-A/unit manager,

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2 510	Continued From page 6 stated none of the residents were to have both wheelchair brakes locked while at the table. She stated the brakes would be a restraint for the residents and the facility was restraint free. She confirmed R12 had not been assessed for the ability to release the wheelchair breaks and if the brakes were on, then R12 would be considered restrained. Review of the Physical Restraint policy dated 2/16/10, did not address locking wheelchair brakes at a table. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure potential restraint use is identified. Those residents utilizing potential restraints could be comprehensively assessed and the information brought to the interdisciplinary team to ensure it is the least restrictive alternative for each individual. The information could be shared with the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 510		