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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HZ3T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00443

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/17/2015** (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)
09/30

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

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 06/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/17/2015 (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
04/11/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/03/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245463

June 17, 2015

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

Dear Ms. Watkins:

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

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

Effective June 5, 2015 the above facility is certified for:

105 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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
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

Electronically delivered
June 17, 2015

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

RE: Project Number S5463025

Dear Ms. Watkins:

On May 15, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 30, 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 June 17, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 1, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 5, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 30, 2015, effective June 5, 2015 and therefore remedies outlined in our letter to you dated May 15, 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.

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245463	A. Building B. Wing	6/17/2015

Name of Facility	Street Address, City, State, Zip Code
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **06/05/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **06/05/2015**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **06/05/2015**
ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **06/05/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/05/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/05/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **06/05/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/05/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **06/05/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/05/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	06/17/2015	28035	06/17/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
4/30/2015	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245463	A. Building B. Wing **02 - MAIN BLDG TWO**	6/1/2015

Name of Facility	Street Address, City, State, Zip Code
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **05/22/2015**	ID Prefix	Correction Completed **05/29/2015**	ID Prefix	Correction Completed **05/22/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0018		LSC K0069		LSC K0154	
ID Prefix	Correction Completed **05/22/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0155		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	06/17/2015	27200	06/01/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/30/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245463	A. Building B. Wing 03 - SOUTH BLDG 3	6/1/2015

Name of Facility	Street Address, City, State, Zip Code
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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 Reg. # NFPA 101 LSC K0154	05/22/2015	ID Prefix Reg. # NFPA 101 LSC K0155	05/22/2015	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	06/14/2015	27200	06/01/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/30/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HZ3T

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/30/2015** (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)
09/30

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

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

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

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
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Beth Nowling, HFE NEII — 05/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 06/02/2015 (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
04/11/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/03/2015 Co.

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

Electronically delivered
May 15, 2015

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

RE: Project Number S5463025

Dear Ms. Watkins:

On April 30, 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:

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

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

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

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

<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 June 9, 2015, 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 30, 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 October 30, 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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	04/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		6/5/15

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

Electronically Signed | 05/22/2015

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician was notified of a change in condition related to the development of a pressure ulcer on the right buttocks for 1 of 4 residents (R9) in the sample who were reviewed for pressure ulcers. Findings Include: R9's quarterly Minimum Data Set (MDS) dated 2/20/15, indicated R9's diagnoses included diabetes mellitus, Alzheimer's disease, dementia, anxiety disorder and depression. The MDS also indicated R9 had moderate cognitive ability, impaired motor coordination and required 2 staff assist with bed mobility. The last Braden Scale for predicting pressure sore risk was dated 2/20/15, which indicated R9 was at risk for skin breakdown. The checklist of skin risk factors and interventions dated 2/20/15, indicated R9 was chair fast, had cognitive impairment and incontinent of bowel and bladder. R9's progress notes dated 4/24/15, indicated R9 had an open area that was approximately 1 cm	F 157	1. Jill Baldwin PA notified 5/12/15 of change of skin condition which occurred on 4/24/15 and was documentation as healed 4/29/15 for R9. 2. A skin inspection was conducted on all residents to identify residents with changes in skin condition on 5/21/15. 3. The policy `Change in a Resident¿s Condition or Status¿ was updated stating the facility will notify physician of any change in skin condition resulting in open areas. 4. All of the Licensed Nurses will be educated on the policy Change in a Residents Condition or Status on 5/28/15. Audits of changes of skin condition will be completed monthly x 3 months by DON or designee to assure appropriate notification of physician. Results will be reported at a quarterly Quality Assurance	

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F 157	Continued From page 2 (centimeter) in size on right buttock and treatment was set up for protective barrier cream three times a day. R9's medical record lacked indication the physician was notified of the wound on the right buttocks after it developed. On 4/29/15, at 9:13 a.m. nursing assistant (NA)-F stated R9 required total assistance with cares, will try to feed herself and uses the PAL lift to stand. On 4/29/15, at 1:28 p.m. NA-E stated they try to reposition R9 every 2 hours unless she is in an activity. NA-E stated R9 will sleep in the chair and has difficulty with breathing if in bed. NA-E stated every once in while R9 gets a red bottom, and they put barrier cream on it and tell the nurse. On 4/29/15, at 1:39 p.m. registered nurse (RN)-A verified R9 had an area on her buttocks, it was a 1 cm open area from maceration and they had put protective ointment on it. At 2:03 p.m. RN-A stated the doctor was not notified of the open area on R9's buttocks. RN-A stated if the open area was something like maceration, they would just put barrier cream on it and not notify the doctor. RN-A said it would depend on the size, location, if the area was macerated, for doctor notification. RN-A said if the maceration was the size of a person's palm she would notify the doctor but indicated if it was the size of the tip of a little finger she probably wouldn't notify the doctor. On 4/30/15, at 10:21 a.m. the clinic was contacted to interview the resident's physician. The clinic licensed practical nurse stated the	F 157	Committee meeting and further direction will be taken from this committee.	

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F 157	Continued From page 3 facility should call the doctor about an open area right away. The nurse stated the doctor verified he not aware of an open area and there was no record of a fax being sent. The facility's policy titled: Change in a Resident's Condition or Status, with revision date of 9/2013, indicated the facility should promptly notify the physician and representative of changes in the resident's medical/mental/ condition or status. In addition, notifications will be made within 24 hours of a change occurring unless it is a medical emergency.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents could safely self administer medications after being assessed for 1 of 2 residents (R9) observed to self administer a nebulizer treatment. Findings include: R9's quarterly Minimum Data Set (MDS) dated 2/20/15, indicated R9 had moderately impaired cognition, sometimes understanding others by responding to simple direct communication, and had diagnoses which included diabetes mellitus, Alzheimer's disease, mild mental retardation and	F 176	1. R9 was assessed for self administration of medications on 5/18/15 and deemed inappropriate. 2. An audit was completed on 5/21/15 to identify all resident who self admin meds. This audit included review of documentation to assure assessment for self administration of medications was completed and appropriate. 3. The policy `Self Administration of Medications¿ was reviewed.	6/5/15

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F 176	Continued From page 4 anxiety. R9 was observed on 4/27/15, at approximately 8:10 a.m. sitting in a reclining chair in her room receiving a nebulizer treatment with no staff present. At 8:19 a.m. the licensed staff came back into the room to discontinue the administration of the nebulizer treatment. The Self Administration of Med's (Medication) assessment dated 9/28/09, indicated the resident would not be able to self administer medications due to impaired cognition and impaired motor coordination. Review of R9's Medication Review Report with order date of 9/11/14, indicated R9 was to receive Albuterol sulfate nebulization solution 2.5 milligram/3 milliliters (ml) 0.083% 3 ml inhale orally via nebulizer four times a day as needed for dyspnea (shortness of breath) and may self administer after set up. On 4/29/15, at 12:04 p.m. licensed practical nurse (LPN)-A stated the resident received nebulizer treatments four times a day and verified yesterday she didn't stay in the room with the R9 while the nebulizer treatment was administered. She added she had left the room to help some one else. LPN-A stated the resident didn't have an order to self administer medications. The facility's policy titled: Self Administration of Medications, with review date of 12/2012, indicated the staff and practitioner will assess each resident to determine if they are capable of self administering medications. If it is determined the resident can't safely administer medications the staff will do it for them. In addition, the staff	F 176	4. All Licensed Nurses will be educated on the policy Self Administration of Medication on 5/28/15. Audits will be completed on random residents monthly x 3 months to assure appropriate assessment for Self Administration of Medications. Results will be reported to the quarterly Quality Assurance Committee and further direction will be taken from this committee.	

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F 176	Continued From page 5 and practitioner will periodically (for example during quarterly Minimum Data Set reviews) reevaluate a resident's ability to continue to self administer medications.	F 176		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		6/5/15

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This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to comprehensively assess pressure ulcers at the time of the initial Minimum Data Set (MDS) for 2 of 4 residents (R159, R104) reviewed for pressure ulcers.
Findings include:

R159 was admitted with a pressure ulcer, however, the pressure ulcer was not identified on the admission Minimum Data Set (MDS), therefore a comprehensive assessment skin assessment was lacking.
The admission MDS dated 3/27/15, identified R159 as being at risk for pressure ulcers, however, there were no pressure ulcers staged on the MDS even though there was one identified upon admission. The treatment section of the MDS indicated the resident had a pressure reducing mattress and R159 had an application of a non-surgical dressing applied to areas other than the feet.
The Care Area Assessment (CAA) dated 4/1/15, did not identify any skin assessment as pressure ulcers had not triggered.
R159's care plan dated 3/20/15, identified R159 had a skin care plan to prevent potential skin integrity.
The Braden Scale For Predicting Pressure Sore Risk was completed on 3/20/15. R159 was identified to be at risk for skin breakdown with an

1. R104 was discharged from Pioneer 1/13/15. R159 was discharged from Pioneer Care 4/28/15.

2. Audits of all residents were completed on 5/21/15 to assure that Pressure Ulcer Risk assessments were completed with previous admission, annual, significant change or quarterly assessment.

3. Pressure Ulcer Risk Assessment policy was updated to include assessment completion with admission, quarterly and with significant change. Pressure Ulcer risk assessment will be completed upon admission, and then weekly times 3 weeks, with each additional assessment, quarterly, annually and with significant changes. Nurses will conduct skin inspections weekly to identify changes. Skin conditions and risk factors will be reviewed weekly at the Inter disciplinary meeting, and PRN as risks are identified. MDS accuracy will be reviewed at the interdisciplinary meeting and PRN, for those resident identified with altered skin conditions, and skin risk factors.

4. All RN clinical coordinators were educated on the policies Pressure Ulcer

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F 272	Continued From page 7 acquired score of 15. R159's admission progress notes dated 3/21/15, skin and wound note indicated R159 as having a dressing to the mid left buttock. The progress notes addressing the wound documented: - 4/2/15, "Change Allevyn to buttocks every three days until healed, missed doing it earlier. Sleeping now." - 4/8/15, "Change Allevyn to buttocks every three days until healed one time a day every 3 day(s)." - 4/23/15, "Change Allevyn to buttocks every three days until healed one time a day every 3 day(s) resolved." The progress notes lacked evidence of any wound measurements and the characteristics of the wound. The care plan lacked any revisions and any additional interventions to promote wound healing for the wound that was identified on 3/21/15. The Tissue Tolerance Testing (used to assess appropriate repositioning schedule) form was completed on 3/21/15. The section for off-loading in a chair indicated R159 could go two hours without changing position. The section for repositioning in bed dated 3/23/15, dated indicated R159 could lay in bed for three hours without repositioning. On 3/24/15, the bed positioning schedule indicated R159 could go fours without repositioning. R159 was seen by the physician on 3/23/15, and by the nurse practitioner (NP) on 3/27/15. Neither note made reference to the wound that was identified on 3/21/15. The physician's order dated 3/24/15, directed the staff to, "Change Allevyn to buttocks every three days until healed one time every 3 day(s)." The March 2015 Treatment Administration Record (TAR) indicated the nurses had changed the Allevyn twice. The April 2015 TAR indicated	F 272	Risk Assesssment and Standing Orders for Wound Care Policy on 5/19/15. Random audits will be completed monthly x3 months by DON or designee of completion of Pressure Ulcer Risk Assessment and weekly documentation on pressure ulcers. Results will be reported at quarterly Quality Assurance committee and recommendations from this committee will be followed.	

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the nurses changed the dressing nine times in April. The TARs lacked any evidence of wound measurement and the characteristics of the wound.

During interview on 4/28/15, at 10:07 a.m. registered nurse (RN)-D confirmed R159 was admitted with an Allevyn dressing on her buttocks for a reddened area, and the ulcer was not assessed during her admission assessment process. At 10:25 a.m. RN-D verified that she could not find any documentation to determine what R159 had on her buttocks when she came from the hospital and stated, "We use PRC protocol [Pioneer Care Center] and if the treatment is not working, we update the medical doctor."

During interview on 4/30/15, at 10:55 a.m. RN-D confirmed R159 had a stage one pressure ulcer (skin intact with non-blanchable redness) to her buttocks and stated, "No we were not monitoring it daily, we were only changing the Allevyn every three days, we were not documenting the size, location or pain." RN-D verified the medial doctor should have been notified of the ulcer and stated they usually do rounds 7 or 10 days after admission

During interview on 4/28/15, at 10:44 a.m. the director of nursing (DON) confirmed R159 was admitted with an Allevyn dressing on her buttocks for a pressure ulcer area and stated, "We should find out why it is on there, remove it, find out what is going on, and assess it [buttocks]." DON verified a skin assessment should have been done on admission. She added the plan of care is based off the skin assessment and the medical doctor should be updated. Further more she stated she would expect her staff to follow through with assessing the ulcer, then document on it and update the physician.

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F 272	Continued From page 9 Review of facility policy titled: Standing Orders For Wound Care Protocol, dated 4/28/15, indicated skin care shall be provided according to standardized procedures or specific physician order. The following skin care protocols will be used to provide consistency in the prevention and treatment of skin conditions. Under Pressure Ulcers: Stage one- Redness of intact skin caused by pressure. Is typically non-blanchable. Procedure: relieve pressure, monitor daily, apply protective dressing or ointment if indicated (possibly an adhering or non-adhering hydrocellular pad). Document: size (width and length in cm), location of wound, assessment and management of pain. Review of facility policy titled: Pressure Ulcer Risk Assessment, revised on 2/14, indicated the purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers. Review of facility policy titled: Resident Assessment Instrument, revised 10/2010, indicted a comprehensive assessment of a resident's needs shall be made within fourteen days of the resident's admission. R104's initial MDS dated 12/11/14, identified R104 had diagnoses of ulcer of foot, cellulitis (infection and inflammation of skin tissue/cells) and septicemia (systemic infection in the blood stream). However, section M (skin conditions) of the MDS lacked any identification of R104's foot ulcer, nor any wound or other skin problems. R104's Pressure Ulcer CAA dated 12/16/14, also lacked any mention of R104's foot ulcer.	F 272		

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R104's hospital discharge summary dated 12/4/14, identified R104 had a superficial ulcer of the distal aspect of third right foot toe. The discharge summary also identified R104 had the diagnoses of sepsis with streptococcus algalactia (a bacteria) from right lower leg cellulitis.

A RN assessment dated 12/4/14, revealed no sores on feet or any pressure areas.

R104's physician orders signed 12/29/14, revealed an order to apply a crest pad and gel toe cap to R104's third toes of both feet daily (dated 12/8/14.)

Review of R104's progress notes from 12/4/14 (admission date) to 1/13/15, revealed a plan of care note on 12/9/14, identifying R104 had returned from a clinic appointment with orders to discontinue wound care to right third toe but to continue with cap and toe crest. The progress notes lacked any assessment, evaluation or overall information to R104's toe ulcer prior to the clinic visit.

A clinic referral podiatry form dated 12/9/14, revealed R104's right third toe wound had healed, there was still bilateral lower extremity cellulitis, no clinical signs of infection were noted on foot and direction for R104 to follow up with a practitioner on 12/12/14.

A practitioner progress note dated 12/12/14, revealed R104 had an active problem with a toe ulcer and had a dark erythema of second toe of right foot. The note revealed a plan to start R104 on Bactrim DS 800/160 mg (antibiotic) one table twice daily for 14 days for cellulitis.

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A practitioner progress note dated 12/18/14, revealed R104 had thin skin and chronic venous stasis changes. The note lacked any mention of R104's toe ulcer(s.)

Review of R104's care plan dated 12/16/14, lacked any mention of R104's toe ulcer(s), treatments, or risk for infection.

Review of R104's Medication Administration Record (MAR) dated 12/4/14 to 1/6/15, revealed R104 had been receiving the ordered treatment to the third right toe since admission.

On 4/30/15, at 8:56 a.m. RN-C verified R104's initial MDS did not reflect any skin conditions such as ulcers or wounds in section M of the MDS. RN-C confirmed there had been no assessment of the ulcer, therefore the ulcer was not coded on the MDS nor was it addressed in R104's CAA or care plan. RN-C confirmed the ulcer should
have been coded on the MDS.

On 4/20/15, at 11:47 a.m. the DON stated she would have expected the ulcer to have been addressed on the MDS and the CAA for R104's ulcer of the foot. The DON also stated she expected the MDS coding to reflect the resident's condition and assessments to be completed and accurate for resident concerns/problems.

A facility policy titled: Resident Assessment Instrument revised 2010, directed facility to use the MDS form currently mandated by federal and state regulations to conduct the resident assessment. The policy revealed the purpose was to describe the resident's impairments and capabilities.

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PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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F 272	Continued From page 12 A facility policy titled: Pressure Ulcer Risk Assessment, revised 2014, directed facility staff to complete an admission evaluation to help define initial care plans and approaches. The policy also provided guidelines for the assessment and identification of residents at risk for pressure ulcers.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess pressure ulcers at the time of the significant change of status assessment for 1 of 4 residents (R118) reviewed for pressure ulcers. Findings include: R118's significant change Minimum Data Set	F 274	1. R118 was comprehensively assessed for pressures ulcers 5/1/15. Correction MDS for significant change MDS dated 2/23/15 was completed 5/18/15 to include Stage II pressure ulcer. 2. All residents with pressure ulcers were audited by the RN Clinical Coordinator to assure Significant change	6/5/15

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F 274	Continued From page 13 (MDS) dated 2/23/15, identified R118 was at risk for pressure ulcers, but did not address a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer) to the coccyx identified 2/15/15. Review of the facility form titled: Wound Skin Assessment/Weekly dated 2/18/15, identified the following: - B. observations/data: site: coccyx, type: pressure, length:0.5, width: 0.5, depth: 0.1, stage: 2. - B #5c. granulation tissue (new connective tissue and tiny blood vessels that form on the surfaces of a wound during the healing process). Review of the nurse's progress notes identified the following: - 2/15/15, "Resident's coccyx is starting to break down. Area is reddened and in the middle is a 1.5 cm (centimeter) x 0.5 cm white area with some skin missing." - 2/16/15, "Talked with hospice about pressure sore to coccyx." - 2/20/15, "He does currently have a small, superficial open area from pressure to coccyx." R118's Medical Administration Record review identified an order to check Allevyn dressing on coccyx and replace if needed one time a day for pressure area, start date 2/16/15, and discontinue date of 4/13/15. During an interview on 4/30/15, at 9:28 a.m. registered nurse (RN)-C verified she had completed the significant change MDS dated 2/23/15. RN-C indicated the pressure ulcer on R118's coccyx was not identified in the MDS because it had been marked as healed on the	F 274	MDS was done appropriately on 5/21/15. 3. The policy Change in a Resident¿s Condition or Status was reviewed. 4. Education of the RN MDS Coordinator and RN Clinical Coordinators was completed on 5/19/15 on the policy Change in a Resident¿s Condition or Status. Random audits will be completed by DON or designees of those residents with pressure ulcers monthly x 3 months to assure significant change assessments are conducted as needed. Reports will be reported at quarterly Quality Assurance committee and recommendations from this committee will be followed.	

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F 274	Continued From page 14 skin assessment dated 2/23/15. During an interview on 4/30/2015, at 1:44 p.m. the director of nursing (DON) verified MDS questions to RN-C who completed the MDS assessments. The facility policy titled: Change in a Resident's Condition or Status, revised 9/2013, identified "a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI Instruction Manual."	F 274		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		6/5/15

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F 279	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include non-pharmacological interventions for pain on the plan of care for 1 of 3 residents (R12) reviewed for pain; and failed to address insomnia for 1 of 1 resident (R61) reviewed who is receiving an antidepressant medication for sleep. Findings include: R12's quarterly Minimum Data Set (MDS) dated 3/19/15, identified R12 was cognitively intact and had frequent, severe pain which R12 had received scheduled pain medications, no as needed (PRN) medications and no non-pharmacological interventions for pain management. R12's Pain Care Area Assessment (CAA) dated 9/22/14, revealed R12 had complained of pain during a pain interview and had frequent severe pain in the back. The CAA revealed R12 was receiving scheduled and as needed pain medication, however, the CAA lacked whether non-pharmacological interventions were used or were to be attempted. R12's care plan revised 3/04/15, revealed R12 had pain and used pain medication. However, the care plan lacked individualized non-pharmacological interventions for pain, monitoring and documenting attempts at non-pharmacological interventions. R12's pain assessment dated 3/19/15, revealed R12 had reported frequent, severe pain in which	F 279	1. Non pharmacological interventions were identified and implemented on care plan for R12 for pain management on 4/30/15. Plan of care for R61 was updated 5/19/15 to include insomnia and non-pharmacological interventions for sleep. 2. All residents care plans were audited on 5/21/15 to identify and implement non-pharmacological interventions for pain management as appropriate and to assure that those residents receiving medication for insomnia had a insomnia care plan with non-pharmacological interventions. 3. Pain Assessment and Management Policy was updated. Sleep Assessment policy was developed. 4. All Licensed Nurses will receive education on the policy Pain Assessment and Management and Sleep Assessment Policy 5/28/15. Pain management audits will be conducted on random residents every 2 weeks x 3 months by DON or designee to assure appropriate non-pharmacological interventions are implemented. Audits will be conducted on random residents every 2 weeks x 3 months for insomnia addressed on care plan and non-pharmacological interventions for sleep. Results will be reported at quarterly Quality Assurance Committee and recommendations will be	

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F 279	Continued From page 16 R12 received scheduled Tylenol 650 milligrams (mg) daily, Ultram (non-opioid analgesic) 75 mg four times a day (qid), Celebrex (anti-inflammatory agent) 200 mg daily. The assessment revealed R12 complained of back and knee pain in which the nurse had noted an increase in knee pain. The note indicated R12 would be seen later that day by the primary medical doctor (MD.) The assessment lacked any indication if non-pharmacological interventions were in place and/or were attempted for pain management. R12's pain assessment dated 12/17/14, revealed R12 had reported frequent, severe pain in which R12 received scheduled Tylenol 650 mg daily, Ultram 75 mg qid, Celebrex 200 mg daily for pain. The assessment lacked indication of non-pharmacological interventions. A physician progress note dated 3/19/15, identified R12 had complained of bilateral knee pain that had been bothersome upon sitting and standing. The note further revealed a recommendation for an orthopedic evaluation for possible steroid injections. An orthopedic physician progress note dated 3/26/15, identified R12 had the diagnoses of osteoarthritis of multiple sites, kyphoscoliosis, osteoporosis and pain of left shoulder. The progress note revealed R12 had been seen for bilateral knee pain. Further, the note revealed R12 had bursitis of the left hip and had received a steroid infection to the left greater trochanteric bursa (bony prominence that is on the side of the thigh bone down approximately six inches from the hip joint).	F 279	followed from this committee.	

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F 279	Continued From page 17	F 279		

On 4/29/15, at 7:31 a.m. R12 stated she had pain all of the time in the back and had pain in both knees due to arthritis. R12 verified no non-pharmacological interventions were attempted for pain control, (such as changing position, massage, warm or cool packs, therapeutic 1:1 time.)

On 4/29/15, at 1:33 p.m. nursing assistant (NA)-A revealed R12 had pain daily. NA-A also stated R12 responded well to 1:1 time when she hurt as it would take her mind off of the pain and also helped to voice her feelings.

On 4/29/15, at 1:40 p.m. NA-B stated R12 had pain daily in her back and knees. NA-B stated R12 responded well to 1:1 time by allowing R12 to vent her feelings, though was unaware of any non-pharmacological interventions that were to be used for R12's pain.

On 4/30/15, at 11:21 a.m. registered nurse (RN)-A confirmed R12's care plan did not list any individualized non-pharmacological interventions for pain management. RN-A also confirmed R12 had often refused non-pharmacological interventions, however, was unable to provide documentation of failed attempts.

On 4/3/15, at 11:47 a.m. the director of nursing (DON) stated she would expect non-pharmacological interventions to be care planned and implemented for R12 for pain management /30/2015 11:47:54 AM

On 4/3/15, at 1:41 p.m. the pharmacy consultant (PC) stated the facility staff should be attempting non-pharmacological interventions for pain management for R12 as well as documenting

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F 279	Continued From page 18 effectiveness as well as whether the intervention was accepted by R12. A facility policy titled: Pain Assessment and Management, revised 2010, directed facility staff to implement pain management strategies including non-pharmacological interventions with monitoring and modifying approaches. R61's quarterly MDS dated 3/11/15, identified R61's diagnoses to include Alzheimer's disease, dementia, and depression. The MDS did not identify R61 had received a hypnotic during the assessment period. R61's physician orders dated 3/11/15, identified R61 received Trazadone 50 mg for the diagnoses of insomnia with a start date of 10/8/14. Review of the current care plan with a revision date of 1/5/15, did not address R61's diagnosis of insomnia or direct staff with interventions to assist R61 with sleep. During an interview on 4/30/15, at 11:45 a.m. RN-E verified R61's current care plan did not address insomnia and did not provide staff with any non pharmacological interventions to aid R61 with sleep. During an interview on 04/30/2015, at 1:44 p.m. the DON verified the expectation of R61's care plan to have addressed sleep.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		6/5/15

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F 280	Continued From page 19 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise each resident's plan of care upon development of a pressure ulcer for 1 of 4 residents (R9) reviewed for pressure ulcers. Findings include: R9's quarterly Minimum Data Set (MDS) dated 2/20/15, identified the resident to have moderate cognitive impairment, with diagnoses of diabetes mellitus, Alzheimer's, dementia, anxiety and depression. Review or R9's Braden Scale (a tool used to predict pressure ulcer risk) dated 2/20/15, indicated R9 was at risk for skin breakdown. The checklist of skin risk factors and interventions had	F 280	1. R9 had a skin assessment completed 5/19/15 which included Braden Scale, Tissue Tolerance and Comprehensive Skin Assessment. Care Plan was updated to reflect interventions to prevent skin breakdown. OT will assess for proper positioning in chairs. 2. Skin inspections of all residents were completed by 5/21/15 to identify any pressure ulcers. Audits were completed 5/21/15 for appropriate interventions on the care plan for treatment of pressure ulcers.	

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F 280	Continued From page 20 identified the following risk factors: diabetic, chair fast, cognitively impaired, incontinent of bowel and bladder and moisture. R9's plan of care with a revision date of 3/1/15, directed various interventions to maintain skin integrity, including to reposition every 2 hours with one assist, pressure reducing cushion in wheelchair seat and pressure relieving mattress on the bed. R9 required a PAL lift (mechanical lift to stand) and 1 staff if resident was alert, 2 staff assist and hoyer lift (total body mechanical lift) if resident was lethargic for transfers. In addition, R9 slept in the recliner. The care plan did not address interventions for the pressure ulcer for R9. Review of R9's progress note dated 4/24/15, indicated an open area that is approximately 1 cm (centimeter) in size on the right buttock and treatment was set up for protective barrier cream three times a day. On 4/29/15 at 1:39 p.m.(RN)-A said she was not aware of a pressure area on R9, she had an area on her bottom that was 1 cm (centimeter) open and it was from maceration and they had put protective cream on it. The facility policy titled Standing Orders for Wound Care dated 11/9/12, indicated each skin problem/need, goal and plan developed should be addressed on the care plan. In addition, the standing orders indicated to use a hydrocolloid, hydrocellular,or transparent dressing to a stage 2 (superficial skin loss) area.	F 280	3. Pressure Ulcer Risk Assessment policy was updated to include weekly skin inspections to identify alterations in skin condition. Care Plan Comprehensive policy was revised to ensure revisions of care plan occurs with skin condition changes. Policy states Assessment of resident are ongoing and care plans are revised as information about the resident and the residents condition change. Implementation of interventions for potential/ and altered skin conditions will be reviewed at weekly interdisciplinary team meeting and PRN as risks are identified. 4. All Licensed Nurses will be educated on the policy Pressure Ulcer Risk Assessment, and Care Plans Comprehensive policy on 5/28/15. Random audits will be completed on residents with pressure ulcers for assessments and implementation of interventions monthly x 3 months. Results of audits will be reported to the Quality Assurance committee and recommendations of the committee will be followed.	
F 314	483.25(c) TREATMENT/SVCS TO	F 314		6/5/15

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F 314 SS=D	Continued From page 21 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a skin assessment after developing a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer) to the right buttocks for 1 of 4 residents (R9) reviewed for pressure ulcers. Findings Include: R9 developed a pressure ulcer on the right buttocks on 4/25/15, however, a comprehensive assessment was not completed to address the potential contributing factors to develop an appropriate care plan. R9's quarterly Minimum Data Set (MDS) dated 2/20/15, identified the resident to have moderate cognitive impairment, with diagnoses of diabetes mellitus, Alzheimer's dementia, anxiety and depression. In addition, R9 required extensive assistance of 2 staff for turning from side to side and for positioning of her body while in bed. Review or R9's Braden Scale (a tool used to predict pressure ulcer risk) dated 2/20/15,	F 314	1. Braden Scale, Comprehensive Skin Assessment and Tissue Tolerance test were completed 5/19/15 on R9. 2. Skin inspections of all residents were completed by 5/21/15 to identify any pressure ulcers. Audit was completed 5/21/15 for assessments and for appropriate interventions in treatment of the pressure ulcer. 3. The facility will ensure the problem does not occur by having updated Pressure Ulcer Risk Assessment Policy to include weekly skin inspections to identify alterations in skin condition and implementation of interventions. Change in Resident Condition or Status policy was updated to reflect notifying MD of skin open areas upon identifying areas. Standing Orders for Wound Care Protocol was reviewed and updated to ensure each skin care problem/need is addressed on the care plan and reflected in the charting	

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F 314	Continued From page 22 indicated R9 was at risk for skin breakdown. The checklist of skin risk factors and interventions dated 9/28/09, had identified the following risk factors: diabetic, chair fast, cognitively impaired, incontinent of bowel and bladder and moisture. During observations on 4/29/15, at 7:11 a.m. R9 was in her recliner in her room with feet elevated on the recliner's footrest with eyes closed. At 10:10 a.m. R9 was in the recliner and nursing assistant (NA)-E entered R9's room and had told the resident she would be getting her up and dress her. R9 was placed on the PAL lift (mechanical lift to stand) and was brought into the bathroom. R9's right buttocks was observed to be healed and licensed practical nurse and (LPN)-A applied protective barrier cream to the right buttocks. There was no cushion in the resident's recliner. R9's plan of care with a revision date of 3/1/15, had identified potential for breakdown and directed various interventions to maintain skin integrity which included to reposition every 2 hours with one assist, pressure reducing cushion in wheelchair seat and pressure relieving mattress on the bed. R9 required the PAL lift and 1 staff if resident was alert, 2 staff assist and hoyer lift (total body mechanical lift) if resident was lethargic for transfers. In addition, R9 slept in the recliner versus the bed. However, the plan of care did not address any pressure redistribution device in the recliner or other interventions due to added pressure from sleeping upright. R9's nurse progress note dated 4/24/15, indicated R9 had an open area that was approximately 1 cm (centimeter) in size on the	F 314	weekly. Skin condition and current care plan interventions will be reviewed at weekly interdisciplinary meeting and PRN as risks are identified to ensure appropriate skin preventions and treatment measures are in place. 4. All Licensed Nurses will be educated on 5/28/15 Pressure Ulcer Risk Assessment, Standing Orders for Wound Care Protocol, and Change in Resident Condition or Status policy. Random audits will be completed on residents with pressure ulcers to assure assessments and interventions were implemented appropriately weekly x 3 months. Results of audits will be reported at the quarterly Quality Assurance committee and recommendations of the committee will be followed.	

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F 314	Continued From page 23 right buttock and treatment was set up for protective barrier cream three times a day. However, there was no assessment of the pressure ulcer, nor was the care plan updated. R9's skin assessment dated 9/29/09, identified tissue tolerance (used to determine how long pressure on bony prominence's may result in skin breakdown) indicated R9 was able to tolerate laying and sitting for 2 hours with no alteration in skin integrity and to continue to assist to turn and reposition every 2 hours and as needed. However, a reassessment of the resident's risk factors was not completed following the development of the pressure ulcer. On 4/29/15, RN-A stated R9 had a 1 cm open area on the buttocks and it was from maceration. RN-A confirmed the last tissue tolerance testing was done was on 9/29/09. On 4/30/15, at 10:21 a.m. the clinic was contacted to interview the resident's physician. The clinic licensed practical nurse stated the facility should call the doctor about an open area right away. The nurse stated the doctor verified he was not aware of an open area and there was no record of a fax being sent. The facility policy revised on 2/2014, on Prevention of Pressure Ulcers, provided information regarding identifications of pressure ulcer risk factors and interventions but didn't include when a skin assessment needed to be completed.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		6/5/15

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	245463	A. BUILDING _____ B. WING _____	04/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 24 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate indications for the ongoing use of sleep medication and appropriate monitoring of resident sleep pattern to determine efficacy for the use of the medication, and failed to identify non-pharmacological interventions for 1 of 1 residents (R61) reviewed to receive a sleep medication. Findings include:	F 329	1. R61 was reviewed by consultant pharmacist, reviewing sleep medication and clinical indications on 5/19/15. Sleep study was completed 5/6/15 on R61 and insomnia with non-pharmacological interventions was added to R61¿s care plan 5/19/15. 2. RN Clinical Coordinators audited all residents physician orders and identified those receiving sleep meds on 5/21/15.	

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F 329	Continued From page 25 R61's physician orders dated 3/11/15, identified R61 received Trazodone (a medication for depression sometimes used for insomnia) 50 milligrams (mg) prescribed for the diagnoses of insomnia, with a start date of 10/8/14. The physician orders reviewed since 10/14, indicated an attempt at tapering the dosage had not been attempted. Review of the quarterly Minimum Data Set (MDS) dated 3/11/15, identified R61's diagnoses to include Alzheimer's disease, dementia, and depression. The MDS identified R61 had received an antidepressant medication all 7 days during the assessment period. Review of the current care plan with a revision date of 1/5/15, did not address R61's diagnosis of insomnia or direct staff with interventions to assist R61 with sleep. During an interview on 4/30/15, at 11:45 a.m. registered nurse (RN)-E verified R61's current care plan did not provide staff with non-pharmacological interventions to aid R61 with sleep. RN-E verified the most recent sleep study was completed 10/21/14, and had not been completed quarterly as expected. RN-E verified with review of R61's documentation, it could not be determine if the medication had been effective or not. During an interview on 04/30/2015, at 1:44 p.m. the director of nursing (DON) verified the expectation of R61's care plan to have addressed sleep and weekly documentation of the resident's sleep habits. The DON indicated a sleep monitoring study was to be completed	F 329	3. Sleep Policy was developed. A sleep log will be conducted x 3 nights for the resident receiving sleep medication upon admission, prior to onset of use of sleep medication, and with reduction attempts. For Residents with sleep medication ordered to promote sleep staff will interview /observe resident to determine efficacy of drug use and record finding in Residents progress notes, within the week after start of the medication, and quarterly after the start of medication. Consultant pharmacist will reviewed charts monthly and report any irregularities in initiation of sleep logs and clinical indications for use to the DON. Sedative Hypnotic Dose Reduction assessment form will be presented to the prescribing physician quarterly to determine ongoing clinical indications. 4. All Licensed Staff will be educated on the Sleep Assessment policy on 5/28/15. Random audits of residents using sleep meds, clinical indications, and non-pharmacological interventions will be conducted weekly for 1 month, if no irregularities will audit, monthly x 3 months. Results will be reported to quarterly QA Committee and recommendations of committee will be followed.	

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F 329	Continued From page 26 quarterly for residents receiving a medication for sleep. The requested facility policy was not provided.	F 329		
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. 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.	F 356		6/5/15

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F 356	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nursing hours posting was updated daily to reflect current hours worked. This had the potential to affect all 93 residents who resided in the facility and family / visitors who wished to view this information. Findings include: During the initial tour on 4/27/15, at 11:35 a.m. the nursing hours posting was observed in a plastic sleeve, sitting on the executive assistant's (EA) desk on the left hand corner, directly across from the elevator in the main lobby on the second floor. The posting included the current resident census, facility name, date, hours of labor and each shift of work for registered nurses (RNs), licensed practical nurses (LPNs) and nursing assistants (NAs). However, the posting was dated 4/24/15, and was not updated to reflect the hours worked on 4/27/15. During interview on 4/27/15, at 11:38 EA confirmed the findings that the staff posting did not reflect the current hours and was dated 4/24/15, and stated, "The lady that is responsible for the staff posting is sick today and that's why it didn't get changed." During interview on 4/29/15, at 12:05 p.m. the director of nursing (DON) confirmed the findings that the staff posting did not reflect the current hours and was dated 4/24/15. The DON verified the facility's scheduler was responsible for updating the nursing hours posting during the	F 356	1. On 4/27/15 the Pioneer Care Staffing Report was updated with the appropriated information for that day. 2. The Direct Care Daily Staffing number posting in one area at Pioneer Care located on the 2nd floor by the Administrative Assistance Desk. 3. Reviewed and updated the policy for Posting of Direct Care Daily Staff. Weekdays the Staffing Coordinators will update and keep current the Posting of Direct Care Staffing Numbers, weekends the Nurse Supervisor will update and keep current the Posting of Direct Care Staffing Numbers. 4. Education by DON will be held on 5/28/15 for licensed nurses and staffing coordinators regarding policy. Audits of Direct Care Staff Posting will be completed by the DON or designee weekly x 1 month, if audits unremarkable then audits weekly x 3 months. Results will be reported at the quarterly Quality Assurance committee and recommendations will be followed.	

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F 356	Continued From page 28 week and stated, "She was not here on Monday." The DON also verified the supervisor was responsible for updating the posting on weekends. The DON verified the staff posting should have been updated daily and stated, "It should reflect the right day, should be accurate, and should be changed over the weekend as well." Review of the facility's policy titled: Posting Direct Care Daily Staffing Numbers, revised 8/2006, indicated the facility was to post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the licensed pharmacist reported drug irregularities to the attending physician and the director of nursing for 1 of 1 resident (R16) reviewed to receive a sleep medication.	F 428	1. A sleep study and assessment of effectiveness of Trazadone was conducted for R61 on 5/6/15. 2. All residents receiving sleep medications were identified via physician orders. Audit was conducted to assure a	6/5/15

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F 428	Continued From page 29 Findings include: R61's physician orders dated 3/11/15, identified R61 received Trazadone (a medication for depression sometimes used for insomnia) 50 milligrams (mg) prescribed for the diagnoses of insomnia, with a start date of 10/8/14. The physician orders reviewed since 10/14, indicated an attempt at tapering the dosage had not been attempted. Review of the quarterly Minimum Data Set (MDS) dated 3/11/15, identified R61's diagnoses to include Alzheimer's disease, dementia, and depression. The MDS identified R61 had received an antidepressant medication all 7 days during the assessment period. Review of the current care plan with a revision date of 1/5/15, did not address R61's diagnosis of insomnia or direct staff with interventions to assist R61 with sleep. Review of the monthly pharmacy consultant reviews from 10/14 to current indicated on 10/21/14, the pharmacist documented, "Trazadone added, 11/18/14 sleep log completed -noted to sleep well." There was no further documentation noted regarding the lack of on going sleep monitoring, failure to attempt tapering of the dosage, and lack of care plan non-pharmacological interventions. During an interview on 4/30/15, at 11:45 a.m. registered nurse (RN)-E verified R61's current care plan did not provide staff with non-pharmacological interventions to aid R61 with sleep. RN-E verified the most recent sleep study was completed 10/21/14, and had not been	F 428	quarterly sleep log and assessment was completed on 5/21/15. 3.Policy Sleep Assessment was developed. A sleep log will be conducted x 3 nights for the resident receiving sleep medication upon admission, prior to onset of use of sleep medication, and with reduction attempts. For Residents with sleep medication ordered to promote sleep staff will interview /observe resident to determine efficacy of drug use and record finding in Residents progress notes, within the week after start of the medication, and quarterly after the start of medication. Consultant pharmacist will reviewed charts monthly and report any irregularities in initiation of sleep logs and clinical indications for use to the DON. Sedative Hypnotic Dose Reduction assessment form will be presented to the prescribing physician quarterly to determine ongoing clinical indications. 4.All Licensed Nurses will be educated on Sleep Assessment policy on 5/28/15. Random audits will be conducted on residents receiving sleep meds to assure quarterly sleep logs and assessments are completed monthly x 3 months. Results will be reported at a quarterly Quality Assurance meeting and recommendations of committee will be followed.	

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F 428	Continued From page 30	F 428		

completed quarterly as expected. RN-E verified with review of R61's documentation, it could not be determine if the medication had been effective or not.

During an interview on 04/30/2015, at 1:34 p.m. the pharmacy consultant (PC) indicated the facility should follow their policies regarding medication monitoring/review. The PC could not verify the expectation of a sleep log or study for the use of a sleep medication, however, stated the facility generally performs them. The PC stated if a psychiatrist has ordered the medication "its their specialty... if the med is started they feel it is needed." The PC stated, "Hopefully non-pharms [pharmacological interventions] would be tried for sleep prior to starting a sleep medication." The PC further stated as long as they haven't needed to increase the medication a "routine med [medication] would not need non pharms....the med is working."

During an interview on 04/30/2015, at 1:44 p.m. the director of nursing (DON) verified the expectation of R61's care plan to have addressed sleep and weekly documentation of the resident's sleep habits. The DON indicated a sleep monitoring study was to be completed quarterly for residents receiving a medication for sleep.

The requested facility policy was not provided.

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K 000	INITIAL COMMENTS FIRE SAFETY Building 02 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 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 Care Center was not 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. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2015

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was surveyed as two buildings. Pioneer Care Center is made up of two buildings. Building 02 main building is a 2-story, without a basement and is Type II (111) construction. Building 03 is a 1-story building without a basement, Type V (000). The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 2007 edition. The facility has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 2007 edition. The fire alarm is monitored for automatic fire department notification. The sleeping rooms have smoke detection in them and all hazardous areas have	K 000		

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K 000	Continued From page 2 automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The facility has a licensed capacity of 105 beds and had a census of 101 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had a corridor door that did not meet the requirements of NFPA 101 LSC (00) Section 18.3.6.3.6. This deficient practice could affect the safety of residents, staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 10:00 AM and 2:00 PM on 04/30/2015, it was observed that the loading dock double doors the lead to the corridor had a 1/4 inch gap between the door leafs. The deficient practice were confirmed by the	K 018	Astragals have been ordered from Fargo Paint and glass will be installed on 5/22/15 by Brad Bushinger, Environmental Service Director.	5/22/15

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K 018	Continued From page 3 Maintenance Supervisor (BB).	K 018		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on a complaint received from the Minnesota Department of Health survey team and staff interview, the facility is cooking food that produces grease-laden vapors on a counter top electric grill 6 of 7 days a week basis (not limited), without the proper exhaust hood equipment and extinguishing system in accordance with NFPA 101(00), Section 19.3.2.6 and NFPA 96(98) 1-3.1. This deficient practice could affect residents, staff, and visitors. Findings Include: At 5:35 PM on 04/29/2015, information was received via email from a Minnesota Department of Health (MDH) surveyor notifying me that on 04/29/15 she had witnessed a facility cook frying bacon in a portable griddle that was creating grease laden vapors in the resident dining rooms located in the first floor short stay unit. The deficient practice were confirmed by the Maintenance Supervisor (BB).	K 069	Employee was educated on 5/21/2015 regarding not cooking food that produces grease laden vapors in the household kitchen. Employee received a disciplinary action regarding cooking food that produces grease laden vapors in household kitchens on 5/21/2015. All homemakers and chefs will be educated on not cooking food that produces grease laden vapors in the household kitchens on 5/28/2015. Random audits will be completed every week for 2 months to assure cooking is not being done on household kitchens that produce grease laden vapors. Liane Barton, Activity Coordinator / Jill Fjestad, Registered Dietitian.	5/29/15
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified,	K 154		5/22/15

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K 154	Continued From page 4 and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM to 2:00 PM on 04/30/2015, during record review and an interview with the Maintenance Supervisor (BB), the facility failed to update and provide a complete list of contact information on the fire sprinkler system out of service policy. The policy was lacking the required contact notification information. The deficient practice were confirmed by the Maintenance Supervisor (BB).	K 154	Local Fire Marshal contact information has been added to the Fire Protection System Out Of Service policy 5/11/15. Completed by Brad Bushinger, Environmental Service Director	
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the	K 155		5/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **02 - MAIN BLDG TWO** B. WING _____	**04/30/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 155	Continued From page 5 building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the fire alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM to 2:00 PM on 04/30/2015, during record review and an interview with the Maintenance Supervisor (BB), the facility failed to update and provide a complete list of contact information on the fire alarm system out of service policy. The policy was lacking the required contact notification information. The deficient practice were confirmed by the Maintenance Supervisor (BB).	K 155	Local Fire Marshals Contact information has been added to the Fire Protection Out Of Service policy 5/11/15. Completed by Brad Bushinger, Environmental Services Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **03 - SOUTH BLDG 3** B. WING _____	**04/30/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY Building 03 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 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 Care Center was not 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. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **03 - SOUTH BLDG 3** B. WING _____	**04/30/2015**

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was surveyed as two buildings. Pioneer Care Center is made up of two buildings. Building 02 main building is a 2-story, without a basement and is Type II (111) construction. Building 03 is a 1-story building without a basement, Type V (000). The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 2007 edition. The facility has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 2007 edition. The fire alarm is monitored for automatic fire department notification. The sleeping rooms have smoke detection in them and all hazardous areas have	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **03 - SOUTH BLDG 3** B. WING _____	**04/30/2015**

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

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K 000	Continued From page 2 automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The facility has a licensed capacity of 105 beds and had a census of 101 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM to 2:00 PM on 04/30/2015, during record review and an interview with the Maintenance Supervisor (BB),	K 154	Local Fire Marshal contact information has been added to the Fire Protection System Out Of Service policy 5/11/15. Completed by Brad Bushinger, Environmental Service Director	5/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **03 - SOUTH BLDG 3** B. WING _____	**04/30/2015**

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K 154	Continued From page 3 the facility failed to update and provide a complete list of contact information on the fire sprinkler system out of service policy. The policy was lacking the required contact notification information. The deficient practice were confirmed by the Maintenance Supervisor (BB).	K 154		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the fire alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM to 2:00 PM on 04/30/2015, during record review and an interview with the Maintenance Supervisor (BB), the facility failed to update and provide a	K 155	Local Fire Marshals Contact information has been added to the Fire Protection Out Of Service policy 5/11/15. Completed by Brad Bushinger, Environmental Services Director.	5/22/15

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K 155	Continued From page 4 complete list of contact information on the fire alarm system out of service policy. The policy was lacking the required contact notification information. The deficient practice were confirmed by the Maintenance Supervisor (BB).	K 155		