



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

July 29, 2020

Administrator  
Pioneer Care Center  
1131 South Mabelle Avenue  
Fergus Falls, MN 56537

RE: CCN: 245463  
Cycle Start Date: July 28, 2020

Dear Administrator:

On July 28, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The CMS-2567 is being electronically delivered.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

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

cc: Licensing and Certification File

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

PRINTED: 07/29/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245463</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>PIONEER CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments  A COVID-19 Focused Infection Control survey was conducted 7/28/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was in compliance.  Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.  Although no plan of correction is requires, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS  A COVID-19 Focused Infection Control survey was conducted 7/28/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was in compliance.  Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.  Although no plan of correction is requires, it is required that the facility acknowledge receipt of the electronic documents.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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