DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 26, 2022

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

RE: CCN: 245463
Cycle Start Date: March 24, 2022

Dear Administrator:

On April 24, 2022, we notified you a remedy was imposed. On April 27, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 22, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 24, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 7, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 24, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 22, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us
cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 26, 2022

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

RE: CCN: 245463
Cycle Start Date: March 24, 2022

Dear Administrator:

On April 24, 2022, we notified you a remedy was imposed. On April 27, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 22, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 24, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 7, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 24, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 22, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us
cc: Licensing and Certification File

Electronically delivered
April 7, 2022

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

RE: CCN: 245463
Cycle Start Date: March 24, 2022

Dear Administrator:

On March 24, 2022, a survey was completed at your facility by the Minnesota Department(s) 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 24, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective.June 24, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 24, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 24, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Pioneer Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 24, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 24, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/21/22, to 3/24/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/21/22 to 3/24/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5463079C (MN00072579). H5463080C (MN00073495). H5463081C (MN00080146). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/14/2022

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 _____ B. WING _____	C 03/24/2022

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	Continued From page 1 regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be	F 550		4/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 550	Continued From page 2 free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure assistance was provided to maintain dignity for 1 of 1 resident (R15) with facial drooling in a public area who was reviewed for dignity. Findings include: R15's quarterly Minimum Data Set (MDS) dated 12/23/21, indicated R15 had severe impaired cognition. The MDS identified R15 had diagnoses which included: aphasia (impaired communication), dementia, and depression. R15's MDS indicated R15 required extensive assistance of one staff with personal hygiene, dressing, eating, locomotion, transfers, bed mobility, and total dependence of two staff with toileting. R15's care plan dated 1/31/22, included a focus area related to activities of daily living self-care deficit and instructed staff to offer ice chips to manage salivary excess problem and monitor for signs and symptoms of dysphagia (swallowing difficulty): pocketing, chocking, coughing, drooling. The care plan indicated R15 was totally dependent on one staff for personal hygiene and oral care. During an observation on 3/21/22, at 6:25 p.m. nursing assistant (NA)-I removed R15 from the dining room table and pushed him in the wheel	F 550	Staff addressed R 15 drooling, by cleaning face and replacing soiled clothing protector with a clean clothing protector 3/23/2022. Care plan was reviewed, and updated, with family and resident participation, addressing residents drooling, including direction on use of clothing protectors, and wiping saliva from mouth. All residents residing at Pioneer Care Center are at risk for being treated in an undignified manner, as all residents are vulnerable adult. Each residents Care Plan was reviewed to ensure the resident is being cared for in a manner that promotes and enhances his or her sense of wellbeing, level of satisfaction with life, and feeling of self worth and self esteem. Dignity policy was reviewed. All staff will be educated on this policy by April 22, 2022. The Director of Nursing or her designee will conduct random audits to ensure appropriate dignified individualized interventions are in place in the residents Plan of Care. This will occur weekly x 4 weeks, every other week for 1 month, and monthly for 2 months. The results of these audits will be brought to the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 550	Continued From page 3 chair over to the rocker recliner in the resident lounge. R15 had on a cloth protector fastened around his neck soiled with food and cream colored drool. R15 had a moderate amount of cream colored drool dangling from his mouth and spreading onto his chin. NA-I assisted R15 into the rocker recliner and walked away. NA-I was not observed to assist R15 with clearing away the facial drooling. During observations on 3/22/22, at 1:30 p.m., 2:00 p.m., 2:30 p.m., 3:00 p.m. and 3:47 p.m. R15 was seated in a rocker recliner in the resident lounge along with three other residents. R15 had a soiled cloth protector positioned across his chest and fastened around his neck with brownish stains present on it. R15 had a moderate amount of thick frothy/foamy cream colored drool that dripped down from his mouth onto his chin. At 4:46 p.m. NA-H walked over to R15, looked at him and walked away. NA-H was not observed to assist R15 with changing the soiled cloth protector or with clearing away the drainage from his mouth. During an observation on 3/22/22, at 6:27 p.m. NA-I pushed R15 in the wheel chair to the lounge area and assisted him into the rocker recliner and NA-I walked away. R15 had a moderate amount of cream colored frothy/foamy drool coming out of his mouth which had run down onto his chin, and dripped onto his chest cloth protector. R15's clothing protector had been positioned off to the right side of his chest and the dark blue shirt underneath was noted to be soiled from his neck area down to the abdominal area. NA-I was not observed to assist R15 with changing the soiled clothing protector or with clearing away the facial drooling.	F 550	Improvement Committee for review and further direction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 550	Continued From page 4 During an observation on 3/22/22, at 6:35 p.m. R15 was seated in a rocker recliner in the resident lounge and had a large amount of drool substance hanging from his chin which spread down onto his clothing protector. NA-M walked by R15 and did not assist him with clearing away the facial drooling. At 6:39 p.m. NA-K walked by R15 and did not assist him with clearing away the facial drooling. At 6:40 p.m. NA-M walked by R15 again and did not stop to assist him with clearing away the drool. R15's shirt was noted to be wet and soiled with drool and food. During an interview on 3/23/22, at 2:15 p.m. NA-J indicated staff were expected to remove R15's clothing protector after every meal and should have been replaced with a clean one. NA-J stated R15's drool went down his face and would have made him very upset and was considered to be a dignity issue. During an interview on 3/23/22, at 2:32 p.m. NA-L stated staff were expected to change R15's clothing protector when it had become soiled. NA-L indicated R15 was unable to wipe off his own face and staff were expected to stop and offer assistance as needed. NA-L stated R15 drooled a lot and the clothing protector looked nasty, wet, and would have been considered a dignity issue and caused embarrassment for R15. During an interview on 3/23/22, at 2:48 p.m. NA-I stated R15 drooled a lot and his clothing protector would become soaked with the drooling. NA-I verified staff were expected to assist R15 when needed and the clothing protector should have been changed when soiled. NA-I indicated R15 was not able to do a whole lot by himself and	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 550	Continued From page 5	F 550		

relied on staff to assist him. NA-I stated staff were expected to provide R15 with personal cares and to do what they could to promote dignity.

During an interview on 3/24/22, at 12:51 p.m. a homemaker/activity aid (HA)-A stated she had known R15 many years ago and he would have wanted the drool to be cleared away. HA-A indicated it would have been a dignity issue for R15.

During a phone interview on 3/24/22, at 1:56 p.m. family member (FM)-B stated the excessive drooling saturated his shirt, and clothing protector and was not a good thing for R15. FM-B compared the excessive drooling to a baby who sat in a wet diaper and it would have definitely made R15 feel terrible. FM-B stated R15 had been prone to neatness and the excessive drooling on the face and chest area made him feel awful and really bothered him. FM indicated other family members had commented to her about how bad the stains present on his clothing protector and clothing had looked when they had visited him.

During an interview on 3/24/22, at 2:54 p.m. with director of nursing (DON) stated staff were expected to have provided assistance during rounds to R15 and should have offered to change his clothing protector and shirt after it became soiled. DON indicated it was most certainly a dignity issue.

Review of the facility policy titled "Dignity" dated February 2021, identified each resident would have been cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feeling of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 550	Continued From page 6 self-worth and self esteem. The staff were expected to assure the residents were treated with dignity and always respected.	F 550		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of	F 567		4/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 567	Continued From page 7 the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents had access to petty cash on weekends and holidays for 1 of 1 resident (R65) who had a personal funds deposited with the facility. This had the potential to effect all 27 residents who utilized a personal funds account. Findings include: On 3/21/22, at 1:40 p.m. R65 verified she had a personal funds account with the facility. R65 stated she has not had any problems getting money out her account, except for on weekends and holidays. R65 indicated the facility had a debit card that all residents could use however facility staff had to be with you to have access to the pin number to even use the debit card. On 3/24/22, at 12:49 p.m. the accounts receivable specialist (ARS) confirmed the findings and indicated the facility had cash boxes located down stairs at the receptionist desk and the keys were hidden. ARS stated they recently moved the cash boxes and verified other staff did not have access to the keys or where they were located for resident to have access to their money. The ARS indicated residents had to use the facility debit card which the facility social worker and activity staff had access to for resident accounts on the	F 567	Resident Trust account funds were made available for R 65 on weekends. R 65 was educated on the process of requesting and receiving funds. Identified those residents at risk of being affected by by querying PCC report, Trust – Current Account Balance. This report indicates those residents with active Resident Trust Accounts. Those residents listed were educated on the process of requesting and receiving funds from their Trust Account. Resident Trust Account (RTA) – Staff Protocol policy was updated. Update included direction - cash is kept in the Short Stay Medication Room for resident access after Business Hours, Charge Nurse may access this money at the resident request. Admission Information updated to include fund availability to residents 7 days a week, 24 hours a day. All staff will be educated on this policy, and Admission Information update by April 22, 2022 The Director of Nursing or her designee will conduct random audits to ensure staff knowledge of how to access Resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 567	Continued From page 8 weekends if staff were available. ARS stated she was not aware of any other means residents would have access to their money. On 3/24/22, at 1:21 p.m. the administrative assistant (AA) confirmed residents who had a trust account with the facility would have to see her to withdraw money out of their accounts. The AA indicated the money drawer was locked at night, on the weekends and holidays when she was not present in the facility. The AA stated residents were able to withdraw money out of their accounts Monday through Friday however AA was not sure if the residents were able to withdraw money out of their accounts on the weekends and holidays. The AA indicated she was not aware of any other staff members who had access to the money boxes when she was not present in the building. On 3/24/22, at 2:10 p.m. the administrator confirmed the above findings and stated she would expect the receptionist to be available during the week, so resident's would have access to their money and on the weekends staff should have been utilizing the money box which contained 100 dollars on the short term stay unit. Review of the facility policy titled Resident Trust Account (RTA) - Staff Protocol undated, indicated during business hours, staff would forward the withdrawal request to the administrator assistant, who was authorized to handle the transaction. The administrative assistant would verify that sufficient funds were available in the RTA and completed the transaction. After business hours staff would forward the request to the charge nurse, who was authorized to handle transactions. The charge nurse would verify that	F 567	Trust Account money upon resident request. This will occur weekly x 4 weeks, every other week for 1 month, and monthly for 2 months. The results of these audits will be brought to the Quality Improvement Committee for review and further direction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 567	Continued From page 9 sufficient funds were available in the RTA and completed the transaction.	F 567		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance with routine grooming cares which included facial hair removal for 1 of 1 residents (R7) who required assistance with grooming and personal hygiene. Findings include: R7's annual Minimum Data Set (MDS) dated 12/15/21, identified R7 had severe cognitive impairment and diagnoses which included heart failure, cataracts (clouding of eye lens which may cause visual impairment) and arthritis. R7's MDS indicated R7 required extensive assistance with personal hygiene and assistance with bathing. R7's care plan, revised 3/22/22, identified R7 had an activities of daily living (ADL) self-care performance deficit related to activity intolerance, fatigue, and impaired balance. R7's care plan indicated R7 required assistance with bathing and personal hygiene. R7's care plan intervention revised on 3/22/22, identified R7 refused at times to have chin hair removed and staff were expected to ask R7 on her bath day if she would like them shaved or plucked.	F 677	R 7 refused to have her facial hair removed. Care plan was updated to reflect her preference and refusal of facial hair removal. All residents residing at the Care Center have the potential to be affected as they all require assistance with ADL's. Each resident Care Plan was reviewed for direction on facial hair removal. Each resident was examined by the Director of Nursing or her designee to assure facial hair is groomed/ removed according to the individuals care plan. Shaving/ Care of Facial Hair of the Resident policy was reviewed. All nursing staff will be educated on the policy by April 22nd, 2022. The Director of Nursing or her designee will conduct random audits to ensure appropriate delivery of care if completed in regards to facial hair grooming. This will occur weekly x 4 weeks, every other week for 1 month, and monthly for 2 months. The results of these audits will	4/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 677	Continued From page 10 On 3/21/22, at 2:56 a.m. R7 was seated in her recliner in her room with the door open. R7 was alert and dressed in street clothes. R7 had 5-8 long white facial hairs approximately ten (10) to twelve (12) millimeters (mm) in length present along the lower level of her chin and under her chin. On 3/22/22, at 9:57 a.m. R7 was seated in her recliner, feet on the floor with one leg crossed; her eyes open dressed in street clothes. R7 continued to have 5-8 long white facial hairs approximately 10-12 mm in length present along the lower level of her chin and under her chin. On 3/22/22, at 3:39 p.m., R7 was seated in her recliner and continued to have 5-8 long white facial hairs approximately 10-12 mm in length present along the lower level of her chin and under her chin. On 3/22/22, at 3:48 p.m. a phone interview was completed with R7's family member (FM)-A. FM-A confirmed R7 always plucked her facial hairs in the past, however indicated that she had not done them herself after she began to decline both physically and cognitively. FM-A stated she would like staff to help R7 keep her facial hair removed. On 3/22/22, at 3:59 p.m. licensed practical nurse (LPN)-A confirmed R7 had long white facial hairs, and indicated she thought R7 removed them herself. LPN-A indicated staff assisted residents to remove facial hair on bath days, or on days between if needed. On 3/23/22, at 11:11 a.m. NA-B indicated R7 was independent with most of her cares, however R7	F 677	be brought to the Quality Improvement Committee for review and further direction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 677	Continued From page 11	F 677		

required more assistance on bath days with dressing, bathing and hygiene. NA-B stated on other days they did not assist her very much with cares unless needed. NA-B stated their usual practice included assisting residents with facial hair removal using residents' personal electric razors, or they could have used the facility's disposable razors. NA-B entered R7's room, then returned and confirmed R7 had long white facial hairs present on her chin. NA-B stated it was R7's birthday today, and indicated R7 should have had her facial hairs removed.

On 3/23/22, at 2:15 p.m. registered nurse, clinical coordinator (CC)-A confirmed R7 had long white facial hairs present on her chin. CC-A stated she became aware of R7's long facial hairs on 3/22/22. CC-A confirmed she reviewed R7's electronic health record, and there was no documentation of R7's refusal of facial hair removal or preferences prior to 3/22/22.

On 3/24/22, at 8:50 a.m. director of nursing (DON) confirmed the facility had a grooming policy, and stated when staff noticed longer facial hair, she expected they would offer to assist the residents with removing the hair. DON stated when a resident refused to allow staff to assist them with removal of the facial hair, she would expect the staff re-offer to remove the facial hair and to document if refused. DON indicated she expected the resident's care plan to be updated with their grooming preferences.

The facility policy titled Shaving/Care Of Facial Hair Of The Resident, revised 2/2018, instructed staff to review the resident's care plan to assess for any special needs/requests of the resident example (ex)-requests for beard, requests of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 677	Continued From page 12 tweezering facial hair. The policy identified staff were to document if the resident refused the treatment, the reason(s) why and the intervention taken. The policy identified the supervisor should be notified if the resident refused the procedure.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement pressure relieving interventions for 1 of 1 resident (R33) reviewed for current pressure ulcers. Findings include: R33's quarterly Minimum Data Set (MDS) dated 1/19/22, identified R 33 had severely impaired cognition and had diagnoses which included dementia, coronary artery disease (CAD), and muscle weakness. The MDS indicated R33 required extensive assistance with toilet use, personal hygiene, dressing, transfers, and	F 686	R 33 Braden assessment, and Tissue Tolerance Test were conducted. Care Plan was reviewed to ensure appropriate pressure reducing measures. Pressure reducing interventions were implemented, per care plan. Braden assessments were conducted on all residents to determine risk for skin breakdown. A skin inspection was conducted on all residents to determine signs of skin breakdown. Residents with moderate to high risk	4/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 686	Continued From page 13 locomotion. The MDS identified R33 was at risk for pressure ulcers and had the following preventive treatments in place: pressure relieving device on bed and wheel chair. The MDS identified R33 had no behaviors or refusals of care during the seven day look back period. R33's current care plan revised 3/3/22, revealed R33 was dependent on staff for repositioning and turning in bed every 2 hours when sitting and every 4 hours while laying, required the use of a mechanical lift for transfers, and staff assistance for all mobility. R33's care plan revealed various interventions to prevent impairment to skin integrity which included: good nutrition and hydration to promote healthier skin, pillows to protect the skin while in bed. The care plan did not identify any further pressure relieving interventions such as pressure relieving boots or heel cup protector. R33's current nursing orders dated 3/24/22, identified: -Monitor left heel twice a day (BID). Cover with heel cup dressing update MD (medical doctor) if it worsened. Discontinue when healed. Ordered on 3/18/22. -Float heels or apply pressure relieving boots to bilateral feet every shift for skin alteration. Ordered on 3/18/22. -Cleanse right lateral ankle ulcer per facility protocol. Apply anasept gel to wound bed, cover with hydrocolloid, and change every other day. Ordered on 3/9/22. The undated nursing assistant (NA) Kardex (care	F 686	scoring on the Braden assessment, and residents with wounds care plans were reviewed to determine appropriateness of pressure reducing interventions. Audits were completed with residents with moderate to high risk scoring on the Braden assessment, and residents with wounds to assure appropriate pressure relieving interventions were in place according to resident Care Plan. Dressings, Dry/ Clean , and Pressure Ulcers/Skin Breakdown – Clinical Protocol policies were reviewed and updated. Updates include New Wound Checklist. All nursing staff will be educated on the policy by April 22nd, 2022. The Director of Nursing or her designee will conduct random audits to ensure appropriate pressure reducing interventions are in place. This will occur weekly x 4 weeks, every other week for 1 month, and monthly for 2 months. The results of these audits will be brought to the Quality Improvement Committee for review and further direction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 686	Continued From page 14	F 686		

guide) revealed R33 was totally dependent on staff for repositioning and turning every 2 hours while sitting and every 4 hours while laying. The guide indicated R33 was to be fully reclined in tilt in space wheelchair while resting.

The Kardex lacked any further pressure relieving interventions.

R33's Braden Scale dated 1/19/22, indicated score of 14.0 which identified R33 was at moderate risk for pressure sores.

During an observation on 3/21/22, at 12:38 p.m. R33 laid in a low bed on her right side. R33 had a pressure relieving boot on left foot only. R33's lateral side of her right foot rested on the mattress. The other pressure relieving boot was located at the end of the bed. R33's feet had blue socks on.

During an observation on 3/22/22, at 8:46 a.m., 9:30 a.m., and 9:55 a.m. R33 laid in bed on her right side without pressure relieving boots on her feet. R33's right leg was bent upwards and the left leg stretched out. R33's right outer lateral part of her foot and the left heel rested on the mattress. One of R33's pressure relieving boots was located on top of the blankets against the wall and the other one was located at the end of the bed.

During an observation on 3/22/22, at 3:00 p.m. R33 sat in her wheel chair in the resident lounge. R33's feet were elevated and both heels rested on the platform with black socks on and without pressure relieving boots present on either foot.

During an observation on 3/22/22, at 3:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 686	Continued From page 15	F 686		

nursing assistant NA-H and NH-I entered R33's room with a total lift machine (Hoyer). R33 laid in her bed on her right side with black socks on both feet and without pressure relieving boots on. R33's right leg was bent upwards and the left leg was straight and stretched out. R33's right outer lateral part of her foot and the left heel rested on the mattress. One of R33's pressure relieving boots was located on top of the blankets against the wall and the other one was located at the end of the bed. NA-H and NH-I hooked the loops from the hoyer to the lift sheet located underneath R33. NA-I picked up R33's feet around the heal area of both with her right hand and R33 moaned out-loud. NA-I stated, "oh does that hurt? I am sorry."

During an observation on 3/23/22, at 7:12 a.m. R33 laid in a low bed with eyes closed on her right side with both legs slightly bent. R33 had black socks on her feet without the pressure relieving boots on. R33's left inner lateral part of the left foot rested on the mattress and the outer lateral part of the right foot rested on the mattress. R33 was observed to slide her feet back and forth on the mattress during this observation.

During an observation and interview on 3/23/22, at 9:02 a.m. licensed practical nurse (LPN)-B entered R33's room to assess her feet. R33 was seated in her wheel chair with head up at 90 degrees, both feet elevated, and heels rested on the foot rest. R33 had black socks on both feet and a pressure relieving boot on the left foot only. LPN-B removed the dressing from the lateral side of the right foot. LPN-B stated the open area was approximately 0.5 centimeters (cm), with granulation tissue on the moist outer edges,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 686	Continued From page 16 yellow- green area in the bed of the wound, and moderate amount of serous drainage. LPN-B cleansed off the area with dermal wound cleanser, wiped it with a clean paper towel, and stated the whitish scab came off and was able to see a pink wound bed at the bottom. LPN-B indicated the wound was very superficial, approximately 1 millimeter in depth and was healing. LPN-B applied the Anased Gel in wound bed, a hydrocolliod wound dressing, and an Allevyn dressing to cover it. LPN-B removed R33's sock from the left heel and the heel cup had not been applied. LPN-B verified the heel cup had not been applied and stated it should have been placed on the left heel to protect it and was unsure how long it had been off. The heel cup was noted to be on R33's dresser. LPN-B stated the left heel had an open blister approximately 1 cm. in size and the surrounding skin was pink. LPN-B indicated the left heel did not have any treatments and applied the heel cup with a sock over it. LPN-B did not apply the pressure relieving boot to the left foot. LPN-B washed his hands and exited the room. During an observation and interview on 3/23/22, at 10:40 a.m. R33 was seated in her wheel chair at 90 degrees with head drooped forward, and eyes closed in the resident lounge. R33 had a pressure relieving boot present on the left foot, black socks on both feet and no pressure relieving boot noted on the right foot. R33's right heel rested on the foot platform that was slightly elevated. Registered nurse (RN)-C pushed R33 in her wheel chair back to her room. R33's other foot protector boot was noted to be on top of a chair in 33's room. RN-C removed the pressure relieving boot and black sock from the left foot and the black sock from the right foot. RN-C	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 686	Continued From page 17	F 686		

stated the right lateral foot wound measured 1.5 cm by 1.0 cm and depth 1.0 cm. with circular edges pink and well defined, 100 percent slough (Slough is necrotic/dead tissue that needs to be removed from the wound for healing to take place), wound bed had epithelial pink tissue, surrounding skin had no significant discoloration and moderate amount of clear drainage. RN-C stated the overall condition of the ulcer had improved with no signs of infection noted. RN-C indicated she considered the ulcer to be an arterial type wound. RN-C replaced the dressing to the lateral side of the right foot. RN-C then removed the black sock and heel protector cup and measured blister located on R33's left heel. RN-C stated the open blister on the left heel measured 2.5 cm by 3 cm, surrounding skin intact and no drainage noted. RN-C indicated the last time she had measured the wound it was 4.5 cm by 3.0 cm, and stated it had improved since then. RN-C placed the heel proctor cup to the left foot and secured it with the foot protector boot.

Review of R33's wound consultation dated 3/4/22, titled Wound Care Skin Integrity, and Evaluation identified right lateral ankle, open wound, non-pressure, serosanguinous drainage, and size 1.5 cm by 1.5 cm, depth undermined. Treatment interventions: 1. Cleanse wound per facility protocol. 2. Apply anasept gel to wound bed. 3. Cover with hydrocolloid. 4. Change every other day.

Review of weekly skin assessments from 3/2/22, through 3/16/22, identified:

-On 3/2/22, right outer foot pressure ulcer facility acquired, 1.0 cm by 1.0 cm, unstagable, necrotic tissue present, dry, no drainage, infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 686	Continued From page 18	F 686		

suspected, inflammation/induration present, and pinkish-red tender peri wound with well defined edges. Preventive measures: pressure relieving mattress to bed and pressure relieving boot to right foot.

-On 3/9/22, right outer foot pressure ulcer facility acquired, 1.0 cm by 1.0 cm stage 3, improving , granulation tissue present, moist serous drainage .4 cm by .4 cm whitish area to center of wound, drainage, and pinkish-red tender peri wound with well defined edges with no signs of infection noted. Antibiotic completed today. Preventive measures: pressure relieving mattress to bed and pressure relieving boot to right foot.

-On 3/17/22, right outer foot pressure ulcer facility acquired, 1.0 cm by 1.0 cm depth 0.1 cm stage 3, and also a left heel blister 4.5 cm by 3.0 cm. improving, dry, no signs of infection. Preventive measures: pressure relieving mattress to bed and pressure relieving boot to right foot and heel cup under left heel to relieve pressure.

During an interview on 3/23/22, at 2:15 p.m. NA-J stated she relied on the care sheets daily located in each resident closet to care for each resident. NA-J verified the heel cup protector and pressure relieving boots were not included on the care sheet for R33.

During an interview on 3/23/22, at 2:32 p.m. NA-L stated she relied on the care sheets quite a bit to care for each resident. NA-L indicated she had been aware R33 had a dressing change and staff were expected to apply the white protector boot on the right foot at all times.

During a phone interview on 3/24/22, at 9:35 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 686	Continued From page 19 with R33's primary care physician (PCP)-A stated R33 had been at risk for skin break down and presently had an ulcer that became infected. PCP-A verified he expected staff to have put in place the following interventions to prevent pressure on her feet: position changed at least every couple to three hours and pressure relieving boots. Review of a facility policy dated September 2013, titled Dressing, Dry/Clean directed the staff nurse to record in the resident's medical record, treatment sheet or designated wound after inspecting the wound: wound appearance, all assessment data to include wound bed color, size, and drainage.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions to prevent further falls for 1 of 1 resident (R 66) who had multiple falls in the facility. Findings include: R66's quarterly Minimum Data Set (MDS) dated	F 689	R 66 fall interventions on resident Care Plan were reviewed for appropriateness. Gripper socks were applied per CP. A Fall Risk Assessment was completed for each resident to determine those at risk of falls. Care Plans were audited for appropriate for fall inventions, related to results of Fall Risk assessment. Audits	4/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 689	Continued From page 20 3/3/22, identified R66 had moderately impaired cognition and had diagnosis which included cerebral vascular accident (CVA) and hemiparesis. The MDS identified R66 required extensive assistance with activities of daily living (ADL's) which included, bed mobility, transfers, toileting, ambulation, and locomotion. The MDS identified R66 required physical assistance to maintain balance during transition, ambulation, toileting and had one-sided upper and lower extremity impairment. The MDS revealed R66 has two falls with no injury since the last required assessment. R66's admission Care Area Assessments (CAA), dated 9/3/21, identified R66 had moderately impaired cognition and had diagnosis which included left sided weakness due to CVA, hx of polio (virus that may cause paralysis), Guillan Barre syndrome (autoimmune disorder in which a person's own immune system damages the nerves causing muscle weakness). R66's CAA identified R66 required extensive assistance with ADL's. The CAA identified R66 was a potential risk for falls related to balance problems and a recent fall. Review of R66's most recent fall risk assessment dated 3/3/22, identified R66 was at high risk for falls related to impaired mobility, impaired cognition,urinary urgency and impulsiveness. Review of R66's current care plan revised 3/18/22, revealed R66 had limited mobility and required assistance with transfers and toileting. The care plan revealed R66 was at high risk for falls related to de-conditioning and gait/balance problems. R66's care plan listed various fall interventions which included; ensuring the urinal	F 689	were conducted to ensure proper application of appropriate fall interventions. Falls and Fall Risk Managing, and Care Plans Comprehensive Person – Centered policies were reviewed. All nursing staff will be educated on these policies by April 22, 2022. The Director of Nursing or her designee will conduct random audits to ensure appropriate fall interventions are in place according to the individuals Care Plan. This will occur weekly x 4 weeks, every other week for 1 month, and monthly for 2 months. The results of these audits will be brought to the Quality Improvement Committee for review and further direction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 689	Continued From page 21	F 689		

was close at hand, ensuring call light was within reach, ensuring resident was wearing appropriate footwear when ambulating or mobilizing in wheelchair, signs were present to remind R66 to wear gripper socks and to call for help.

Review of R66's undated nursing assistant (NA) worksheet revealed the following; R66 required assistance with transfers, toileting, and used a urinal at bedside. The worksheet directed staff to ensure signs were placed to remind resident to wear gripper socks before walking and to ensure the urinal was close at hand.

Review of R66's adverse event reports from 10/2/21, to 2/1/22, revealed the following:

-10/2/21, R66 had an unwitnessed fall at 10:05 a.m. The event report revealed R66 was found sitting on the floor with his back against the bed and his legs in front of him. The report revealed R66 had spilt his urinal and was reaching for his walker to go to the bathroom. The report lacked immediate interventions to prevent future falls.

-10/12/21, R66 had an witnessed fall at 4:55 a.m. The event report revealed R66 was ambulating back to bed using his walker and fell onto buttocks, landing on the footrest of the wheelchair. The report lacked a comprehensive assessment and failed to implement immediate interventions to prevent future falls.

-10/15/21, R66 had an unwitnessed fall at 3:25 p.m. The event report revealed R66 was found sitting on the floor beside the bed when staff came in to answer the call light. The event report revealed that R66 stated he was trying to use the urinal and slid out of bed. The report revealed an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 689	Continued From page 22 immediate intervention to remind R66 to use the cal light. -1/4/22, when staff answered the call light R66 was found lying on the floor between the bed and bathroom door. The report revealed R66 stated he was returning from the bathroom and lost his balance and fell. A progress note dated 1/4/22, revealed an intervention to place signage in R66's room to remind him of the need for proper footwear prior to transferring. -1/29/22, R66 was found on the floor at the foot of the bed. The report revealed R66 got out of his wheelchair, lost his balance ,and fell while wearing gripper socks. The report revealed an intervention of reminding R66 to lock brakes before transfers and to use call light. -2/1/22, staff were responding to the call light and found R66 sitting on the floor with one hand grabbing the side bar of the bed. The report revealed that resident needed to use the bathroom and self transferred with bare feet. A progress note dated 2/1/22, revealed an intervention to encourage therapy to complete a physical therapy (PT) eval. Care plan revised 2/1/22 revealed an intervention of keeping the urinal close at hand. During an observation on 3/21/22, at 2:55 p.m. R66 was observed to be lying in bed wearing regular socks. A sign on the bathroom door stated "rock your gripper socks". On 3/21/22, at 6:44 p.m. R66 was seated in his wheelchair next to his bed wearing regular socks. -At 6:54 p.m. R66 was lying in bed wearing	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 689	Continued From page 23	F 689		

regular socks. No staff were observed entering or leaving R66's room between the time he was seated in his wheelchair and the time he was lying in bed.

During an observation on 3/22/22, at :832 a.m. R66 was seated on the toilet wearing regular socks.

-At :834 a.m. R66 was seated in his wheelchair as NA-C entered the room to take R66 for a bath. NA-C verified R66 had self transferred to the toilet and back into his wheelchair wearing regular socks.

During an interview on 3/24/22, at 0:942 a.m. NA-A stated R66 was a fall risk because he self transferred and was not always safe. NA-A indicated there were signs in his room to remind him to wear gripper socks and to call for help however if the staff did not get there fast enough he would transfer himself.

During an interview on 3/24/22, at 12:45 p.m. NA-B stated there were times R66 did not like to leave his room and preferred to have the door shut which contributed to his fall risk. NA- B indicated R66 liked to do things himself instead of allowing staff to assist him.

During an interview on 3/24/22, at 12:50 p.m. NA-C stated R66 was a high risk for falls related to his self transferring. NA-C stated one of the fall interventions for R66 was to ensure that he was wearing gripper socks before he transferred. NA-C verified that on 3/22/22,when he went to give R66 a bath R66 had transferred himself wearing regular socks instead of gripper socks. NA-C indicated R66 had at least one fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 689	Continued From page 24 previously while wearing regular socks. During an interview on 3/24/22, at 1:07 p.m. LPN-B verified R66 required assistance to use the bathroom. LPN-B stated R66 had diseases which contributed to his fall risk and that he should have been wearing gripper socks before any transfers or walking. During an interview on 3/24/22, at 1:14 p.m. director of nursing (DON) indicated R66 required assistance from staff for transfers and toileting. DON stated R66 had been admitted to the facility because he was having falls and had continued to have falls while in the facility. DON confirmed R66 was not safe when he self transferred and her expectation was staff would ensure R66 would have gripper socks or non skid footwear before any transfers. A facility policy titled" Falls and Fall Risk Managing", revised 3/18, revealed the facility would identify interventions related to the resident's specific risks to prevent the resident from falling. The policy revealed if the resident continued to fall, staff would re-evaluate the situation and determine whether it was appropriate to continue or change the interventions.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 689	Continued From page 25	F 689		
F 880 SS=D	. . . Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		4/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 26 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 27 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate transmission based precautions on the Autumn Lake wing and Apple Blossom wing for 2 of 2 residents (R230, R45) who were in quarantine. In addition, the facility failed to implement proper use of personal protective equipment (PPE) per Centers for Disease Control and Prevention (CDC) to prevent and/or minimize spread of COVID-19. This deficient practice had the potential to affect 30 residents who resided on the wings. Findings include:	F 880	Staff placed signage on R 230 and R45 doors, indicating Transmission Based Precautions were in place 3/23/2022. Implementation of Conventional Strategies for use of N95 masks were implemented house wide 3/23/2022. All residents electronic medical records were reviewed by the Infection Preventionist determining which residents are not up to date with current COVID vaccination recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 28 CDC guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 2/2/22, identified the facility must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and healthcare professionals in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death, which included: -Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection, identified the following guidelines which included: healthcare personnel (HCP) who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use an approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). -NIOSH-approved N95 or equivalent or higher-level respirators can also be used by HCP working in other situations where additional risk factors for transmission are present such as the patient is not up to date with all recommended COVID-19 vaccine doses -Empiric use of Transmission-Based Precautions (quarantine) is recommended for patients who have had close contact with someone with SARS-CoV-2 infection if they are not up to date with all recommended COVID-19 vaccine doses. CDC guidance, Interim Infection Prevention and Control Recommendations to Prevent	F 880	A Root Cause Analysis was conducted on the failure of implementation of appropriate transmission based precautions for those residents who were on quarantine. Coronavirus Disease (COVID 19) – Using Person Protective Equipment, Personal Protective Equipment – Contingency and Crisisi Use of Eye protection (COVID 19 Outbreak), Person Protective Equipment – Contingency and Crisis Use of N 95 Respirators (COVID 19 Outbreak), Person Protective Equipment – Contingency and Crisis Use of Gloves (COVID 19 Outbreak), Person Protective Equipment – Contingency and Crisis Use of Gowns (COVID 19 Outbreak),), Person Protective Equipment – Contingency and Crisis Use of Facemasks (COVID 19 Outbreak), Coronavirus Disease (COVID 19) – Facemask as Source Control, Isolation – Categories of Transmission – Based precautions – Policies were reviewed. All staff will be educated on these policies by April 22, 2022. Education will include Appropriate use of PPE and Donning and Doffing of PPE. Source Control masking for staff, visitors, and resident audits will be conducted by the DON, or Infection Preventionist, or designee all shifts 4 times a week for 1 week, then twice weekly for one week, once compliance is met. Audits will continue until 100% compliance is met on source control masking. Results will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 29 SARS-CoV-2 Spread in Nursing Homes, updated 2/2/22, included the following: -In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit. -In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission. CDC guidance, Strategies for Optimizing the Supply of N95 Respirators updated 9/16/21, identified the following: -as of May 2021: The supply and availability of NIOSH-approved respirators have increased significantly over the last several months. Healthcare facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices. -N95 respirators were intended to be used once and then properly disposed of and replaced with a new N95 respirator. -Conventional capacity: measures consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in healthcare settings. R230 R230's electronic health record identified R230 was admitted to the facility on 3/21/22. R230's Minnesota Immunization Information Connection	F 880	reported and reviewed at QA meeting. The DON, or Infection Preventionist, or designee will conduct Audits of donning / doffing PPE with Transmission Based Precautions. Audits will be conducted all shifts 3x a week x 1 week, all shifts 2x a week, all shifts 1x a week until 100% compliance is met. Results will be reported and reviewed at QA meeting. The DON, or Infection Preventionist, or designee will conduct real time Audits on all aerosolized generating procedures to ensure PPE is in use . Audits will be conducted all shifts 3x a week x 1 week, all shifts 2x a week, all shifts 1x a week until 100% compliance is met. Results will be reported and reviewed at QA meeting. The DON, or Infection Preventionist, or designee will conduct real time Audits on the proper use of gowns to ensure PPE is in use. . Audits will be conducted all shifts 3x a week x 1 week, all shifts 2x a week, all shifts 1x a week until 100% compliance is met. Results will be reported and reviewed at QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 30	F 880		

form identified R230 had not received a COVID-19 vaccination. R230's Pioneer Care Rapid Covid-19 Testing form, dated 3/22/22, identified she received a rapid Abbot BinaxNOW Now Covid-19 AG CARD test that was confirmed negative.

On 3/22/22, at 8:20 a.m. R230's door was slightly ajar. At 8:25 a.m. licensed practical nurse (LPN)-D exited R230's room, wearing a surgical mask and eye protection, then sanitized her hands. LPN-D was not observed to wear a N-95 mask when she exited R230's room.

On 3/22/22, at 8:34 a.m. R230's had a paper sunshine sign above her name plate on the door frame. R230's door lacked any signs to identify the type of transmission based precautions or instructions on PPE to be used. Outside R230's door was a clear plastic three drawer bin, which had gowns in the top drawer, a few face shields in the second drawer and some infection control signs in the bottom drawer. On top of the plastic bin there was a sanitation wipe container and hand sanitizer. The bin did not contain any gloves or N95 masks.

On 3/22/22, at 8:40 a.m. nursing assistant (NA)-N entered R230's room, wearing only a surgical mask and eye protection. NA-N was not observed to apply a gown, gloves or N-95 mask before entering R230's room, who was on transmission based precautions. NA-N exited R230's room at 8:42 a.m.

On 3/22/22, at 9:45 a.m. R230's door was wide open while homemaker/activity (HA)-A stood four to six feet into R230's room. HA-A wore a surgical mask and eye protection. HA-A did not have on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 31 gown, gloves or N-95 mask. At 3/22/22, at 9:46 a.m. HA-A left R230's room, leaving R230's door wide open. R230's door had 2 signs posted on the inside of her door, Special Droplet/Contact Precautions, revised 3/9/20, and Special Droplet/Contact Precautions, revised 3/9/20, which included instructions for personal protective equipment. The outside of R230's door continued to lack any signs to identify the type of transmission based precautions or instructions for personal protective equipment use. On 3/23/22, at 9:09 a.m. clinical coordinator (CC)-A walked to R230's door, sanitized hands, applied a gown and gloves, then set a paper bag onto the attached book shelf outside R230's door. CC-A removed an N95 mask from the paper bag, placed it over her surgical mask, which she then removed from under the N-95 mask. CC-A placed the surgical mask inside the brown paper bag on the shelf, then entered R230's room, while carrying a clear bag of medication bottles. At 9:13 a.m. CC-A left R230's room, while continuing to wear a N-95 mask and eye protection. CC-A removed her N-95 mask, removed the surgical mask from inside the brown paper bag, then placed the N-95 mask into to the bag and placed the surgical mask back on. CC-A was not observed to discard the N-95 mask after use, and re-used the surgical mask from the brown paper bag. On 3/23/22, at 11:05 a.m. three signs were now noted to be posted on the outside of R230's door, Special Droplet/Contact Precautions revised 3/9/20, Special Droplet/Contact Precautions which included instructions for PPE, revised 3/9/20, and an untitled sign from CDC, which included donning and doffing instructions.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 32 On 3/23/22, at 10:53 a.m. during a phone interview NA-N stated she only wore her surgical mask and eye protection yesterday in R230's room, because she was not aware R230 was on TBP at that time. NA-N indicated she had not seen any signs which indicated R230 was on precautions and had not been informed R230 was on precautions during report. NA-N indicated she was now aware R230 was on precautions due to being newly admitted to the facility. NA-N stated her usual practice was to put on a N-95 mask, gown and gloves before entering a room of a resident who was on TBP. On 3/23/22, at 1:32 p.m. during a phone interview, LPN-D indicated R230 was a new admission to the facility and was on TBP. LPN-D stated on the morning of 3/22/22, she was in R230's room and had discussed her medications with her, and asked her what she wanted for breakfast. LPN-D stated she had worn a gown, gloves and N-95 mask while she was in R230's room, however had removed all prior to exiting the room. LPN-D stated she had removed her N-95 mask and discarded it in R230's bathroom garbage before she left the room. LPN-D indicated she had kept her N-95 mask in her pocket yesterday, but typically kept her N95 mask in the medication room in a brown paper bag and re-used it. LPN-D stated she had thrown her away that day prior to leaving R230's room because she was not feeling well, but normally would lace it in a brown paper bag with her name on it. LPN-D indicated at times they kept a bedside stand outside a resident's room who was on TBP, to keep everyone's bags with N95's in there. LPN-D confirmed R230's door had no TBP signs posted on the outside of her door to identify	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 33 R230 was on TBP and instead they were posted on the inside of her door, which she found peculiar. On 3/23/22, at 1:49 p.m. HA-A confirmed she had entered R230's room without wearing a gown, gloves and N-95 mask. HA-A stated she had worn a gown, gloves and surgical mask earlier, however had just stopped into R230's room for a short time to tell her about her spouse, who also was a resident on the unit. HA-A indicated she had a N-95 mask and did not wear one yesterday. HA-A stated her usual process when someone was in quarantine included: having the resident wear a mask, wear full PPE, and remove PPE before leaving the room. HA-A stated that normally she would have closed R230's door after leaving, however she forgot yesterday. On 3/23/22, at 2:06 p.m. CC-A confirmed R230 was on quarantine for the first 14 days after her admission because she was not fully vaccinated. CC-A stated R230 had been tested her first day and was negative for COVID-19. CC-A indicated her expectations for R230 was for her to remain in her room and every time staff entered her room they wore a gown, gloves and N95 mask with eye protection. CC-A indicated they were to remove the gown, and gloves before leaving the room and sanitize their hands. CC-A stated it was important for all staff to wear their PPE every time they entered a resident's room who was in quarantine, to protect other residents and staff. CC-A indicated all staff had their own N-95 mask which they kept in a brown paper bag. CC-A stated she currently had hers for a couple of weeks, and after a few weeks if it didn't fit any more, or soiled they were to get a new one. CC-A indicated they were able to wear the same N-95	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 34 mask when caring for more than one resident. R45 R45 admission Minimum Data Set (MDS) dated 2/3/22, indicated R45 had diagnoses which included a fracture of lower end left tibia, malnutrition, anxiety and was cognitively intact. The MDS identified R45 required staff assistance with her activities of daily living (ADL's). R45's Rapid Covid-19 Testing dated 3/21/22, indicated R45 had a Covid-19 antigen test performed and the test results revealed R45 was negative for Covid-19. R45's Rapid Covid-19 Testing dated 3/23/22, indicated R45 had a Covid-19 antigen test performed and the test results revealed R45 was negative for Covid-19. R45's MICC report dated 1/27/22, indicated R45 had not been vaccinated for Covid-19. R45's Immunization Report dated 3/24/22, indicated R45 had refused step one and step two of the Covid-19 vaccination. Review of R45's Progress Note dated 3/21/22, revealed R45 had known close contact with a Covid-19 positive individual. The progress note instructed staff to monitor R45 for symptoms consistent with Covid-19. The progress note identified R45 needed to be quarantined for 10 days, if R45 tested negative per Centers for Disease Control and Prevention (CDC) guidelines and had no symptoms, R45 could be removed from transmission based precautions. The plan was to test R45 immediately on 3/21/22, on	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 35 3/23/22 (5-7 days) and on 3/27/22 (10 days) post exposure. During observations on 3/22/22, at 8:25 a.m. the door to R45's room had a sunshine sticker on it and a sign posted on the outside of her door indicating she was on isolation precautions. To the left side of R45's door outside of her room was a clear plastic storage bin which contained several disposable gowns. On top of the bin was a container of Sani wipes, hand sanitizer and a clear plastic equipment holder that contained a thermometer, a blood pressure cuff and other supplies to take R45's vitals. During the observation, staff had not posted signs outside of R45's door on how to properly donn and doff PPE and no supplies of N95 masks or gloves were in R45's plastic storage bin outside of her room. - at 8:40 a.m. the door to R45's room had a sign posted on the outside of her door indicating she was on droplet/contact precautions and a sign posted on the door for proper use of disposable respirators. The plastic storage bin outside of R45's room remained the same. - at 9:18 a.m. the door to R45's room continued to have a sign posted indicating she was on droplet/contact precautions and a signed posted on the door for proper use of disposable respirators. The plastic storage bin outside of R45's room remained the same. - at 9:35 a.m. the door to R45's room continued to have the signs posted on her door and the plastic storage bin outside of R45's room remained the same. - at 9:45 a.m. the door to R45's room continued to	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 36 have the signs posted on her door and the plastic storage bin outside of R45's room remained the same During an observation on 3/23/22, at 7:17 a.m. there was no change to the sign posted on R45's door or in R45's bin located outside her room. During an observation at 8:37 a.m. registered nurse (RN)-B indicated when she entered R45's room she was to wear a N-95 mask. RN-B walked over to the nurses station, opened up the cupboard and grabbed a brown paper bag with her name on the bag. RN-A revealed she had her N-95 mask inside of the paper bag and placed the bag on top of her medication cart next to the nurses station. On 3/23/22, at 8:37 a.m. RN-B confirmed R45 was on precautions due to an exposure and had not been vaccinated for Covid-19 due to her refusal. RN-B indicated due to the exposure staff were expected to wear full PPE before they entered R45's room which included: gown, gloves, N-95 mask and eye wear. RN-B indicated she had been fit tested for her N-95 mask and she was directed to re-use her N-95 mask. RN-B stated she would put her N-95 mask in a brown paper bag with her name on it and stored it in the cupboard at the nurses station until she needed to use it. RN-B indicated the only time she changed her N-95 mask was when it had become soiled or damaged- On 3/23/22, at 9:06 a.m. nursing assistant (NA)-G indicated she would wear a gown, gloves, N-95 mask and eye protection when she entered a quarantine or isolation room. NA-G opened the middle cupboard up at the nurses station which	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 37 revealed several brown paper bags with names on them inside the cupboard. NA-A grabbed her brown paper bag, which contained her N-95 mask. NA-G indicated she would re-use and store her N-95 mask in the brown paper bag until she needed it. NA-G indicated if she needed a new N-95 mask for any reason, she would obtain a new one out of the storage room. On 3/23/22, at 2:42 p.m. infection preventionist (IP)-A stated the facility followed CDC recommendations to test all residents newly admitted and place in quarantine those residents who were not fully vaccinated. IP-A indicated her expectations for all staff to wear when a resident was in quarantine included: eye protection, gloves, gown, and N95 mask. IP-A confirmed all resident's doors who were on transmission based precautions should have signs on the outside of their doors which instructed staff on what type of TBP, donning and doffing instructions and instructions on what type of PPE was to be worn. IP-A stated it was expected staff were to have N95 mask instructions posted. IP-A stated the plastic drawer bins outside the rooms should include gloves, gowns and a tray next to the table with N95 masks. IP-A stated the paper sunshine signs posted on the doors notified the staff of the date the resident may come off of TBP. IP-A stated all staff had been fit tested for N95 masks, and any staff member who could not wear a N95 mask was informed to not go into rooms of residents with suspected or confirmed COVID-19. IP-A stated the facility was following a re-use policy for their N95 masks, and encouraged them to wear them until they did not fit properly or were soiled, and to wear them only a few days. IP-A indicated the staff were informed not to wear them for more than one resident. IP-A confirmed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 38	F 880		

with conventional status for PPE supplies the N-95 masks should have been discarded after each use, however with contingency status they may be stored and reused. IP-A confirmed she had not had any difficulty ordering their N95 mask supply once they identified which vendors supplied the different types needed.

On 3/24/22, at 8:26 a.m. during a follow up interview, IP-A stated the admitting nurse was responsible to assure signs were posted on resident's doors who were placed on quarantine at the time of their admission. IP-A confirmed the facility had ample supply of N-95 masks and were now going to assure N-95 masks were stocked in the plastic bins outside the resident's rooms on TBP. IP-A stated the facility will now have the staff discard their N95 masks after use. IP-A confirmed prior to today, they were reusing their N95 masks, for about 5 days or less if they became soiled, then discarded them. IP-A confirmed the facility did not have difficulty to obtain any PPE supplies since last October or December, including N95 masks, and had not needed to reach out for assistance with their coalition or state agency (SA) since then for supplies. IP-A confirmed the facility currently had: 300 of the 1870 N95 masks, 200 of the 1860 N95 masks, 200 of the 9210 N95 masks, and 160 of he 8210 N95 masks. IP-A identified the facility obtained their N95 masks from two vendors.

On 3/24/22, at 8:44 a.m. director of nursing (DON) confirmed she expected signs to be posted on resident's doors within a few hours of their admission who were on precautions, or within 24 hours for sure. DON indicated she expected direct care staff to wear N95 masks, gowns and gloves when in the room of residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 39	F 880		

who were on quarantine. DON stated she would not expect staff to apply PPE if they were going into a resident's room on quarantine for a short time, such as to drop off a tray. DON stated it was important for signs to be posted to identify the type of precautions so staff were aware what to wear when entering the room as it was important to be aware for infection control purposes. DON indicated it was important for staff to follow TBP to prevent the spread of COVID-19. DON confirmed the facility had been reusing their N95 masks for about five times, unless they became soiled.

The facility policy titled Isolation-Categories Of Transmission Based Precautions, revised 10/18, identified TBP were initiated when a resident developed signs and symptoms of a transmissible infection, arrived for admission with symptoms of an infection, or had laboratory confirmed infection; and was at risk of transmitting the infection to other residents. The policy indicated when a resident was placed on TBP, appropriate notification was placed on the room entrance door so that personnel and visitors were aware of the need for the type of precaution.

The facility policy titled Coronavirus Disease (COVID-19)-Identification And Management of Ill Residents revised 9/21, identified strategies used for the rapid identification and management of COVID-19 infected residents were consistent with current recommendations for CDC. The policy identified residents with suspected COVID-19 infections would be moved to a single-person room with a private bathroom while test results were pending. The door to the room remained closed to reduce the transmission of SARS-CoV-2 (COVID-19). The policy instructed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 40 staff to place residents who were not up to date with all required COVID-19 vaccinations, who had close contact with someone with SARS-CoV-2 infection were placed in quarantine for 14 days after their exposure, even if viral testing was negative. Staff caring for them used full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). The policy further identified all residents not up to date with COVID-19 required vaccinations who were new admissions were placed in a quarantine based off of CDC recommendations, even if they had a negative test upon admission. The facility policy titled Coronavirus Disease (COVID-19)-Managing Supplies and Personal Protective Equipment, revised 9/21, identified inventory of PPE was managed systemically. The policy identified the inventory and supply chain for PPE were established and managed by the infection prevention and control supply coordinator. The supply coordinator was responsible for maintaining relationships with the local, regional and tribal planning groups, vendors, and/or healthcare coalitions. The policy further identified strategies for optimizing the supply of PPE during surges were based on the CDC's Optimizing Personal Protective Equipment (PPE) supplies. The policy identified contingency capacity strategies were only implemented after considering and implementing conventional capacity strategies. Contingency capacity strategies were used temporarily during periods of anticipated PPE shortages. Decisions to implement contingency and crisis strategies were based up on the following assumptions; including inventory and supply chain for PPE were well understood, PPE utilization rate was known ,and communication had been established with local	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/24/2022

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 880	Continued From page 41 healthcare coalitions, federal, state and local public emergency preparedness and response organizations to identify sources of additional supplies. The policy identified returning to conventional strategies would be made when PPE availability was sufficient to meet demands.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **02 - MAIN BLDG TWO** B. WING _____	**03/24/2022**

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 An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/24/2022. At the time of this survey, Pioneer Care Center Building 02 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The facility was surveyed as two buildings. Pioneer Care Center is made up of two buildings. Building 02 is 2-stories without a basement and is built of Type II (111) construction. Building 03 is a 1-story building without a basement, built of Type V (111). The building is fully sprinkler protected and has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor, and all common areas that is monitored for automatic fire department notification. In addition, the sleeping rooms have smoke detection in them, and all hazardous areas have automatic fire detection. The facility has a licensed capacity of 105 beds and had a census of 81 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **03 - SOUTH BLDG 3** B. WING _____	**03/24/2022**

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 An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/24/2022. At the time of this survey, Pioneer Care Center building 3 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The facility was surveyed as two buildings. Pioneer Care Center is made up of two buildings. Building 02 main building is a 2-story, without a basement and is Type II (111) construction. Building 03 is a 1-story building without a basement, Type V (111). The building is fully sprinkler protected and has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all common areas that is monitored for automatic fire department notification. The sleeping rooms have smoke detection in them and all hazardous areas have automatic fire detection. The facility has a licensed capacity of 105 beds and had a census of 81 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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