MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: V9ZY
Facility ID: 00469

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245301**

2. STATE VENDOR OR MEDICAID NO.
(L2) **358342200**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/09/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
03/31

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

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

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

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program
Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	68			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 05/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/29/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/23/2016
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245301

June 29, 2016

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

Dear Mr. Champ:

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

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

Effective May 6, 2016 the above facility is certified for:

68 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 24, 2016

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

RE: Project Number S5301025

Dear Mr. Champ:

On April 5, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 31, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 9, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 13, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 31, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 6, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 31, 2016, effective May 6, 2016 and therefore remedies outlined in our letter to you dated April 5, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

An equal opportunity employer.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245301 Y1	A. Building B. Wing Y2	5/9/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242 Reg. # 483.15(b) LSC	Correction Completed 04/19/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) LB/mm	DATE 05/24/2016	SIGNATURE OF SURVEYOR 28035	DATE 05/09/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/31/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245301	A. Building 01 - MAIN BUILDING 01 B. Wing	5/13/2016

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

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

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 04/13/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 04/04/2016	ID Prefix Reg. # NFPA 101 LSC K0051	Correction Completed 04/13/2016
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/14/2016	ID Prefix Reg. # NFPA 101 LSC K0066	Correction Completed 04/18/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 04/04/2016
ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 03/30/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	05/24/2016	36536	05/13/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/30/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245301	A. Building 02 - 2005 ADDITION 02 B. Wing	5/13/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 04/22/2016	ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 05/06/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 04/04/2016
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 04/04/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 05/24/2016	SIGNATURE OF SURVEYOR 36536	DATE 05/13/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/30/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: V9ZY
Facility ID: 00469

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245301**

2. STATE VENDOR OR MEDICAID NO. (L2) **358342200**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/31/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA**
02 SNF/NF/Dual **06 PRTF** **10 NF** **14 CORF**
03 SNF/NF/Distinct **07 X-Ray** **11 ICF/IID** **15 ASC**
04 SNF **08 OPT/SP** **12 RHC** **16 HOSPICE**

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **03/31**

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	68			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE
Theresa Gullingsrud, HFE NEII
Date : 04/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 05/20/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 5, 2016

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

RE: Project Number S5301025

Dear Mr. Champ:

On March 31, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> <u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> <u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;
>
> <u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 10, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 10, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by July 1, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING ______ B. WING ______	03/31/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure choices related to the preference of number of bathes each week was assessed and provided for 1 of 2 residents (R33) reviewed for choices and was not provided with the desired number of baths per week. Findings include: On 3/29/16, at 8:43 am. R33 indicated she	F 242	R33 indicated she currently received one bath per week but would prefer to receive more than one per week. Facility's Corrective action was accomplished on 3/31/16: D.O.N. met with R33 to discuss option of more than one bath per week. Resident bathing schedule changed to accommodate second bath Monday evenings per resident request.	4/19/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/18/2016

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F 242	Continued From page 1 currently received one bath per week but would prefer to receive more than one per week. R33 stated she had not spoken to anyone about it as she didn't think her opinion mattered. R33's Diagnosis/History form dated 10/1/15, indicated R33 had diagnoses of macular degeneration (an eye disease that causes vision loss), polymyalgia rheumatica (an inflammatory disorder causing muscle pain and stiffness around the shoulders and hips) and depression. R33's annual Minimum Data Set (MDS) dated 1/1/16, indicated R33 was cognitively intact and was independent with all activities of daily living (ADL) including bathing. The MDS also indicated it was very important for R33 to choose between a tub bath, shower, bed bath or sponge bath but did not address R33's choices for frequency of bathing. R33's care plan dated 1/12/16, indicated R33 was unable to bathe independently but was independent in all other ADL tasks and displayed appropriate cognitive and physical abilities to do so. The plan directed staff that R33 preferred bathing in the tub, in the morning, with one staff person to assist with bathing. However, did not identify R33's preference for bathing frequency. The plan directed staff to allow R33 to do as much as possible by herself for bathing and shampooing and then to help her finish as needed. The undated Bath Schedule indicated R33 was	F 242	Facility identified that all other residents potentially could be affected by this deficiency. Current residents will be reassessed at next Care Conference to determine bathing frequency, time, and that day of the week are accurate and in accordance with resident preference. New admissions will be addressed on admission care plan on day of admission to determine bathing frequency, time, and that day of the week are accurate and in accordance with resident preference. D.O.N. will audit assessments Q montlyx3 to assure all resident's have been assessed properly for bathing preferences. Results will be discussed at QA.	

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F 242	Continued From page 2 scheduled for one bath per week. On 03/30/2016, at 8:58 a.m. R33 stated when she was admitted over four years ago she was used to taking a shower daily and at the time of admission she was not asked how many baths she preferred, but rather was assigned to having one bath a week. R33 stated she was not satisfied with having only one bath a week but had not reported this to anyone here at the nursing home because she did not like complaining. On 3/30/16, at 9:08 a.m. trained medication aide (TMA)-A stated residents were not routinely asked how often they preferred to have their bath because the facility didn't have the staff to allow the resident to choose more than one bath a week. TMA-A stated they had a certain number of bath slots and when they were full, no further baths could be accommodated. TMA-A also indicated there were only two residents who received more than one bath per week due to hygiene issues. TMA-A further stated she was not sure if the residents' were asked their preference for bathing frequency at the time of admission or periodically thereafter. On 3/30/2016, at 12:07 p.m. the director of nursing (DON) and licensed social worker (LSW) stated resident choices were addressed on the resident admission care plan. They indicated residents were informed the facility scheduled for one bath per week and reviewed the schedule with the resident to identify a desired time. Residents were also told at that time if more	F 242		

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F 242	Continued From page 3 baths were desired, the facility would give more baths but it may not be at the desired time. For example, the additional bath may have to occur after breakfast until the desired time slot opened up. The DON and LSW stated they worked with all of the residents so they received at least one bath at their desired time and if they wanted more they would be scheduled when there was an opening. The DON and LSW confirmed R33 had been at the facility approximately four years and at the time she was admitted, bathing preferences were not addressed. They indicated R33 had never asked for another bath and stated residents were asked at their quarterly care conference if they were satisfied with their care. The DON and LSW indicated R33 had offered no complaints with her care during the previous two care conferences since the LSW had been hired in November 2015. However, confirmed she was not specifically asked about bathing preferences/frequency and verified R33 was not likely to complain or make requests for additional services. On 3/30/2016, at 3:34 p.m. the DON and administrator confirmed there was no evidence R33's bathing frequency preference was addressed. They stated residents were polled about issues related to bathing frequency at resident council meetings, but confirmed it was not documented. No policy regarding bathing or resident choices was provided.	F 242		

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

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FORM APPROVED
OMB NO. 0938-0391

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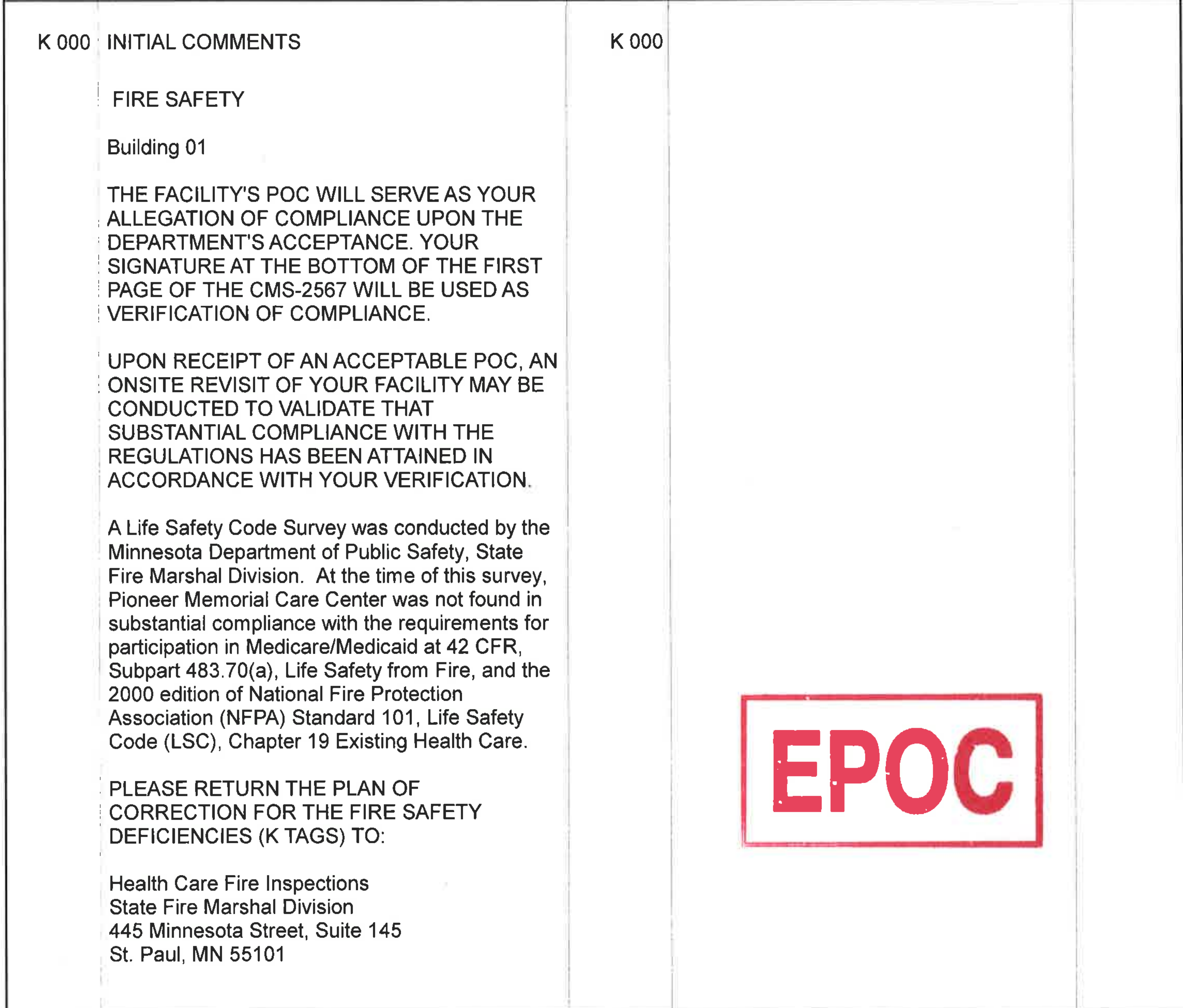

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

Building 01

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Memorial Care Center was not found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/19/2016

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Pioneer Memorial Care Center was built in 1985, is one story with a partial basement and was determined to be Type V(111) construction. In 1997 a 1-story addition was constructed to the east of the original building with out a basement, was determined to be Type V (111) construction and which is separated with a 2-hour fire barrier. In 2005 an 1-story addition was constructed to the south of the original building that has a full basement and was determined to be a Type V (111) construction. The facility is protected with a complete automatic sprinkler system and has a fire alarm system with corridor smoke detection and smoke detectors in all common areas, installed. Additional single smoke detectors are in all sleeping rooms of the 2005 addition, the remodeled east wing and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code	K 000		

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K 000	Continued From page 2 2007 edition. The facility has a capacity of 68 beds and had a census of 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 1 corridor doors according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 18 of the 62 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include:	K 018	Maintenance technician fixed door frame/door to make door fit tight in frame, as laid out by regulations. Maintenance tech fixed door on 4/13/16 Maintenance Tech, Randy, will do walkthrough/audit one wing per week for 3 months (all 68 rooms checked monthly), making sure each door on each wing	4/13/16

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K 018	Continued From page 3 On the facility tour between 9:15 am to 2:45 pm observations and staff interview revealed a door to room 312 did not fit tight in the frame. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 018	meets LSC regulations.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improperly trained staff would affect the safe evacuation of all 62 residents and undetermined amount of staff and visitors Findings include: On the facility tour between 9:15 am to 2:45 pm record review and staff interview revealed in the last 12 months fire drills were not conducted one per quarter on each shift. The night shift of the 2nd quarter and the day shift of the 3rd quarter	K 050	On 4/4/16, Maintenance Technician met with Administrator to review Fire Drill Schedule. Schedule was modified to assure 2016 schedule will meet regulation standards. Maintenance tech will verify quarterly that each shift has had at least one fire drill. Deficiency has been corrected as of 4/4/16 and Administrator or Environmental Services director will update fire drill schedule going forward on annual basis.	4/4/16

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K 050	Continued From page 4 were missed. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor	K 050		
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (00) section 19.3.4.2, 9.6.1.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 25 of the 62 residents and an undetermined amount of staff and visitors.	K 051	Maintenance techs moved smoke detector over 2 panels in ceiling to assure detector met LSC regulations. Maintenance techs completed this on 4/13/16. All other detectors are in compliance. Will verify they are still in compliance upon testing of smoke detectors per	4/13/16

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K 051	Continued From page 5 On the facility tour between 9:15 am to 2:45 pm observations and staff interview revealed a smoke detector in the food storage room was within 36 inches of a diffuser. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 051	regulations.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 62 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:15 am to 2:45 pm observations and staff interview revealed four faulty sprinkler heads, one in the main dining area and three in wing two dining area. This deficient practice was verified by the Facility Admistrator and the Maintenance Supervisor.	K 062	New Fire Sprinkler heads have been ordered and installed for the four deficient areas. These were installed on 4/14/16 by maintenance tech. Maintenance techs or Environmental Services Director will audit sprinkler heads when testing smoke detectors per regulations.	4/14/16

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K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to provide readily available metal containers with self closing lids in which ashtrays can be emptied, in all smoking areas, as per NFPA 101, (00) Life Safety Code section 19.7.4 item 4. This deficient practice could allow a fire to start if an ashtray is not emptied into a proper container and could affect 17 of the 62 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:15 am to 2:45 pm observations and staff interview revealed the smoking area outside the employee lounge did	K 066	An approved smoking container has been ordered and placed outside employee lounge. Approved container was installed 4/18/16 by maintenance techs Maintenance techs/Environmental Services director will check smoking container weekly for 3 months and ongoing monthly to assure it is in compliance.	4/18/16

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K 066	Continued From page 7 not have metal container with a self closing lid. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator	K 066		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all 62 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:15 am to 2:45 pm observations, record review and staff interview revealed there was no record of the generator cool down cycle and the generator remote annunciator panel was not in a continuously monitored location. This deficient practice was verified by the Facility Administrator and the Maintenance Supervisor	K 144	Generator log has been updated with column to document the generator cool down time, as required per regulations. Log was updated on 4/4/16 by Administrator. Maintenance Tech or Environmental Services Director will keep up to date ongoing. RE: Remote annunciator panel: Call to Deputy State Fire Marshal Inspector- Bob Baumen, he stated our secondary annunciator at the intersection of Valley and Evergreen wings with Main street will suffice, as it displays everything that the main panel needs to display, and this annunciator IS IN a highly monitored area.	4/4/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in	K 147		3/30/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/30/2016**

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

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K 147	Continued From page 8 accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain electrical devices in accordance with NFPA 70 (99), National Electrical Code this deficient practice could negatively affect the safety of 2 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:15 am to 2:45 pm observations and staff interview revealed a power strip being used for a refrigerator in room 208 and in room 405 an outlet box was not secured to the framing. This deficient practice was verified by the Facility Administrator and the Maintenance Supervisor	K 147	Resident Refrigerator policy will created and placed in Admission packet given to all residents upon admission (and given to all current residents). Resident in 208's refrigerator has been unplugged from power strip 3/30/16. Maintenance tech's will audit new admission rooms within 1 week of admission, and all other rooms on a monthly basis to assure fridges are plugged into walls, not power strips, per regulations.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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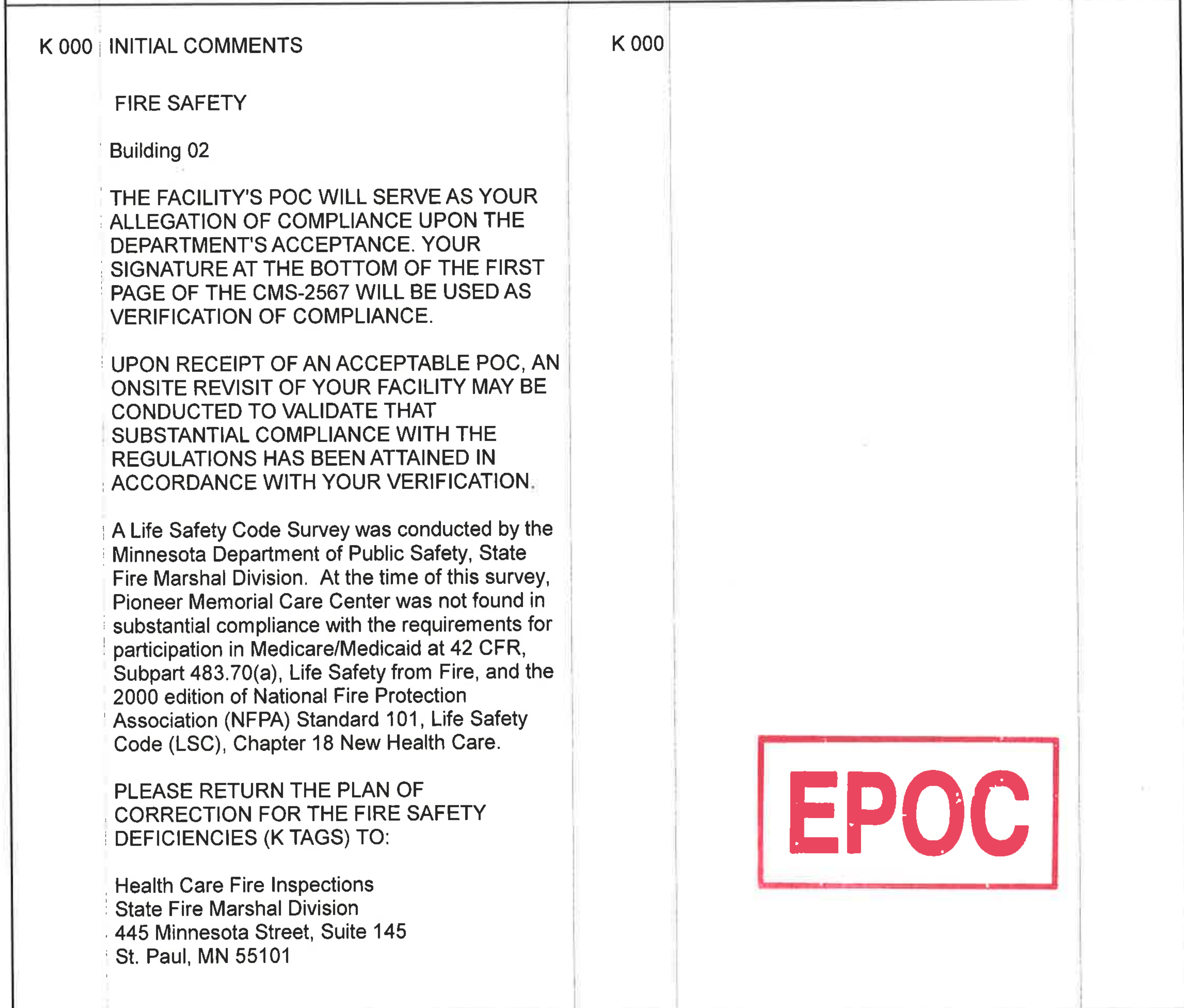
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING **02 - 2005 ADDITION 02** B. WING _____	**03/30/2016**

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



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K 000	INITIAL COMMENTS FIRE SAFETY Building 02 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Memorial Care Center was not found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/19/2016

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

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	245301	A. BUILDING **02 - 2005 ADDITION 02** B. WING ______	**03/30/2016**

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

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K 000	Continued From page 1	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Pioneer Memorial Care Center was built in 1985, is one story with a partial basement and was determined to be Type V(111) construction. In 1997 a 1-story addition was constructed to the east of the original building with out a basement, was determined to be Type V (111) construction and which is separated with a 2-hour fire barrier. In 2005 an 1-story addition was constructed to the south of the original building that has a full basement and was determined to be a Type V (111) construction.

The facility is protected with a complete automatic sprinkler system and has a fire alarm system with corridor smoke detection and smoke detectors in all common areas, installed. Additional single smoke detectors are in all sleeping rooms of the 2005 addition, the remodeled east wing and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code

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	245301	A. BUILDING 02 - 2005 ADDITION 02 B. WING ______	03/30/2016

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

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K 000	Continued From page 2 2007 edition. The facility has a capacity of 68 beds and had a census of 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 18.3.7.1, 18.3.7.3. This deficient practice could allow the products of combustion to spread throughout the smoke compartment in the event of a fire which could affect 18 of the 62 residents,and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:15 am to 2:45 pm observations and staff interview revealed a penetration above the ceiling line in the smoke barrier near room 100C. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor	K 025	Maintenance tech's will fix smoke barrier penetration in the oak tub room by spraying foam insulation, and mudding over, along with spraying high temperature fire caulking to make full barrier, per regulations. Maintenance tech's will have completed by 4/22/16 All other smoke barriers are in compliance. Will monitor annually.	4/22/16
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		5/6/16

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	245301	A. BUILDING **02 - 2005 ADDITION 02** B. WING ______	**03/30/2016**

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

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K 038	Continued From page 3 Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to provide 1 of several exit discharge walking surfaces in accordance with NFPA 101 Life Safety Code (00) edition, Section 7.1.6.2. During an evacuation this deficient practice could affect 18 of the 62 residents, staff and visitors. Findings include: On the facility tour between 9:15 am to 2:45 pm observations and staff interview revealed the concrete outside the east exit in the Oak wing exceeded the maximum 1/2 inch abrupt change in elevation. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor	K 038	Temperatures are such right now that concrete mix will not set overnight, however temps are warming up. Maintenance techs will use mix and have concrete leveled out by creating a ramp like effect, as to create the correct change in elevation per regulations. If temperatures cooperate, maintenance techs will have this completed by 5/6/16. All other concrete exits are in good order at this time. Will audit quarterly.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed	K 050	On 4/4/16, Maintenance Technician met with Administrator to review Fire Drill	4/4/16

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K 050	Continued From page 4 to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improperly trained staff would affect the safe evacuation of all 62 residents and undetermined amount of staff and visitors Findings include: On the facility tour between 9:15 am to 2:45 pm record review and staff interview revealed in the last 12 months the fire drills were not conducted one per quarter on each shift. The night shift of the 2nd quarter and the day shift of the 3rd quarter were missed. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor	K 050	Schedule. Schedule was modified to assure 2016 schedule will meet regulation standards. Maintenance tech will verify quarterly that each shift has had at least one fire drill. Deficiency has been corrected as of 4/4/16 and Administrator or Environmental Services director will update fire drill schedule going forward on annual basis.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all 62 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:15 am to 2:45 pm observations, record review and staff interview	K 144	Generator log has been updated with column to document the generator cool down time, as required per regulations. Log was updated on 4/4/16 by Administrator. Maintenance Tech or Environmental Services Director will keep up to date ongoing. RE: Remote annunciator panel: Call to Deputy State Fire Marshal Inspector- Bob	4/4/16

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K 144	Continued From page 5 revealed there was no record of the generator cool down cycle and the generator remote annunciator panel was not in a continuously monitored location. This deficient practice was verified by the Facility Administrator and the Maintenance Supervisor	K 144	Baumen, he stated our secondary annunciator at the intersection of Valley and Evergreen wings with Main street will suffice, as it displays everything that the main panel needs to display, and this annunciator IS IN a highly monitored area.	