Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 31, 2024

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

RE: CCN: 245463
Cycle Start Date: July 24, 2024

Dear Administrator:

On July 24, 2024, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "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
2312 College Way
Fergus Falls, 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, 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, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 24, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by January 24, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

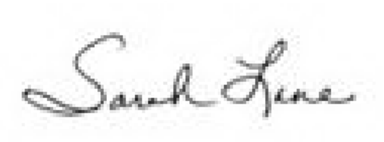
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 07/24/2024

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 7/22/24 to 7/24/24, 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 7/22/24 to 7/24/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed. The following complaints were reviewed with no deficiency issued. H54636121C (MN00100533). H54636007C (MN00102472). H54635086C (MN00104433). H54636110C (MN00105073). 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/02/2024

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 07/24/2024

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 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 regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nebulizer medication was administered safely for 1 of 1 resident (R28) who was observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Findings Include: R28's admission Minimum Data Set (MDS) dated 6/9/24, identified R28 was cognitively intact and had diagnoses which included: chronic obstructive pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed airflow from the lungs), heart failure and anxiety disorder. Indicated R28 required partial/moderate assistance with upper body dressing, transfers, and hygiene. R28's care plan revised 6/27/24, identified R28 had activities of daily living (ADL) self-care performance deficit and required assistance for dressing, personal hygiene and transfers. R28	F 554	R 28 was assessed for appropriateness of Self Administration of Medication Orders on 7/23/2024. All residents have the potential to be affected by this practice as all residents have medication orders. All residents were assessed for the appropriateness of Self Administration of Medication process. Self Administration of Medication policy was reviewed. Licensed Nurses and TMA□s will receive education on the policy - Self Administration of Medication by 8/16/2024 Random audits will be conducted of appropriateness of Self Administration of	8/16/24

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 07/24/2024

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 554	Continued From page 2 had potential for respiratory status/difficulty breathing related to COPD and interventions included administer medication/puffers as ordered. R28's care plan lacked self administration of medication interventions. R28's Medication Review Report signed 7/8/24, included orders for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligrams (MG)/3 milliliters (ML) (a bronchodiator medication that helps relax muscles in airway to increase air flow) one unit inhale orally four times a day for COPD. R28's Medication Review Report lacked an order to self-administer medication. R28's medical record lacked documentation of a self-administration medication (SAM) assessment completed. During an observation and interview on 7/23/24 at 8:36 a.m., trained medication aide (TMA)-A indicated R28 was probably done with her nebulizer medication, entered R28's room, unhooked the nebulizer mask and cup from the nebulizer machine, rinsed it in the sink and set it on a paper towel to dry. At 8:41 a.m., TMA-A indicated he planned to set up R28's nebulizer around lunch time and R28 would administer it herself after set up. During an observation and interview on 7/23/24 at 11:30 a.m., TMA-A entered R28's room, removed a vial of R28's Ipratropium-Albuterol Inhalation Solution from a locked medication drawer, opened the vial and poured it into the nebulizer cup. TMA attached the mask to the tubing on the nebulizer machine and handed the nebulizer to R28. TMA-A turned on the nebulizer machine,	F 554	Medications, and appropriate assessments/ documentation on 4 residents weekly x 6 weeks, every other week x 2, and monthly x 2. Audit results will be reviewed by the Quality Assurance Committee, recommendations for follow up by the committee will be followed. Date of Substantial compliance: 8/16/2024	

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 07/24/2024

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 554	Continued From page 3 sanitized hands and exited R28's room. At 11:33 a.m., TMA-A was at the nursing desk. TMA-A indicated he thought R28 had been assessed to be safe to self administer medications. TMA-A reviewed R28's electronic medical record and verified it lacked a SAM for R28 to self-administer medications. TMA-A stated his usual practice was to set up R28's nebulizer, leave the room and R28 would administer the medication and shut it off when done. At 11:35 a.m., R28 continued to be self-administering her nebulizer in her room while no other staff member was present. During an interview on 7/23/24 at 3:34 p.m., unit manager registered nurse (RN)-A confirmed R28 did not have a SAM assessment, or an order for self administration of medications, which included the nebulizer. RN-A indicated the usual process was to complete a SAM assessment and if it was determined the resident was appropriate to self-administer medications, it should have been added to care plan. In addition, an order should have been obtained and it should have been identified on the resident's electronic health record banner. RN-A stated it was important to complete the SAM and obtain orders to assure medications were administered appropriately and would not cause harm. During an interview on 7/23/24 at 4:11 p.m., director of nursing (DON) indicated the facility's usual process was for licensed staff to complete a SAM and obtain an order for self-administration if the SAM determined the resident was safe to self- administer meds. DON expected staff to re-evaluate quarterly and when a significant change occurred. DON verified an order for self-administration of meds should have been obtained and should have been documented in	F 554		

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 07/24/2024

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 554	Continued From page 4 the resident's care plan and electronic record banner. DON indicated it was important to complete the process to assure the resident received the medications as prescribed by their provider. During an interview on 7/23/24 at 5:03 p.m., R28 confirmed all nursing staff set up her nebulizer medications and did not remain with her while she self-administered the nebulized medication. R28 stated no one had discussed self-administering her nebulizer medication with her and she just automatically completed the task. During a telephone interview on 7/23/24 at 5:19 p.m., pharmacy consultant (PC)-A indicated it was her expectation the facility would have completed a SAM assessment and obtained an order for R28 to self administer her nebulizer medication. PC-A indicated for nebulized medication, the facility needed to assure the resident would keep the nebulizer mask in place and not remove it before the medication administration was completed. The facility policy titled Self-Administration Of Medications revised 2/21, identified residents had the right to self-administer medications if the interdisciplinary (IDT) team had determined that it was clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the IDT team assessed each resident's cognitive and physical abilities to determine whether self-administration medications was safe and clinically appropriate for that resident. If deemed safe and appropriate for a resident to self-administer medications, this would have been documented in the medical	F 554		

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 07/24/2024

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 554	Continued From page 5 record and the care plan.	F 554		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech,	F 676		8/16/24

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 07/24/2024

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 676	Continued From page 6 (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 2 residents (R75) who required assistance with hygiene, and was reviewed for activities of daily living (ADL). Findings Include: R75's quarterly Minimum Data Set (MDS) dated 4/16/24, identified R75 was severely cognitively impaired, with diagnoses which included dementia, coronary artery disease (CAD), and hypertension. Indicated R75 required substantial/maximal assistance with shower/bathing, and partial/moderate assistance with upper and lower body dressing. Identified R75 was independent with personal hygiene. R75's care plan revised 6/28/24, identified R75 had an ADL self-care performance deficit related to confusion, fatigue and impaired balance. R75 required assistance of one staff for dressing, bathing, and personal hygiene. R75's interventions identified R75 preferred no facial hair. During an observation and interview on 7/22/24 at 9:48 a.m., R75 was dressed in street clothes and seated in her recliner chair in her room. R75 had multiple white facial hairs approximately one quarter inch long across both cheeks, chin and around her mouth. R75 had a couple of approximately half inch long white facial hairs on her chin. R75 rubbed her chin and indicated she was unable to take them off by rubbing them.	F 676	R 75 facial hair was removed on 7/23/24, according to the Care Plan. All residents have the potential to be affected. The RN Clinical Coordinators assessed facial hair removal and interventions on Care Plans for each resident. Review of the policy Activities of Daily Living Supporting was completed. All licensed nurses, TMAs and CNA□s will receive education on this policy by 8/16/2024 The Director f Nursing or designee will conduct a random audit of at least 4 residents per week for 6 weeks, then every other week x 2, and monthly x 2 to ensure proper care for facial hair is completed according to resident Care Plans. Audit results will be reviewed by the Quality Assurance Committee, recommendations for follow up by the committee will be followed. Date of Substantial Compliance: 8/16/2024	

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 07/24/2024

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 676	Continued From page 7 During an observation on 7/23/24 at 9:16 a.m., R75 was seated in her chair in her room and dressed in street clothes. R75 was looking for a pen to complete her word search puzzle book. R75 continued to have multiple white facial hairs approximately one quarter inch long across both cheeks, chin and around her mouth. R75 had a couple of approximately half inch long white facial hairs on her chin. During an interview on 7/23/24 at 9:18 a.m., nursing assistant (NA)-B stated she had not assisted R75 that morning with cares however, had noticed R75 had a large amount of facial hair present. NA-B indicated her usual practice when she observed R75 with facial hair, was to ask her if she could remove the hair and then remove it. NA-B stated it was important to assist R75 to remove facial hair to maintain her dignity. During an interview on 7/23/24 at 9:32 a.m., NA-C confirmed assisting R75 with ADL cares that morning and another day earlier that week. NA-C indicated the usual practice was to assist residents to remove facial hair when observed. NA-C had not looked closely at R75 that morning to check for facial hair however, should have done so. NA-C indicated it was important to assist residents with facial hair removal, as most of the female residents did not want any facial hair present. During an interview on 7/23/24 at 10:32 a.m., clinical manager registered nurse (RN)-A indicated the facility's usual practice was to ask residents or family members if the resident wished to have facial hair removed. RN-A stated if a resident wished to have facial hair removed, it	F 676		

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 07/24/2024

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 676	Continued From page 8 was her expectation that staff checked for the presence of facial hair and asked them daily if they want it removed, as it was important to maintain dignity. During an interview on 7/23/24 at 10:39 a.m., director of nursing (DON) stated the facility's usual practice was for staff to offer to remove the resident's facial hair daily when present with morning cares. If a resident refused the offer, DON expected staff to document it. DON stated the resident's facial hair preference would have been identified on the resident's care plan. DON indicated it was important to assist residents to remove facial hair if they were unable to complete the task themselves to maintain dignity, to promote confidence and to have pride in their appearance. During a telephone interview on 7/23/24 at 10:48 a.m., family member (FM)-A stated R75 did not want to have any facial hair present and expected it to be removed. The facility policy titled Shaving The Resident revised 2/18, identified the purpose was to promote cleanliness and to provide skin care. The policy instructed to review the resident's care plan to assess for any special needs of the resident. The policy instructed to notify the supervisor if the resident refused the procedure.	F 676		
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-	F 686		8/16/24

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 07/24/2024

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 9 (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 comprehensively assess, monitor, develop and implement interventions to promote healing for 1 of 3 residents (R38) reviewed for a current, facility acquired, stage two pressure ulcer. Stage two pressure ulcer; partial-thickness skin loss with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Findings include: R38's significant change of status assessment (SCSA) Minimum Data Set (MDS) dated 7/2/24, identified R38 had diagnoses which included dementia, aphasia (loss or impairment to use or comprehend language), cerebral infarction (brain lesion in which a cluster of brain cells die when they don't get enough blood), congestive heart failure, chronic respiratory failure and dependence on supplemental oxygen. Indicated R38 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) which included bed mobility,	F 686	A Comprehensive Skin Assessment was completed on 8/1/2024, weekly skin assessments were implemented and treatment of Aquaphor to area BID until healed was implemented on 7/24/2024 for R 38. All residents have the potential to be affected. Each resident will have a comprehensive skin assessment completed, and residents with skin areas will be identified. Review of the policies Documentation of Wound Treatments, Skin Assessment, and Change in a Residents Condition or Status was completed. All licensed nurses, TMAs and CNAs will receive education on these policies by 8/16/2024 The Director of Nursing or designee will conduct a random audit of at least 4 residents per week for 6 weeks then every other week x 2, and monthly x 2 to ensure comprehensive skin assessment, weekly monitoring, and appropriate	

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 07/24/2024

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 10 transfers, toileting, dressing, personal hygiene and bathing. Identified R38 was at risk for developing pressure ulcers. The MDS lacked documentation of R38 having a pressure ulcer. R38's SCSA care area assessment worksheet (CAA) dated 7/9/24, identified R38 required extensive assistance with bed mobility, had a pressure reducing mattress on his bed and no noted skin issues. Identified R38 demonstrated a steady decline over the past several months and spent more time in bed. R38's care plan revised 2/3/24, identified R38 had potential impairment of skin integrity. R38's care plan lacked documentation of a current pressure ulcer. Furthermore, R38's care plan indicated R38 had shortness of breath related to diagnosis of chronic respiratory failure and received oxygen via nasal cannula continuously. R38's care plan lacked documentation of interventions to prevent pressure ulcers related to oxygen tubing. R38's Braden scale (tool used to determine risk for pressure ulcer development) dated 7/16/24, identified R38 was at moderate risk for pressure ulcer development due to the following risk factors; slightly limited sensory perception, very moist skin, was chairfast, slightly limited mobility and very poor nutrition. In addition, friction and shearing were a potential problem for R38 who required moderate to maximum assistance with moving. R38's nursing respiratory assessment dated 7/16/24, identified R38 had oxygen continuously via nasal cannula and would not experience discomfort or altered quality of life related to respiratory status.	F 686	interventions are in place in identified residents with open skin areas. Audit results will be reviewed by the Quality Assurance Committee, recommendations for follow up by the committee will be followed. Date of Substantial Compliance: 8/16/2024	

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 07/24/2024

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 11 R38's nursing assessment dated 7/16/24, identified R38 had no skin concerns. Skin remained intact. Cushion applicators present behind ears. R38's progress note weekly skin assessment dated 7/9/24, identified R38 continued to have skin breakdown behind left ear from nasal cannula tubing. Skin protector applicator was placed on nasal cannula tubing and a treatment to monitor R38's ear until healed was setup by nursing. The note lacked a description of the breakdown and the type of treatment initiated by nursing staff. R38's progress note weekly skin assessment dated 7/16/24, identified R38 had no skin alterations. R38's progress note weekly skin assessment dated 7/23/24, identified R38 had no skin alterations. R38's progress notes lacked assessment of the pressure ulcer including measurements, interventions implemented to promote healing and prevent further breakdown and weekly monitoring of the ulcer to determine if it was healing or worsening. R38's nursing assistant (NA) care guide/Kardex printed 7/24/24, indicated R38 had oxygen via nasal cannula continuously. The Kardex lacked documentation of the presence of a pressure ulcer. During an observation on 7/23/24 at 3:04 p.m., R38 was laying in bed with the nasal cannula on	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 07/24/2024

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 12 and foam protectors on oxygen tubing behind bilateral ears. A Band-Aid was observed to be on the back of R38's left ear. During an observation and interview on 7/23/24 at 3:25 p.m., registered nurse (RN)-B stated she was unaware R38 had a Band-Aid to the back of his ear and was unaware that R38 had a pressure ulcer present on the back of the left ear. RN-B removed the Band-Aid and stated the Band-Aid did not look new. RN-B stated the Band-Aid had dried blood on it, no odor, and no drainage noted to the area on back of the left ear. RN-B confirmed there had been no initial assessment of the pressure ulcer on the back of R38's left ear or any measurements of the pressure ulcer documented in the electronic medical record (EMR). At 4:04 p.m., RN-B measured the pressure ulcer of R38's left ear at 0.5 centimeters (cm) long by 0.5 cm wide and was round. RN-B verified the pressure ulcer was located in the middle of the back of R38's left ear and stated the first layer of the skin was gone. The wound bed was red and no drainage was observed. RN-B confirmed it was important to assess and measure a pressure ulcer to determine if the pressure ulcer was improving or worsening and to implement interventions to assist with healing. RN-B stated there was a wound checklist at the nurses' station for nurses to complete when a new pressure ulcer was identified on a resident. During an interview on 7/24/24 at 12:31 p.m., licensed practical nurse (LPN)-A verified the progress note on 7/23/24. LPN-A stated she did not observe a Band-Aid behind R38's left ear during the weekly skin assessment documented on 7/23/24 at 1:51 p.m. LPN-A stated R38 had	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 07/24/2024

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 some redness behind both ears however there were no open areas present. During an interview on 7/24/24 at 12:35 p.m., RN-A stated she was unaware of a skin concern behind R38's left ear prior to last evening on 7/23/24. RN-A confirmed R38 had developed a stage two pressure ulcer to the back of his left ear from the oxygen tubing. RN-A stated the expectation of nursing staff was to complete a wound checklist when a new pressure ulcer was identified and verified the following steps of the wound checklist: -measure wound and describe. -start initial treatment (barrier cream, dressing, monitoring schedule). -notify the following; resident, resident representative, dietary, therapy, doctor, care coordinator. -implement new interventions (start tissue tolerance, air mattress, heel boots, etc.). -update care plan. -document. -once completed turn wound assessment into care coordinator. RN-A confirmed the progress note on 7/9/24, should have had a wound checklist completed. RN-A verified it was important to complete the wound checklist sheet to determine objectively if the pressure ulcer on the back of R38's ear was healing or worsening and if the right treatment had been implemented. During an interview on 7/24/24 at 1:15 p.m., RN-C verified the progress note on 7/9/24. RN-C stated R38 had a scabbed area to the back of his left ear and RN-C stated the scab was not a new concern.	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 07/24/2024

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 During an interview on 7/24/24 at 12:46 p.m., R38's doctor verified he was not aware of R38 having a pressure ulcer prior to last evening on 7/23/24. R38's doctor confirmed he would expect the facility to update him timely when a pressure ulcer developed and stated it was important to provide the resident with treatment, prevent infection and promote proper healing. During an interview on 7/24/24 at 1:23 p.m., the director of nursing (DON) verified she was not aware R38 had a pressure ulcer prior to last evening on 7/23/24. The DON confirmed R38's care plan lacked documentation about the development of the pressure ulcer to his left ear. The DON stated the expectation of nursing staff was for them to complete a wound checklist whenever a pressure ulcer developed, complete weekly monitoring, updating the care plan, the doctor and provide interventions. The DON verified it was important to complete the wound checklist to ensure a resident's pressure ulcer was healing and not worsening and ensure the interventions in place were effective. Review of the facility policy titled Skin Assessment, undated, identified it was the policy of the facility to complete weekly skin checks and quarterly skin assessments. Indicated it was the facility's procedure once a pressure injury was identified, that assessment and treatments, which included pressure relieving and nutritional interventions, would be implemented, care planned and monitored to promote healing. Review of the facility policy titled Documentation of Wound Treatments, undated, identified a pressure ulcer would be assessed including response to treatment, change in condition and	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 07/24/2024

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 changes in treatment. Pressure ulcers would be monitored for progression of wound healing and care plans would be reviewed and modified as appropriate.	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 **02 - MAIN BLDG TWO** B. WING _____	**07/23/2024**

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 07/23/2024. At the time of this survey, Pioneer Care Center Building 02 was found not 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'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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K	K 000		

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

Electronically Signed | 08/06/2024

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 **02 - MAIN BLDG TWO** B. WING _____	**07/23/2024**

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	Continued From page 1 TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was surveyed as two buildings. Pioneer Care Center is made up of two buildings. Building 02 is a 2-story building with no basement and is Type II (111) construction. It is fully sprinkler protected and has a complete fire alarm system including smoke detectors in the corridor, sleeping rooms and common areas. All hazardous areas have automatic fire detection.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **02 - MAIN BLDG TWO** B. WING _____	**07/23/2024**

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	Continued From page 2 Building 02 is divided into 5 smoke compartments. Building 02 and 03 are separated by a 2-hour fire barrier. The facility has a licensed capacity of 105 beds and had a census of 94 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		8/30/24

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 _____	**07/23/2024**

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 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to install proper protection for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.3.2.5.3 (9). These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/23/2024 between 9:30 AM and 12:00 PM, it was revealed by observation that the stoves throughout the facility in each resident neighborhood area and in the Therapy Room did not have timers, not exceeding 120 minutes, that automatically deactivates the cooktops or ranges, independent of staff action. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	120 Minute Timers have been ordered for all ranges/ stoves in 6 households and therapy department. These timers will be installed on 8/30/2024 by Cossette Electric. Because of the installation, this will not reoccur, and solutions will be sustained. Brad Bushinger Environmental Services Director is responsible for the correct actions and compliance. Proposed date for completion 8/30/24	

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 _____	**07/23/2024**

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 07/23/2024. At the time of this survey, Pioneer Care Center building 03 was found not 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'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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K	K 000		

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

Electronically Signed | 08/06/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **03 - SOUTH BLDG 3** B. WING _____	**07/23/2024**

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	Continued From page 1 TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was surveyed as two buildings. Building 03 is a 1-story building with no basement and is Type V (111) construction. Building 03 is fully sprinkler protected and has a complete fire alarm system including smoke detectors in the corridor, sleeping rooms and common areas. All hazardous areas have automatic fire detection. Building 03 is divided into 3 smoke compartments.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING **03 - SOUTH BLDG 3** B. WING _____	**07/23/2024**

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	Continued From page 2 Building 02 and 03 are separated by a 2-hour fire barrier. The facility has a licensed capacity of 105 beds and had a census of 94 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		8/30/24

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 _____	**07/23/2024**

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 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to install proper protection for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.3.2.5.3 (9). These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/23/2024 between 9:30 AM and 12:00 PM, it was revealed by observation that the stoves throughout the facility in each resident neighborhood area did not have timers, not exceeding 120 minutes, that automatically deactivates the cooktops or ranges, independent of staff action. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	120 Minute Timers have been ordered for all ranges/ stoves in 6 households and therapy department. These timers will be installed on 8/30/2024 by Cossette Electric. Because of the installation, this will not reoccur, and solutions will be sustained. Brad Bushinger Environmental Services Director is responsible for the correct actions and compliance. Proposed date for completion 8/30/24.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 6, 2024

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

RE: CCN: 245463
Cycle Start Date: July 24, 2024

Dear Administrator:

On August 21, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us