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: WOPD
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 **02/14/2014** (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:

**X** 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):
**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
02/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
04/28/2014 (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
**03/04/2014**
(L33)

DETERMINATION APPROVAL

**C&T REMARKS - CMS 1539 FORM** **STATE AGENCY REMARKS**

Page 2
Provider Number: 24-5301
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Based on the plan of correction the facility has corrected the deficiencies issued pursuant to the standard survey January 10, 2014, effective February, 7, 2014.

Effective, February 7, 2014, the facility is certified for 68 skilled nursing facility beds.

*Protecting, Maintaining and Improving the Health of Minnesotans*

Medicare Provider # 245301

February 25, 2014

Ms. Melissa Chisholm, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, MN 56535-9466

Dear Ms. Chisholm:

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 February 7, 2014, 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.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

*Protecting, Maintaining and Improving the Health of Minnesotans*

Ms. Melissa Chisholm, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, MN 56535-9466

RE: Project Number S5301023

Dear Ms. Chisholm:

On January 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 10, 2014 that included an investigation of complaint number H5301011. 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 February 19, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 19, 2014 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 January 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 7, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 10, 2014, effective February 7, 2014 and therefore remedies outlined in our letter to you dated January 21, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Lyla Burkman/BA

Lyla Burkman, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-308-2104 Fax: 218-308-2122

Enclosure: cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245301 | A. Building<br>B. Wing | 2/14/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| PIONEER MEMORIAL CARE CENTER | 23028 - 347TH STREET SOUTHEAST<br>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).

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix F0406<br>Reg. # 483.45(a)<br>LSC | 01/30/2014 | ID Prefix F0431<br>Reg. # 483.60(b), (d), (e)<br>LSC | 01/30/2014 | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
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| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| | | | | |
|---|---|---|---|---|
| Reviewed By ✓ State Agency | Reviewed By 10562 | Date: 2/24/14 | Signature of Surveyor: 10562 | Date: 2/25/14 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

Followup to Survey Completed on:
1/10/2014

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

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| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245301 | A. Building<br>B. Wing 02 - 2005 ADDITION 02 | 2/19/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| PIONEER MEMORIAL CARE CENTER | 23028 - 347TH STREET SOUTHEAST<br>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).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0054 | Correction Completed 02/07/2014 | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
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| | | | | |
|---|---|---|---|---|
| Reviewed By ✓ State Agency | Reviewed By 10562 | Date: 2/24/14 | Signature of Surveyor: 10562 | Date: 2/24/14 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|---|
| 1/9/2014 | | | | |

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

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| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245301 | A. Building / B. Wing: 02 - 2005 ADDITION 02 | 2/19/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| PIONEER MEMORIAL CARE CENTER | 23028 - 347TH STREET SOUTHEAST<br>ERSKINE, MN 56535 |

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| | | | | |
|---|---|---|---|---|
| Reviewed By State Agency ✓ | Reviewed By 10562 | Date: 2/24/14 | Signature of Surveyor: 10562 | Date: 2/24/14 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

Followup to Survey Completed on: 1/9/2014

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: WOPD
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 **02/14/2014** (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:
X A. In Compliance With Program Requirements Compliance Based On:
X 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: **A1*** (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):

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 02/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 03/13/2014 (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
**03/04/2014**
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2
Provider Number: 24-5301
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective February, 25, 2014, the facility is certified for 68 skilled nursing facility beds.

*Protecting, Maintaining and Improving the Health of Minnesotans*

Medicare Provider # 245301

February 25, 2014

Ms. Melissa Chisholm, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, MN 56535-9466

Dear Ms. Chisholm:

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.

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68 Skilled Nursing Facility/Nursing Facility Beds

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Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

*Protecting, Maintaining and Improving the Health of Minnesotans*

Ms. Melissa Chisholm, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, MN 56535-9466

RE: Project Number S5301023

Dear Ms. Chisholm:

On January 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 10, 2014 that included an investigation of complaint number H5301011. 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.

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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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Lyla Burkman/BA

Lyla Burkman, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-308-2104 Fax: 218-308-2122

Enclosure: cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

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| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245301 | A. Building<br>B. Wing | 2/14/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| PIONEER MEMORIAL CARE CENTER | 23028 - 347TH STREET SOUTHEAST<br>ERSKINE, MN 56535 |

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| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix F0406<br>Reg. # 483.45(a)<br>LSC | 01/30/2014 | ID Prefix F0431<br>Reg. # 483.60(b), (d), (e)<br>LSC | 01/30/2014 | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
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| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency ✓ | 10562 | 2/24/14 | 10562 | 2/25/14 |
| CMS RO | | | | |

Followup to Survey Completed on:
1/10/2014

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

Form Approved
OMB NO. 0938-0390

# Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245301 | A. Building<br>B. Wing 02 - 2005 ADDITION 02 | 2/19/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| PIONEER MEMORIAL CARE CENTER | 23028 - 347TH STREET SOUTHEAST<br>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).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix ___<br>Reg. # NFPA 101<br>LSC K0054 | Correction Completed 02/07/2014 | ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed | ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed |
| ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed | ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed | ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed |
| ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed | ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed | ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed |
| ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed | ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed | ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed |
| ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed | ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed | ID Prefix ___<br>Reg. # ___<br>LSC ___ | Correction Completed |

| | | | | |
|---|---|---|---|---|
| Reviewed By ✓ State Agency | Reviewed By 10562 | Date: 2/24/14 | Signature of Surveyor: 10562 | Date: 2/24/14 |
| Reviewed By ___ CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

Followup to Survey Completed on:
1/9/2014

___ 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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
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| 245301 | A. Building B. Wing 02 - 2005 ADDITION 02 | 2/19/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
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| PIONEER MEMORIAL CARE CENTER | 23028 - 347TH STREET SOUTHEAST<br>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).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0054 | Correction Completed 02/07/2014 | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
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| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By State Agency ✓ | Reviewed By 10562 | Date: 2/24/14 | Signature of Surveyor: 10562 | Date: 2/24/14 |
|---|---|---|---|---|
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

Followup to Survey Completed on:
1/9/2014

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: WOPD
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 **01/10/2014** (L34)

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

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) :

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

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)

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):

**See Attached Remarks**

17. SURVEYOR SIGNATURE — Date :
Rebecca Haberle, HFE NE II — 02/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 02/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **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 (L33)

DETERMINATION APPROVAL

**C&T REMARKS - CMS 1539 FORM** **STATE AGENCY REMARKS**

CCN-245301

At the time of the standard survey completed January 10, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to bewidespread 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. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7011 2000 0002 5143 8293

January 21, 2014

Ms. Melissa Chisholm, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, Minnesota 56535-9466

RE: Project Number S5301023 and H5301011

Dear Ms. Chisholm:

On January 10, 2014, 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. In addition, at the time of the January 10, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - 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
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601

Telephone: (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 February 19, 2014, 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 February 19, 2014 the following remedy will be imposed:

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

**PLAN OF CORRECTION (PoC)**

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

**VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

**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 April 10, 2014 (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 July 10, 2014
(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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

| 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 ______ | 01/10/2014 |

RECEIVED FEB 03 2014

| 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<br><br>A standard recertification survey was conducted and a complaint investigation had also been completed at the time of the standard survey. An investigation of complaint H5301011 had not been substantiated during this survey<br><br>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.<br><br>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 | Pioneer Memorial Care Center wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is January 30th, 2014.<br><br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies sanctioned by the Department of Health and Human Services. The plan of correction is prepared and/or executed solely as a requirement by the provisions of Federal and State law. | |
| F 406 SS=D | 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES<br><br>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.<br><br>This REQUIREMENT is not met as evidenced | F 406 | It is Pioneer Memorial Care Center's policy to provide active treatment services for individuals that are assessed to required specialized rehabilitative services for intellectual disability.<br><br>All Residents of Pioneer Memorial Care Center have been reviewed for Intellectual Disability Diagnosis noting two Residents in-house and performed record review of Long Term Care Consultation Screenings and if deemed necessary, the Long Term Care Consultation Community Support Plan / Individual Service Plan. IDT noted no such issues related to the Residents' Plan of Care and providing active treatment. | 1-30-14<br><br>Approved 2/4/14 SB |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Chisholm | TITLE: Administrator | (X6) DATE: 1/31/14

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 |
|---|---|---|---|
| | 245301 | A. BUILDING ______ B. WING ______ | 01/10/2014 |

| 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 406 | Continued From page 1<br>by:<br>Based on observation, interview and document review, the facility failed to ensure active treatment services were provided for 1 of 1 resident (R54) who was assessed to require specialized rehabilitative services for intellectual disability.<br>Findings include:<br><br>R54's medical record Face Sheet dated 1/10/14, indicated R54 was admitted to the facility on 9/11/13, with diagnoses of surgical repair of a fractured right ankle, postoperative pain, intellect disability and episodic mood disorder. R54's Quarterly/30 day Minimum Data Set (MDS) dated 11/25/13, indicated R54 had intact cognition and required extensive assist of two staff for bed mobility, toileting and personal hygiene. The MDS also indicated R54 required total assistance of two staff for transfers and extensive assistance of one staff for dressing. The MDS also indicated R54 could feed self after set up from staff.<br><br>On 01/08/14, at 12:35 p.m. R54 was observed sitting in his wheelchair, alone in his room, listening to the radio.<br>- at 1:30 p.m. R54 was observed in his room.<br><br>On 01/09/14, from 7:12 a.m. until 9:43 a.m. R54 was continuously observed.<br>-At 7:12 a.m. R54 was observed in his room with the lights off. R54 was lying in bed fully clothed , listening to the radio.<br>-At 7:54 a.m. licensed practical nurse (LPN)-A was observed to enter R54's room and administered his medications.<br>- At 8:15 a.m. LPN-A and nursing assistant (NA)-C was observed to enter R54's room and assisted R54 into the chair. | F 406 | R54's Evaluative Report Level II Preadmission Screening for Persons with Developmental Disability or Related Conditions completed on 9-11-13, (Date of Admission to Pioneer Memorial Care Center) was completed by Pennington County Case Manager without having been seen onsite at Pioneer Memorial Care Center. The preadmission screening performed by the County, Department of Health (DHS) accepted the screening on 10-1-12. R54 resides in Pioneer Memorial Care Center subsequent to surgical ankle repair. Prior to R54's transfer to Pioneer Memorial Care Center, R54 resided in an Assisted Living Apartment.<br><br>Amy Bardwell Social Worker of Pennington County had indicated that R54 is not on waiver services therefore he does not qualify for services from the County for active treatment. According to Amy Bardwell, SW; Residents of a Skilled Nursing Facility "never qualifies" for waivered services conducted outside the Skilled Nursing Facility. R54 came to Pioneer Memorial Care Center with the intentions of returning back to the Assisted Living upon rehabilitation and a Physician recommendation to return to the Assisted Living. Prior to admission to Pioneer Memorial Care Center R54 had Case Manager who left Pennington County and the position was not filled prior to December of 2013 for a number of months. Because R54 moved from | |

| 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 ______ | 01/10/2014 |

| 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 406 | Continued From page 2<br>- From 8:23 a.m. to 9:16 a.m. R54 was observed in the dining room seated at a table by himself, eating his breakfast.<br>-At 9:30 a.m. LPN-A and NA-C returned R54 to his bed.<br><br>R54's Evaluative Report Level II Preadmission Screening for Persons with Developmental Disability or Related Conditions completed 9/11/13, specified R54 had developmental disability and "a severe physical illness that has resulted in a level of impairment so severe that, in the judgment of the QMRP (qualified mental retardation professional) the person requires nursing facility (NF) services." The report also indicated the final disposition regarding R54's need for active treatment was specified by an "X" next to the statement "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." The developmental disability screening was approved by the department of health services (DHS) on 10/01/2012.<br><br>R54's care plan dated 10/1/13, indicated R54 had difficulty making decisions related to intellect disability, difficulty at times expressing ideas, needs or wants, required assistance for toileting, bathing, bed mobility, transfers, dressing, grooming, felt isolated from family and community friends and displayed socially inappropriate/disruptive behaviors. R54's care plan lacked a focus of identifying and implementing approaches to meet his specialized rehabilitative needs for intellectual disability.<br><br>On 01/9/14, at 2:40 p.m. R54 was interviewed | F 406 | Pennington County into Polk County for increased need and there was no Case Manager involved during the transition, there was no communication provided on the Individual Service Plan to PMCC although one had not been completed until 1-14-14 subsequent to MDH survey. Pioneer Memorial Care Center was not communicated nor provided the Individual Service Plan from the County as there was no Case Worker overseeing his care. When SSD from PMCC contacted Pennington County it was identified that R54 did not have an Individual Service Plan for the years 2012 to 2013. Upon contacting the County, an Individual Service Plan was completed with Power of Attorney and Social Worker of Pennington County on 1-14-14 which indicates that R54 discontinued participating in the DAC in Pennington County due to pain in his legs and lack of mobility noting to be prior to 11-27-12. In the Community Support Plan, the Power of Attorney has indicated that she was offered the choice to receive services in the Community or in a Nursing facility such as Pioneer Memorial Care Center, given a listing of providers to choose services from, she also indicated that she had a chance to help develop the Individual Care Plan, and is in agreement with the services being provided. | |

| 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 ______ | 01/10/2014 |

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

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F 406 Continued From page 3

regarding his daily activities. R54 stated he liked to play the games the facility offered and enjoyed playing bingo and listening to the radio in his room. R54 also stated activity staff came to his room every day to encourage him to attend the facility's planned activities. R54 stated he had planned to attend the cooking activity this afternoon but he had fallen asleep.

On 01/9/14, at 3:07 p.m. NA-E confirmed R54 attended activities almost every afternoon and would not return to the unit 3 p.m. NA-E stated in the evenings R54 would most often listen to his radio in his room or occasionally watch television in the lounge area.

On 01/10/14, at 8:52 a.m. R54 was interviewed regarding his work history and reported in the past he worked at the Occupational Development Center (ODC) sorting papers and stuffing envelopes for them and would also get together for group activities such as bowling. However, R54 stated he had told his foster mother it was just too much and she let him stay home. R54 stated he could not remember how long it had been since he quit working at ODC.

On 1/10/14, at 9:15 a.m. registered nurse (RN)-A stated she was not aware of any programs in place regarding R54's active treatment plan.

On 1/10/14, at 9:18 a.m. activities staff-A stated she was unaware of any specific programs for R54 related to his intellect disability diagnosis.

On 01/10/14, at 9:19 a.m. the administrator and social service designee (SSD)-A were interviewed. SSD-A stated they do not have an individual service plan from the county for R54.

F 406

Subsequent to MDH survey, R54 had an appointment scheduled with a Specialist to determine if R54 was deemed appropriate to bear weight on his ankle on 1-28-14. At this appointment, R54 was given the order for therapy to review and work with his weight bearing status and to apply weight as tolerated. Resident has been unable to bear weight since admission on 9-11-13 therefore has been limited in the activities of which he can participate in. R54 continues to work towards his goal of returning to the Assisted Living.

Pioneer Memorial Care Center has developed active treatment in-house for Resident R54 which involves delivering mail 3 days per week on his associated wing and assisting staff in gathering recycling products weekly and helping crush soda cans as tolerated and the earnings will be reimbursed to the Resident Activity Fund. R54 has indicated his enjoyment in playing bingo; IDT developed the task of counting the money for the games that will be distributed for prizes and will be responsible for communicating this information with Activities Staff.

Preadmission Screening and Annual Resident Review process was developed by IDT and approved by the Quality Assurance Committee on 1-29-14. Changes in the process and procedures for Residents with Intellectual Disability were communicated with RN Unit Coordinators, Activity Staff, and members of IDT on 1-30-14.

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| | 245301 | A. BUILDING ______ B. WING ______ | 01/10/2014 |

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

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| F 406 | Continued From page 4<br>SSD-A stated she wasn't aware of the assessment indicating R54 required active treatment and wasn't aware of the obligation to provide R54 those services. SSD-A also stated there had been no coordination to provide active treatment services for R54.<br><br>On 01/10/14, at 9:59 a.m. the activities director stated the facility had not provided any specific or special activities for R54. The director confirmed R54 attended and participated in almost all of the scheduled activities at the facility.<br><br>A policy regarding Preadmission Screening and Annual Resident Review (PASARR) was requested of administrator but none was provided. | F 406 | Director of Nursing and Social Services is responsible for the continued compliance with providing active treatment.<br><br>Residents with Intellectual Disability will be reviewed with IDT upon Admission to facility and reviewed quarterly at Quality Assurance Meetings to ensure proper measures are taken in providing services to those deemed appropriate to participate in outside community support programs.<br><br>Completion date: 1-30-14 | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in | F 431 | Administrator and Director of Nursing has reviewed with LPN-B the policy pertaining to Proper Disposal of Medications and was reeducated on the requirement of needing two individuals in the destruction of controlled substances and required to recomplete the "Medication Administration" continued education inservice. Administrator and Director of Nursing held an All Nursing Staff Meeting reviewing and reeducating on the requirements of Proper Drug Labeling techniques, drug storage and biologicals, and disposal of controlled substance on January 30th, 2014. | 1-30-14 |

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

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| F 431 | Continued From page 5<br>locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure Fentanyl (narcotic analgesic) patches were destroyed in a manner to prevent potential diversion for 1 of 2 residents (R32) reviewed with prescribed Fentanyl patches.<br><br>Findings include:<br><br>R32's Physician Orders dated 1/7/14, indicated R32's diagnoses included renal failure and shortness of breath. The orders also indicated an order for Fentanyl patch 25 micrograms (mcg) per hour to be applied topically (to the skin) every 72 hours.<br><br>On 1/10/14, at 8:46 a.m. during the Oakview wing medication storage review, licensed practical nurse (LPN)-B verified R32 was receiving a | F 431 | All Residents with Fentanyl transdermal patches were reviewed and Narcotic Records were reviewed for dual signatures indicating proper disposal of medications.<br><br>It is Pioneer Memorial Care Center's policy that all controlled substances be destroyed with two present individuals witnessing both the quality and type of medication during the disposal process. LPN-B claimed to have had a lapse in judgment and subsequently received correction/disciplinary actions related to the incident.<br><br>Director of Nursing and Unit Coordinator RN staff will audit all medication carts, narcotic books, medication rooms, and refrigerators at one time per week for the next 4 weeks. Any variances will be corrected upon observation, and concerns will be reported and reviewed at Quality Assurance Committee meetings and Interdisciplinary team for further recommendations. Medication administration observation will also include cart staffs' ability to have two participants in the transdermal patches disposal process.<br><br>Unit Coordinator RNs and Director of Nursing are responsible for monitoring of ongoing compliance by random audits and report any issues at the subsequent Quality Assurance Meetings.<br><br>Completion date: 1-30-14 | |

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| F 431 | Continued From page 6<br>Fentanyl Patch. LPN-B stated R32's Fentanyl patch was removed in the morning when a new patch was applied. LPN-B also stated they were not consistently having two nurses witness and sign when the Fentanyl patch was disposed of in the sewer system. LPN-B further stated the facility policy was to have two nurses witness and sign when the patch was destroyed. However, LPN-B stated sometimes it was hard to find another licensed staff member.<br><br>Review of R32's individual narcotic record revealed the following dates lacked documentation of two nurse witness signatures/initials indicating the proper disposal of the Fentanyl patch: 12/5/13, 12/8/13, 12/11/13, 12/14/13, 12/17/13, 12/20/13, 12/23/13, 12/26/13, 12/29/13, 1/1/14, 1/4/13 and 1/7/14.<br><br>The facility's Fentanyl Transdermal Patch policy revised 6/21/13, indicated a second nurse was to witness the disposal of the medication via the sewer system to reduce the risk of potential diversion of this potent narcotic analgesic.<br><br>On 1/10/14, at 9:10 a.m. registered nurse (RN)- A stated she was not aware LPN-B was not having another nurse witness the destruction of the Fentanyl patch as facility policy directed.<br><br>On 1/10/14, at 9:28 a.m. the director of nursing (DON) verified the findings and stated she was not aware the LPN's were not following the policy. In addition, the DON stated there would always be another nurse around to witness the | F 431 | | |

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| F 431 | Continued From page 7<br>destruction. | F 431 | | |

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

F5301023

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

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|---|---|---|---|
| | 245301 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **01/09/2014** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>01 Main Building<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Pioneer Memorial Care Center 01 Main Building found not 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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145<br>St. Paul, MN 55101 | K 000 | POC ok 2-3-14<br><br> <br>RECEIVED FEB - 3 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa [signature] | TITLE: Administrator | (X6) DATE: 1/31/14

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 **01 - MAIN BUILDING 01**<br>B. WING | **01/09/2014** |

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| K 000 | Continued From page 1<br><br>Or by e-mail to:<br>Marian.Whitney@state.mn.us<br><br>Fax Number 651-215-0525<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency<br><br>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 building is divided into 7 smoke compartments by 1-hour fire barriers.<br><br>The facility is protected with a complete automatic sprinkler system installed in accordance with NFPA 13 Installation of Automatic Sprinkler Systems 1999 edition. The 1997 and 2005 additions use quick response sprinkler heads. The facility has a fire alarm system with corridor smoke detection and smoke detectors in all | K 000 | | |

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| | 245301 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 01/09/2014 |

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| K 000 | Continued From page 2<br>common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. 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 2007 edition.<br><br>The facility has a capacity of 68 beds and had a census of 61 at the time of the survey.<br><br>The facility was surveyed as two buildings 01 existing and 02 new.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 018<br>SS=C | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities. | K 018 | | |

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| | 245301 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 01/09/2014 |

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| K 018 | Continued From page 3<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and testing of corridor doors, it was determined that one corridor door did not comply with NFPA 101 "The Life Safety Code" 2000 Edition Section 19.3.6.1. This deficient practice could allow the products of combustion to spread beyond the room of fire origin and negatively impact all 119 residents, any visitors and staff of this facility.<br><br>Findings include:<br>During the facility tour on January 9, 2014 between 10:00 am and 12:15 pm, observations and testing of at least 30 corridor doors, by surveyor 03006, revealed that the east corridor door from the dining room has a coordinator that did not work.<br><br>This deficient practice was confirmed by the Director of Maintenance and the Administrator at the time of the inspection and during the exit conference. | K 018 | Maintenance Department of Pioneer Memorial Care Center has fixed the coordinator on the east corridor door from the main dining room. All other facility doors were checked in the facility to ensure proper working condition noting no further issues.<br><br>The repair to the door was completed on January 30, 2014. | 1-30-14 |

F5301023

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OMB NO. 0938-0391

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| | 245301 | A. BUILDING **02 - 2005 ADDITION 02**<br>B. WING ______ | **01/09/2014** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>02 2005 Building<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Pioneer Memorial Care Center 02 2005 Addition was found not 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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145<br>St. Paul, MN 55101 | K 000 | POC ok 2-3-14<br><br> <br>RECEIVED FEB - 3 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION | |

Dc. 2-19-14

EXIT: 1-10-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Olidsen (signature) — TITLE: Administrator — (X6) DATE: 1/31/14

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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 **02 - 2005 ADDITION 02**<br>B. WING ______ | **01/09/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PIONEER MEMORIAL CARE CENTER** | **23028 - 347TH STREET SOUTHEAST**<br>**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 |
|---|---|---|---|---|
| K 000 | Continued From page 1<br><br>Or by e-mail to:<br>Marian.Whitney@state.mn.us<br><br>Fax Number 651-215-0525<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency<br><br>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 building is divided into 7 smoke compartments by 1-hour fire barriers.<br><br>The facility is protected with a complete automatic sprinkler system installed in accordance with NFPA 13 Installation of Automatic Sprinkler Systems 1999 edition. The 1997 and 2005 additions use quick response sprinkler heads. The facility has a fire alarm system with corridor smoke detection and smoke detectors in all | K 000 | | |

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| K 000 | Continued From page 2<br>common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. 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 2007 edition.<br><br>The facility has a capacity of 68 beds and had a census of 61 at the time of the survey.<br><br>The facility was surveyed as two buildings 01 existing and 02 new.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 054<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3<br><br>This STANDARD is not met as evidenced by:<br>Based on observations of the smoke detection system it was determined that the automatic smoke detection in the new building is not in accordance with NFPA 72 " The National Fire Alarm Code" 1999 Edition section 7-3.2.1. Lack of proper installation of the smoke detectors may allow them to fail or delay alarming in a fire emergency causing a delay in the response to the fire emergency, which would negatively impact all 49 of the residents, the staff and visitors.<br><br>Findings include: | K 054 | Pioneer Memorial Care Center contacted Simplex Grinnell to move the smoke detector approximately one foot from the HVAC diffuser in the corridor outside of room 114 on the Oak Wing. All other smoke detectors of the facility were also reviewed for dust and cleared if noted. The move of the smoke detector was coordinated by Kraig Kubiak, Maintenance Supervisor and oversight was provided by Melissa Chisholm, Administrator.<br><br>The repair is scheduled to be completed by February 7th, 2014. | 2-7-14 |

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

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| K 054 | Continued From page 3<br>During the facility tour on January 9, 2014, between 10:00 am, and 13:15 pm, observations by surveyor 03006, revealed that the smoke detector in the corridor outside of room 114 is to close to the HVAC diffuser. Dust had accumulated on the side of the smoke detector.<br><br>This deficient practice was confirmed by the Director of Maintenance and the Administrator at the time of the inspection and during the exit conference. | K 054 | | |