Electronically delivered
April 2, 2020

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

RE: CCN: 245463
Cycle Start Date: March 10, 2020

Dear Administrator:

During this period of pandemic COVID-19 outbreak, the Centers for Medicare and Medicaid Services (CMS) has directed the State Agencies (MDH) to change the process for survey prioritization and enforcement remedies. CMS is delaying revisit surveys and are exercising enforcement discretion during this prioritization period, beginning March 23, 2020. As a result, the below enforcement actions resulting from this survey cycle will be suspended until revisits are again authorized.

This letter also requests that your facility submit an electronic plan of correction (ePOC). Although revisit surveys will not be conducted during the prioritization period, you may still submit your facility's ePOC during this time and the case will be held. Your facility may delay submission of an ePOC until the prioritization period is over.

On March 10, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

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

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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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	245463	A. BUILDING _____ B. WING _____	C 03/10/2020

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PIONEER CARE CENTER	**1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537**

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F 000	INITIAL COMMENTS On 3/9/20, to 3/10/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Complaint H5463040C was substantiated at F689, at past non-compliance. Although the provider had implemented corrective action prior to survey, harm was sustained. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were free from accident hazards when a resident was transferred without following the plan of care for 1 of 3 residents (R1) who used a front wheeled walker for transfers. R1 fell during the staff assisted transfer without the use of her walker and sustained an acute left maxillary sinus	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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fracture (a sinus located near the nose) and an acute left orbital floor (eye socket) fracture that resulted in harm. The facility had implemented corrective action so the deficient practice is being issued at past non-compliance.

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 1/3/20, identified R1 had moderate cognitive impairment and had diagnoses which included: anxiety, depression, and abnormalities of gait and mobility. R1's MDS further identified she required extensive assistance with transfers, walking, bed mobility and toileting. R1's MDS identified her balance was not steady, only able to stabilize with human assistance with surface to surface transfers and from seated to standing. The MDS identified R1 had two or more falls since last assessment, and one of the falls R1 sustained a minor injury.

R1's significant change of status assessment (SCSA) MDS dated 4/4/19, identified R1 had two or more falls since the last assessment and she acquired one major injury.

R1's SCSA Care Area Assessment (CAA) dated 4/10/19, identified R1 had balance problems and had three falls in the last quarter of which she obtained a wrist fracture. R1's CAA identified fall interventions were in place, and she was at risk of falls related to her balance problems. Falls would be addressed in R1's care plan to maintain current level of functioning and to minimize risks.

R1's care plan revised 3/5/20, identified R1 was at risk of falls, required assistance of 1 for bathing, dressing, personal hygiene and toilet use

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and listed various interventions which included: nursing staff to assist of 1 with FWW (front wheeled walker) for transfers. R1's care plan also directed use of chair and bed alarms, dycem and autolock breaks to wheelchair.

Review of the facility incident report dated 2/28/20, identified R1 was being transferred without the use of a walker, from recliner to wheelchair when R1 lost balance and tipped forward onto the floor. R1's care plan instructed staff to transfer R1 with assistance of one with front wheeled walker, and walker was not used. The facility investigation identified nursing assistant (NA)-B was interviewed, provided education on care plan adherence regardless of familiarity and frequency of working with R1, then NA-B was sent home. R1 was sent to emergency department, and had follow up eye examination appointments on 3/2/20, 3/3/20, and 3/4/20. R1 sustained a laceration above her left eye, carpet burn to her left cheek and fracture of her left ocular cheek bone. R1's care plan was updated to include transfer assitance of 2 staff with front wheeled walker. Facility wide education was put in place for care plan adherence and safe patient handling.

R1's Emergency Department Visit report dated 2/28/20, identified R1 obtained an acute left maxillary sinus fracture, an acute left orbital floor fracture and laceration related to a fall. R1 had orders for Cephalexin (antibiotic) 500 mg orally three times a day for 5 days for prophylaxis (preventive treatment) for sinus fracture.

On 3/9/20, at 9:30 a.m. R1 was in her recliner with feet elevated, covered with a blanket, in her room, bedside table next to her, while she talked

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on the phone. At 11:01 a.m. R1 remained seated in recliner, feet on floor with one shoe on and one shoe off. At that time, registered nurse care coordinator (RNCC)-A entered room, briefly talked with R1 and proceeded to open her armoire, reviewed the care plan attached to the inside of the armoire door, then returned to assist R1 out of the recliner. RNCC-A placed R1's front wheeled walker in front of her, instructed her to push off the recliner's arm rests. R1 placed her hands on the walker, and while RNCC-A held onto R1's transfer belt, R1 stood, pivoted and then sat in wheelchair. Dycem (non-skid sheeting) was observed on the seat of the recliner, as well as an alarm pad. R1's care plan, was observed taped on the inside of R1's armoire, and instructed staff to use 1 assist with front wheeled walker for transfers.

Review of R1's facility incident reports from 12/1/19, to 3/9/20, identified the following:

-12/9/19, at 7:45 p.m. R1 found sitting on floor by bed, R1's roommate informed staff R1 had transferred self from wheelchair to bed, then slid down from the bed to the floor. R1 was reminded to call for help.

-12/21/19, at 4:45 p.m. R1's bed alarm sounding, staff found R1 sitting on floor by bed. R1 informed staff she was trying to go to the bathroom, and refused to ask for assistance. R1 had been toileted twice prior that shift.

-12/30/19, at 4:00 p.m. R1's roommate alerted staff, who found R1 sitting on floor. R1 had self transferred herself. R1's chair alarm was found not to be properly placed.

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-2/28/20, at 1:29 p.m. R1 was assisted by staff with transfer from recliner to wheelchair. R1 sustained a laceration to face and had left shoulder/clavicle pain. R1's front wheeled walker was not in front of her for transfer. R1's primary care provider (PCP) was notified, and order received to send to emergency department.

On 3/9/20, at 9:20 a.m. NA-C indicated the usual facility practice was to place individual resident care plans inside their closets. NA-C indicated if things changed, such as how a resident transfer, then RNCC-A would print off a new one. NA-C indicated she had just received training two days ago regarding care plans and to check them every day you walk into residents' rooms.

On 3/9/20, at 10:06 a.m. trained medication aide (TMA)-A indicated she had attended training last week on care plans. TMA-A indicated staff are to make sure they check the resident's care plans in their armoires before doing anything with the residents. TMA-A indicated the nurses made changes, and we should check the dates of the care plans and if we have issues or concerns we ask the nurse.

On 3/9/20, at 1:06 p.m. voice message was left for NA-B who returned the call on 3/11/20, at 3:31 p.m. NA-B indicated she had transferred R1 on 2/28/20, when she had her fall NA-B indicated she had not used the walker, and R1 tipped forward. NA-B indicated she had training on residents cares prior. NA-B indicated she was not aware R1 used a walker for transfers. NA-B indicated R1 wanted her to rush and get her up. NA-B indicated she was aware all residents had care plans in their closets, but had not looked before she transferred R1. NA-B indicated she

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had received education after the incident which included to check care plans, even if residents were in a hurry, to tell them to wait a minute while you check the care plan.

On 3/9/20, at 1:32 p.m. NA-E indicated all residents had care plans inside their wardrobes in their rooms and she reviewed the individual resident care plans for specific instructions on how to care for the individual resident. NA-E indicated she was scheduled to attend training on care plans within the next week.

On 3/9/20, at 1:38 p.m. NA-F indicated he had received education on how to take care of the residents. NA-F indicated he just completed care plan training again, which included practicing checking care plans to make sure you don't miss something.

On 3/9/20, at 1:45 p.m. NA-G indicated he knew how to take care of residents based of their care plans in their closets. NA-G indicated he was aware R1 had a fall, and there was a change with her transfers. NA-G indicated when he looked at her care plan that morning, she was an assist of one staff with her walker. NA-G indicated for awhile they used two staff. NA-G was unaware if he had education or training scheduled coming up.

On 3/9/20, at 1:49 p.m. NA-A indicated she checked residents care plans, which were taped to the inside of their closet doors to know how to provide cares to residents. NA-A indicated she also could check with her co-workers if had questions. NA-A indicated there was mandatory education for all nursing staff, today or tomorrow and it goes until 3/19/20. NA-A pointed to a sign

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F 689	Continued From page 6 for Mandatory Education for All Nursing Staff which included scheduled dates, posted on the cupboard above the nurses desk. On 3/9/20, at 1:53 p.m. RN-A confirmed mandatory education had been initiated after R1's fall and indicated the mandatory in-service included a simulation regarding care plan compliance, review of abbreviations used, and a pre and post test. During the simulation sessions, RN-A indicated she observed staff and completed any additional education needed at that time. R RN-A indicated 26 nursing staff had compelted the education so far, and identified she thought there were 60 licensed and unlicensed staff who needed to complete the mandatory re-training. RN-A indicated if all staff had not completed it, the facility planned to schedule a make up day. RN-A indicated if a staff member did not complete it by then, they would be taken off the schedule until they reviewed it. RN-A indicated an announcement for the training was also texted to all staff. On 3/9/20, at 2:17 p.m. RNCC-A reviewed R1's electronic health record with surveyor. RNCC-A reviewed R1's history of falls, assessments of the falls and interventions put in place after the falls. RNCC-A identified R1 had five falls since 12/1/19 and indicated R1 had sustained an ocular cheek bone fracture on 2/28/20 when she fell while being assisted by a NA-B to transfer from her chair to her wheelchair. RNCC-A confirmed R1's care plan was not followed and NA-B did not use the walker with the transfer. RNCC-A indicated NA-B received individual education and the facility was in the process of completing facility wide education for all licensed and unlicensed nursing staff.	F 689		

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F 689	Continued From page 7 On 3/9/20, at 2:48 p.m. licensed practical nurse (LPN)-A indicated she was scheduled to attend the mandatory training on Thursday regarding care plans. LPN-A indicated she was not aware of R1's current cares, but indicated she would need to refer to her care plan. LPN-A indicated residents' care plans were printed and placed on the inside door or resident's armoires. LPN-A indicated if there were any changes a new care plan would be put up on the inside of the resident's armoire door. On 3/9/20, at 3:46 p.m. in a follow up interview, RNCC-A indicated R1 had been an assist of one staff with the walker for transfers prior to her fall. RNCC-A indicated the facility had increased her to two staff with walker after the fall for a few days, then reassessed her, and returned her to assist of one staff with the walker for transfers. RNCC-A indicated they had begun to complete audits and continued to have a few going on at that time to regarding following resident care plans. RNCC-A indicated they initially completed audits with NA-B and other specific staff who had an issue with following the care plan. After that, random audits were completed on day and evening shift facility wide. RNCC-A indicated they had planned on completing a few more audits, including another one with NA-B. RNCC-A indicated if a resident had a change in their care plan, they would watch to assure staff were checking the resident's care plan. On 3/9/20, at 4:02 p.m. during a phone interview with family member (FM)-A, FM-A indicated she was notified the staff member transferred R1 from her chair to her wheelchair on 2/28/20, but did not have the walker in front of her, and R1's	F 689		

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legs are not stable and that is how she fell. FM-A indicated R1 had been seen by the eye doctor and an ophthalmologist who examined her to assure her orbital muscle was still intact, and decided no surgery was needed. FM-A indicated she just wanted to be sure when staff helped R1, that they look in the armoire to read the list on how to care for R1. FM-A indicated staff should just remember to check R1's care plan in case something changed, and felt the staff should read it on a daily basis.

On 3/9/20, at 4:07 p.m. during a follow up interview, RN-A indicated when R1 fell, R1 had blood on her hands and the carpet with staff sitting with her. RN-A indicated they got R1 up with a mechanical lift, then applied ice to her shoulder. RN-A indicated R1 had a laceration on her eyebrow and a carpet burn to her cheek. RN-A indicated R1's eye looked blood shot, but no pooling of blood in the eye was noted. RN-A indicated she contacted FM-A, then interviewed NA-B. RN-A indicated NA-B stated she forgot to check R1's care plan to see how to transfer her. RN-A indicated they completed immediate education with NA-B, and then completed audits over the weekend.

On 3/9/20, at 4:43 p.m. during a telephone interview with R1's primary care physician (PCP)-A nurse stated the PCP would return a call tomorrow. On 3/11/20, at 8:45 a.m. PCP-A left a voice message which he indicated he would call back later that day. No further calls or messages were received.

On 3/9/20, at 4:24 p.m. director of nursing (DON) confirmed he was aware R1's care plan was not followed as expected during a transfer and he

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was aware R1 had received a serious injury.

The facility posting titled Mandatory Education undated, identified dates and times listed: 3/5/20, 3/12/20, or 3/19/20, at 7 a. m., 10 a.m., 2 p.m., and 4 p.m. and on 3/6/20, and 3/13/20, at 7 a.m. or 10 a.m. The form identified that one session must be attended and was a mandatory re-training session on care plans, care plan updates and transfers for all licensed nurses, trained medication aides and nursing assistants.

Review of the facility Mandatory re-training session on care plans, care plan updates and transfers for all licensed nurses, trained medication aides and nursing assistants was completed. The education included a posting at all nurses stations, a written test titled Care Plan Education and Review and a simulated care plan. The signature form of those attended identified 26 licensed and unlicensed nursing staff of the 60 staff identified by the facility who required re-education, had attended through 3/6/20.

Review of the facility audit forms titled Transfer Per Care Plan identified staff members were observed to determine if resident care plans were checked then followed during transfers. Seven audits had been completed by 3/9/20. On spot education or resident reassessments were completed as needed.

The facility policy titled Using The Care Plan revised August 2006, identified care plans were placed in the resident's chart, and care kardex were placed in the resident's closet. The policy further identified staff were responsible to provide care as directed on the resident care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	C 03/10/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 The facility policy titled Assessing Falls And Their Causes revised October 2010, identified the purpose of this procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy included areas to follow which included; after the fall, defining details of the fall, identifying causes of a fall or fall risk, documentation and reporting. The past non-compliance that began on 2/28/20, was verified during the 3/9/20, onsite visit and was corrected by the facility on 3/6/20. The facility immediately re-educated NA-B, other staff on that shift who worked with R1 and initiated mandatory retraining sessions for all licensed and unlicensed staff regarding care plans, care plan updates and transfers. The facility began audits to assure care plans were being followed for nursing staff through out the building. Verification of corrective action was confirmed by interview with a variety of nursing staff and documentation of chart audits that verified resident's care plans were being followed while nursing staff provided their cares. There was a plan in place for all licensed and unlicensed nursing staff to be re-educated to care plans, care plan updates and transfers. The education was reinforced by random audits still in place to ensure resident's care plans were being followed while nursing staff provided their cares.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 2, 2020

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

Re: Event ID: QMS211

Dear Administrator:

The above facility survey was completed on March 10, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00443	A. BUILDING: _____ B. WING _____	C 03/10/2020

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/9/20, to 3/10/20, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found to be in compliance with the MN state licensure. Complaint H5463040C was substantiated, no	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00443	A. BUILDING: _____ B. WING _____	C 03/10/2020

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) COMPLETE DATE
2 000	Continued From page 1 licensing orders were issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		