



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 21, 2025

Administrator
Pioneer Care Center

1131 SOUTH MABELLE AVENUE
FERGUS FALLS, MN 56537

RE: CCN:245463

Cycle Start Date: August 6, 2025

Dear Administrator:

On August 6, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by November 6, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 6, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

**Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities**

MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245463		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER Pioneer Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1131 SOUTH MABELLE AVENUE , FERGUS FALLS, Minnesota, 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	
E0000	Initial Comments		E0000			09/03/2025	
F0000	NO deficiencies were cited for Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, CFR §483.73, at the time of the standard recertification survey, exited on 8/6/25.		F0000			09/03/2025	
	INITIAL COMMENTS						
	On 8/4/25-8/6/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance.						
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.						
	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.						
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper implementation of the self-administration of medication (SAM) assessments for 2 of 2 residents (R36, R1), reviewed for medication administration.		F0554	R36, the lidocaine patches were immediately secured in the locked medication drawer on 8/6/25. R1, the Clotrimazole cream and Nystatin powder were immediately removed from the bedside on 8/4/25 and secured in the medication drawer. The Director of Nursing (DON) and Clinical Coordinators reviewed all current resident self-administration of medication (SAM) assessments to ensure accuracy and appropriateness. All resident rooms were audited to confirm that no medications were stored at bedside without an authorized SAM order and assessment. The policy Self Administration of Medications was		09/03/2025	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0554 SS = D	Continued from page 1 Findings include: R36's quarterly Minimum Data Set (MDS) assessment dated 6/4/25, indicated R36 was cognitively intact and diagnoses of diabetes, heart failure, and arthritis and required the assistance of one staff with activities of daily living (ADL's) for transfers and toileting. R36's physician orders dated 8/4/25, revealed the following: - Lidocaine External Patch 4%, apply to back topically two times a day for pain. Apply at bedtime (HS) and remove at morning (AM). R36's electronic medical record (eMAR) dated 7/1/25 to 8/5/25, revealed nursing staff had applied and removed the lidocaine patch daily following physician's orders. R36's self-administration of medication (SAM) assessment dated 6/4/25, indicated R36 was able to self-administer medications after the nurse set-up R36's medications. During an observation on 8/05/25 at 3:45 p.m., trained medication aid (TMA)-C stated R36 was to have a lidocaine patch applied at HS. TMA-C confirmed R36's box of lidocaine patches were sitting out on R36's dresser in R36's room. TMA-C left the room after giving R36's medications, however, did not put R36's box of lidocaine patches away in the locked medication drawer. During an observation on 8/06/25 at 8:09 a.m., R36 continued to have an open box of lidocaine patches, containing three unopen patches, sitting on top of R36's dresser in R36's room. During an observation and interview on 8/06/2025 at 8:52 a.m., R36's lidocaine patches remained in the same position. R36 indicated she had a patch put on at HS and R36 removed the lidocaine patch independently in the AM. During an interview on 8/06/25 at 8:32 a.m., pharmacy consultant (PC) stated R36 was to have one lidocaine patch on at a time and nursing staff should have only leave one patch out for R36 to apply. PC further stated it was important to follow the SAM assessments to ensure residents are appropriately using medications. During an interview on 8/06/2025 at 9:01 a.m., clinical coordinator (CC)-A confirmed R36's order for lidocaine patches. CC-A indicated R36 was not able to apply them independently but could remove them independently. CC-A			F0554	Continued from page 1 reviewed. All licensed nurses and trained medication aides (TMAs) were re-educated by the DON regarding: • The facility policy Self Administration of Medications. • Proper storage of medications when not in use. The DON or designee conducts weekly audits for 4 weeks, then monthly for 3 months, checking 10 resident rooms per audit to ensure no unauthorized medications are stored at bedside. Results of audits are reported to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee determines if ongoing monitoring is required based on compliance trends. Date of Substantial Compliance 09/03/2025		

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F0554 SS = D	Continued from page 2 revealed the lidocaine patches should have been put away in R36's drawer when they were not being used. CC-A entered R36's room and put the lidocaine patches away in R36's locked medication drawer. During an interview on 8/06/25 at 9:21 a.m., director of nursing (DON) confirmed the above findings and stated it was important for medication staff to put medications away in the appropriate location for safety reasons. DON further stated it was important for medication staff to return to the residents' room to ensure medications were taken properly. R1's significant change minimum data set (MDS) dated 6/12/25, revealed R1 had a mild cognitive impairment. R1 had a diagnosis of having an indwelling urinary catheter, heart failure, and hypertension. R1 needed extensive assistance for activities of daily living (ADLs). R1's signed orders dated 6/17/25, had an order for Clotrimazole ointment 1% (antifungal) for cutaneous candidiasis (skin infection), apply to the penis head twice a day, and Miconazole powder (antifungal) to affected red areas topically as needed when the current supply of nystatin powder (antifungal) is exhausted. R1's care plan revised on 6/6/25, revealed R1 is not able to self-administer medications. R1's self-administration of medication assessment dated 6/12/25, revealed R1 was not able to self-administer medications. During an observation and interview on 8/4/25 at 1:07 p.m., a tube of Clotrimazole cream 1% and Nystatin powder was sitting on the nightstand. R1 indicated that staff would leave the cream and powder on the nightstand for staff to apply. R1 indicated that if the medications were not left out on the nightstand, staff would not apply the cream and powder, as only one person can get out the cream and powder and apply it when they are locked up. During an interview on 8/4/25 at 1:26 p.m., licensed practical nurse (LPN)-A verified R1 did not have an order to self-administer medication. LPN-A verified there was a tube of Clotrimazole cream 1% and Nystatin powder on R1 nightstand. LPN-A locked up the medications in the medication drawer. During an interview on 8:33 a.m., pharmacy consultant indicated Clotrimazole and Nystatin are both antifungal			F0554			

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F0554 SS = D	Continued from page 3 medications and should have a self-administered assessment done to ensure the resident knows how to correctly administer the medications. During an interview on 8/6/25 at 9:23 a.m., clinical coordinator manager (CCM)-A indicated medications applied by the nurse or trained medical assistant (TMA) should be in the medication drawer. CCM-A indicated that a self-administration assessment was important to ensure the resident understands how to administer a medication correctly. CCM-A indicated that locking a medication in a medication drawer is important to ensure the safety of residents and visitors. During an interview on 08/06/2025 at 10:23 a.m., director of nursing (DON) verified that creams and powders should be in a locked drawer unless the resident has a self-administration of medications order and was assessed to ensure they were safe to have the medications at bedside. Facility policy titled Self-Administration of Medications dated 2/21, the interdisciplinary team (IDT) assesses each resident's cognitive ability and physical abilities to determine whether self-administering of medications is safe and appropriate. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.		F0554				
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes		F0604	R32's low bed intervention was reassessed. A restraint assessment was completed. Care plan updated to reflect interventions. All residents utilizing low beds or other equipment that could potentially restrict mobility were reviewed to ensure proper restraint assessments were completed. Policy Restraint Free Environment was reviewed. All licensed nurses and nursing assistants were re-educated regarding: • CMS definition of restraints. • Facility policy Restraint Free Environment. DON or designee will audit 10 residents weekly for 4 weeks, then monthly x 3 months, to ensure interventions such are assessed and documented appropriately. Results of audits are reported to the Quality Assurance		09/03/2025	

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F0604 SS = D	Continued from page 4 but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the use of a low bed as a potential restraint for 1 of 1 resident (R32) reviewed for restraints. Findings include: R32's significant change Minimum Data Set (MDS) assessment dated 6/16/25, identified R32 had severe cognitive impairment and diagnosis of Parkinson's, hypertension (elevated blood pressure) and arthritis. R32 required extensive assistance for activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R32 had no impairment of upper or lower extremities, had a history of falls, and required a wheelchair for mobility. MDS indicated R32 did not use any restraints. R32's significant change Care Area Assessment (CAA) dated 6/24/25, identified R32 had severe cognitive impairment and was a fall risk and R32 did not use any restraints. Review of R32's quarterly fall assessment dated 5/29/25, identified R32 had balance problems when walking and standing and was a moderate risk for falls. Assessment did not identify the use of any restraints. Review of R32's current physician orders signed 6/17/25, did not identify an order for a restraint.			F0604	Continued from page 4 and Performance Improvement (QAPI) Committee. The QAPI Committee determines if ongoing monitoring is required based on compliance trends. Date of Substantial Compliance: 09/03/2025		

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F0604 SS = D	Continued from page 5 R32's medical record lacked any evidence a restraint assessment had been completed. R32's care plan revised 7/25/25, identified R32 had a self - care deficit and was at risk for falls related to confusion, impaired balance and limited mobility. Identified 32 had a fall on 7/25/25 and directed staff to ensure R32's bed is in the lowest position at night for safety. Identified R32 transferred using a stand-up lift. R32's progress note dated 7/28/25 at 10:55 a.m., identified on 7/25/25 R32 was found on the floor next to her bed. Identified R32 had attempted to self-transfer from bed. Identified a new intervention after fall was to have bed in lowest position when R32 was in bed. During an observation on 8/4/25 at 6:49 p.m., R32's bed was about 1 ft. off the ground and R32 was sitting at the edge of the bed leaning forward and was yelling " I can't get up come help me." Nursing assistant (NA)-A and NA-B entered R32's room and assisted R32 to lie back down in bed and boosted R32 up in the bed. During a joint interview on 8/4/25 at 6:56 p.m., nursing assistant (NA)-A stated R32 attempts to get out of bed on her own and had fallen. NA-A stated the latest intervention was to put R32's bed in the lowest position to keep R32 from getting up and falling. NA-B stated the low bed makes it really hard for R32 to stand up on her own. NA-A and NA-B stated R32 was able to stand on her own even though it was not always safe. NA-A and NA-B stated they were unsure if R32's low bed was a potential restraint. During an interview on 8/5/25 at 8:26 a.m., licensed practical nurse (LPN)-A stated R32 's bed is in lowest position because R32 has had falls trying to self transfer out of bed. LPN-A verified R32 was able to stand up on her own. LPN-A stated she did not feel putting R32's bed in lowest position was a restraint because even though R32 was able to stand on her own it was not safe for R32 to stand on her own. LPN-A verified R32's low bed was not assessed as a potential restraint.		F0604				

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F0604 SS = D	Continued from page 6 During an interview on 8/5/25 at 8:33 a.m., physical therapy assistant (PTA) stated R32 was able to stand up on her own and she should wait for help to stand up. PTA stated R32's bed is in the lowest position so that if R32 attempts to stand up on her own and falls it won't be so far to fall. PTA stated she did not think of the low bed as a potential restraint for R32 because R32 was not aware of the potential of falls when she stood on her own. During an interview on 8/5/25 at 10:08 a.m., director of nursing (DON) verified R32's care plan revealed R32 had falls attempting to self- transfer and the latest intervention was for 32's bed to be placed in the lowest position. DON verified a restraint assessment had not been completed prior to placing R32's bed in the lowest position. DON stated she had not thought of the low bed as a restraint for R32 because even though R32 was able to self transfer she was not always safe during self- transfers. DON further stated she could see how R32's low bed could be a potential restraint. DON stated her expectation was that a restraint assessment would have been completed prior to placing R32's bed in the lowest position. Review of a facility policy titled Restraint Free Environment revised 2025, identified a physical restrain refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body such as placing a resident in a chair that prevents the resident from rising independently.		F0604				
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification.		F0641	R17's MDS was corrected on 8/5/25 to reflect accurate use of alarms. The MDS Coordinator reviewed all active residents with safety device interventions to ensure the MDS coding matched care plans. Facility policy Resident Assessment was reviewed. MDS Coordinator was reeducated on this policy. MDS Coordinator re-educated regarding review of all available sources (physician orders, Kardex, care plan, staff interview, and direct observation) prior to coding MDS assessments.		09/03/2025	

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F0641 SS = D	Continued from page 7 §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded to include the use of safety alarms for 1 of 1 residents (R17) reviewed for MDS. Findings include R17's significant change in status MDS dated 6/27/25, identified R17 had medically complex conditions, hypertension, anxiety, and depression. R17 needed extensive assistance with activities of daily living (ADLs). R17 did not use a bed alarm, chair alarm, floor mat alarm, or motion sensor alarm. R17's care plan was revised on 7/25/24, revealing R17 had audible wheelchair and silent bed and recliner alarms. R17's signed orders dated 6/17/25, revealed R17 had orders to monitor the placement and function of the bed and recliner alarm, and the audible wheelchair alarm every shift for fall intervention; the order start date was 2/6/24. During an observation on 8/4/25 at 6:48 p.m., R17 was			F0641	Continued from page 7 DON or designee will audit 5 completed MDS assessments weekly x 4 weeks, then monthly x 3 months, to ensure accuracy. Results of audits are reported to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee determines if ongoing monitoring is required based on compliance trends. Date of Substantial Compliance : 09/03/2025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245463		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER Pioneer Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1131 SOUTH MABELLE AVENUE , FERGUS FALLS, Minnesota, 56537			
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F0641 SS = D	Continued from page 8 in the living room area next to the dining room, with a chair alarm on the back of the wheelchair. During an observation on 8/5/25 at 8:05 a.m., R17 was lying down in bed, the bed was low to the floor with a floor mat and a bed alarm attached to the bed. During an observation on 8/5/25 at 12:10 p.m., R17 was not in the room, but the alarm strip was on the bed. R17 was in a wheelchair, sitting in front of the television with an alarm on the back of the wheelchair. During an observation on 8/6/25 at 7:10 a.m., R17 was in a low bed with a bed alarm attached to the bed. During an interview on 8/5/25 at 12:15 p.m., registered nurse (RN)-E, verified R17 has had a bed alarm and a chair alarm since RN-E started working at the facility about a year ago. During an interview on 8/5/25 at 2:17 p.m., MDS coordinator verified the MDS was not coded for a bed alarm or a chair alarm. The MDS coordinator viewed the Kardex and the care plan and verified R17 did have a bed alarm and chair alarm and should have been coded on the MDS. The MDS coordinator indicated the process was to review the assessments, care plan, and care conference notes when completing an MDS. The MDS coordinator indicated at times she would perform a visual assessment on a resident, but did not have a visual assessment when completing R17's MDS. During an interview on 8/5/25 at 2:52 p.m., RN-F viewed R17's care plan and Kardex and verified R17 had a bed alarm and chair alarm and should have been coded on the MDS. During an interview on 8/6/25 at 10:21 a.m., director of nursing (DON) expectation would be for the MDS coordinator to review the care plan. DON verified the bed alarm and chair alarm were located in R17's care plan. DON's expectation would be for the MDS to be coded correctly. Review of the facility policy titled Resident assessments dated October 2023, revealed information in the MDS assessment will consistently reflect information in the progress notes, plans of care, and resident observations/interviews.		F0641				

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F0641 F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure recommended splint or alternative devices were utilized to help prevent further contractures and stiffness for 1 of 1 residents (R11) reviewed for range of motion (ROM). Findings include: R11's annual Minimum Data Set (MDS) assessment dated 7/13/25, identified R11 had severe cognitive impairment and had diagnoses of cerebral palsy (irregular brain development that affects movement and posture), seizure disorder, and malnutrition. Indicated R11 required extensive assistance of staff for activities of daily living (ADLs) including transfers and toileting. R11's care plan revised 7/26/23, identified R11 had limited physical mobility related to the disease process. Additionally, R11 had the potential for skin impairment related to decreased mobility. R11's care planned interventions included: - Apply small towel roll in between left elbow and shoulder and small roll in left palm web space. - Left Hand Contractures: Place foam roll in palm of left hand between thumb and palm to prevent skin			F0641 F0688	Resident R11's restorative interventions were clarified and corrected. Care plan was updated to match current restorative interventions. All residents with restorative nursing programs were reviewed and Orders, TARs, and care plans were audited for consistency. Policy Specialized Rehabilitative Services was reviewed. Licensed nurses and CNA's were re-educated on this policy. DON or designee will conduct weekly audits of 5 residents with restorative interventions to ensure restorative orders, TARS and care plans are consistent for 4 weeks, then monthly x 3 months Results of audits are reported to the Quality Assurance and Performance Improvement (QAPI) Committee. - The QAPI Committee determines if ongoing monitoring is required based on compliance trends. Date of Substantial Compliance 09/03/2025		09/03/2025

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F0688 SS = D	Continued from page 10 breakdown. Remove and check skin every two hours and as needed. R11's treatment administration record (TAR) dated 7/1/25 to 8/5/25, identified R11 was to apply a small towel roll in between left elbow and shoulder and small roll in left palm web space Monday, Wednesday, and Friday. R11's Kardex dated 8/5/25 revealed the following: - Left Hand Contractures: Place small towel/washcloth as resident will tolerate in left palm between thumb and palm every two hours and as needed. - Place small towel/ washcloth as resident will tolerate between left elbow and shoulder. Notify nurse if noted skin alternation. During an observation on 8/4/25 at 12:18 p.m., R11 was lying in bed with eyes closed. R11 left hand was tightly closed with thumb pressed against palm of hand and four fingers placed over thumb. Additionally, R11's left arm was bent up at the elbow. R11 was able to move right hand open and closed. R11 is non-verbal and unable to answer any questions. R11 did not have a washcloth or foam roll placed in R11's left hand and left elbow. During an observation on 8/4/25 3:30 p.m., R11 remained in a similar position as noted above. During an observation on 8/4/25 at 7:02 p.m., R11 was resting in bed with music playing. R11 had a gown on and was covered with a thin blanket. R11 did not have a washcloth or foam roll placed in R11's left hand and left elbow. During an observation on 8/5/25 at 8:20 a.m., R11 was resting in bed covered with a blanket. R11 was listening to music with R11's eyes closed. R11 did not have a washcloth or foam roll placed in R11's left hand and left elbow. During an observation and interview on 8/5/25 to 9:47 a.m., registered nurse (RN)-E entered R11's room to provide medications. RN-E stated R11 did not have a brace for R11's left hand. RN-E further stated staff were to be doing range of motion (ROM) on R11's upper extremities to help reduce further contractures. RN-E provided ROM on R11 after completing medication administration. RN-E completed ROM, cleaned up supplies, left R11's room, and charted ROM in R11's TAR.		F0688				

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F0688 SS = D	Continued from page 11 During an interview and observation on 8/5/25 at 11:06 a.m., rehabilitation director (RD) revealed passive range of motion (PROM) of R11’s upper extremities was an order from occupational therapy (OT). RD further revealed R11’s left hand was contracted when R11 was admitted to the facility and R11 could not use a brace. RD indicated OT ordered the use of a washcloth in place of a brace. RD further indicated R11 had an order to place a washcloth in the left hand and left elbow Monday, Wednesday, and Friday. RD reviewed R11’s care plan and stated another intervention was listed for staff to place a foam roll in R11’s left hand and monitor every two hours. RD confirmed the correct order should have been to place a washcloth in R11’s hand and elbow Monday, Wednesday, and Friday. RD entered R11’s room to evaluate R11’s left hand to see if contractors had gotten worse. RD stated there had not been much change in R11’s left hand and left arm. RD indicated R11 would still benefit from having a washcloth placed in R11’s hand and elbow as tolerated Monday, Wednesday, and Friday. During an interview on 8/5/25 at 11:22 a.m., registered nurse (RN)-F and RD reviewed R11’s orders and care plan. RN-F confirmed the current orders and care plan interventions for R11 and indicated RN-F was unaware what exact orders staff should have been following. RN-F indicated RN-F would contact the clinical coordinator to confirm the correct orders for R11. During a follow-up interview on 8/5/25 at 2:13 p.m., RN-F indicated the clinical coordinator stated R11 should have had the foam roll intervention removed from the care plan. RN-F further indicated the correct order was currently listed on the TAR and staff should have been following the current order. During an interview on 8/5/25 at 2:33 p.m., director of nursing (DON) confirmed the above findings and stated she expected staff to follow the plan of care to ensure residents do not have a decline in care. DON further stated it is important residents continue to keep the highest level of ROM as possible. Facility policy titled restorative nursing services revised 7/17, resident will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitation services. Restorative goals may include, but are not limited to supporting and assisting the resident in: participating in the development and implementation of his/her plan		F0688				

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F0688 SS = D	Continued from page 12 of care.		F0688				
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by		F0732	8/6/2025 the facility corrected the posted staffing information to reflect the current date, census, and actual hours worked by RNs, LPNs and CNAs. DON and Scheduler reviewed posting for the prior 30 days to ensure accuracy. Policy Posting Direct Carae Daily Staffing Numbers was reviewed. Scheduler and Licensed Nurses were educated on this Policy. DON or designee will audit postings for accuracy 3 times a week for 4 weeks, then weekly for 3 months. Results of audits are reported to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee determines if ongoing monitoring is required based on compliance trends. Date of Substantial Compliance: 09/03/2025		09/03/2025	

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F0732 SS = C	Continued from page 13 State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure required nurse staffing information was consistently posted on a daily basis. This had the potential to affect all 90 residents, staff, and visitors who may wish to view the information. Findings include: On 8/4/25 at 11:19 a.m., the facility staff posting was sitting on a desk across from the elevator. The staff posting was dated 8/2/25 with a census of 88. During an interview on 8/4/25 at 11:24 a.m., director of nursing (DON) confirmed the date and census on the staff posting were incorrect. DON indicated the process was to update the nurse staff posting daily. The DON removed the Saturday staff posting, and behind was the Sunday staff posting. Monday's staff posting was located behind Sunday's. Monday was then placed on the counter, which was the current schedule, but had the incorrect census of 88. DON indicated the scheduler is responsible for creating the daily staff posting. The charge nurse was responsible for updating the staff posting with changes regarding resident census or staffing changes. During an interview on 8/4/25 at 12:00 p.m., the scheduler indicated the normal process is to create the nurse staff posting for the following day between 2:00 p.m. and 3:00 p.m. and post it behind the current staff posting. The scheduler indicated on Fridays, she would create the Saturday, Sunday, and Monday schedules and would post them behind Friday, as the scheduler does not work weekends. If there was an admission for the day, the scheduler would not put it on the current census, but would make changes for the following day's staff posting. The scheduler indicated the charge nurse would change the nurse staff posting on the weekends and make any updates regarding changes related to staffing or the census. A review of the facility policy, titled Posting Direct Care Daily Staffing Numbers, dated August 2022, revealed the facility will post on a daily basis for each shift nurse staffing data, including the number of		F0732				

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F0732 SS = C	Continued from page 14 nursing personnel responsible for providing direct care to residents. The information recorded on the form shall include the name of the facility, current date, the resident census at the beginning of the shift for which the information is posted, twenty four hour shift schedule operated by the facility, the shift for which the information is posted, the type and category of nursing staff working during that shift who are paid by the facility, the actual time worked during that shift for each category and type of nursing staff and the total number of licenses and non-licenses nursing staff working for the posted shift.		F0732				
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) 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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled appropriately to include administration directions, insulin pens were dated and not expired and failed to dispose of expired eye drops per manufacturer recommendation's for 9 of 9 residents (R47, R69, R92, R36, R40, R73, R19, R10, R13) reviewed during		F0761	All unlabeled, expired, or undated medications were removed and discarded. This included R 47 Thera Tears, R69 Latanoprost, R 92 Refresh Tears Ophthalmic Solution, Moxifloxacin HCL Ophthalmic Solution Prednisolone Acetate Ophthalmic Suspension, R36 Lantus Solo Star Subcutaneous Solution Pen Injector, R 40 Lantus Solo Star Subcutaneous Solution Pen Injector, R 73 Latanoprost, R 19 Sil Optho Eye Relief and Muro, R10 Nitroglycerin, R 13 Brezti Inhaler and Muro. New medications were obtained. A full medication cart and drawer audit was completed, ensuring appropriate labeling and dating of medications. Policy Medication Labeling and Storage was reviewed. Licensed Nurses and TMAs were educated on the policy Medication Labeling and Storage. DON/designee will audit 10 residents' medications weekly x 4 weeks, then monthly x 3 months. Results of audits are reported to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee determines if ongoing monitoring is required based on compliance trends. Date of Substantial Compliance 09/03/2025		09/03/2025	

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F0761 SS = E	Continued from page 15 medication storage and administration. Finding include: R47's medication review report signed 7/15/25, included orders for Thera Tears (for dry eyes) solution 0.25%, install one drop in both eyes four times a day for dry eyes. During an observation and interview on 8/5/25 at 3:31 p.m., a bottle of Thera Tears 0.25% eye drops was in R47's medication drawer. The bottle had no name, label, or date opened. The directions on the bottle from the manufacturing company indicated to install 1-2 drops in the affected eye as needed. Registered nurse (RN)-B indicated the box the eye drops came in was thrown after it was verified with the EMAR. RN-B checked the EMAR and indicated R47 receives Thera Tears four times a day, which was different than what was written on the bottle. RN-B indicated staff would follow the orders on the MAR and not on the bottle. During an observation and interview on 8/06/2025 at 9:10 a.m., RN-C verified there was no name or directions on the R47 Thera Tears eye drop bottle. RN-C indicated the directions are on the EMAR and would follow the directions on the EMAR. RN-C indicated the family would bring R47's eye drops; that is why there is no name or label on the eye drop bottle. R69 R69's medication review report signed 7/22/25, included orders for latanoprost 0.005%, install one drop in both eyes one time a day for glaucoma. During an observation and interview on 8/5/25 at 3:34 p.m., R69 had a bottle of latanoprost (glaucoma) 0.005% eye drops in the medication drawer. There was no date of when the medication was opened, RN-B indicated the facility has a list of medications and when they expire on the medication cart from the pharmacy. RN-B verified the eye drops were open, and the EMAR indicated the eye drops expire 5/26. During an observation and interview on 8/06/2025 9:12 a.m., RN-C verified R69 latanoprost 0.005% eye drops had no date of when it was opened or when it expired on the eye drop bottle. RN-C indicated the process was to write on the eye drop when it was opened. RN-C indicated latanoprost normally expires in 28-40 days after being opened. RN-C indicated staff would write in the MAR when a medication expires. RN-C looked at the		F0761				

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F0761 SS = E	Continued from page 16 EMAR and showed the EMAR had the latanoprost expiring 5/26. During an interview on 8/6/25 at 9:23 a.m., clinical coordinator manager (CCM)-A indicated staff should date eye drops after opening. CCM-A was under the assumption that latanoprost eye drops expire 28 days after opening. CCM-A indicated staff should throw the eye drops if not dated when opened, and to order new eye drops from the pharmacy. CCM-A indicated it is important not to administer a medication when it has expired, to ensure the medication is working at its full strength. CCM-A checked with the pharmacy and confirmed the latanoprost eye drops were filled on 7/13/25, which indicates the medication had not expired. CCM-A indicated she would date the medication with the correct expiration date. CCM-A also provided a list of medications and expiration dates that the facility uses, and according to the list, latanoprost was good for six weeks after opening and being unrefrigerated. CCM-A also indicated the facility had labels with the resident names and room number for medications that were brought in by family and should have been applied to R47 eye drops. R92 R92's Medication Review Report signed undated, revealed the following: - Artificial Tears Ophthalmic Solution1.4% instill one drop in both eyes as needed for dry eyes four times a day (QID). - Artificial Tears Ophthalmic Solution 1.4% instill one drop in both eyes three times a day for cataract evaluation until 8/4/25. R92's eMAR dated 7/1/25 to 8/5/25, revealed the following: - Ketorolac Tromethamine Ophthalmic Solution 0/5% instill one drop in both eyes one time a day for cataracts for 14 days starting 7/10/25. - Ketorolac Tromethamine Ophthalmic Solution 0/5% instill one drop in both eyes one time a day for cataracts for 14 days starting 7/24/25. - Prednisolone Acetate Ophthalmic Suspension 1% instill one drop in both eyes one time a day for cataract surgery for 21 days starting 7/10/25. - Prednisolone Acetate Ophthalmic Suspension 1% instill		F0761				

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(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	
F0761 SS = E	Continued from page 17 one drop in both eyes one time a day for cataract surgery for 21 days starting 7/17/25. - Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium) instill one drop in right eye three times a day for dry eyes starting 7/11/25. - Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium) instill one drop in right eye as needed for dry eyes starting 7/11/25. - Moxifloxacin HCL Ophthalmic Solution 0.5% instill one drop in both eyes four times a day for cataract surgery for seven days starting 7/10/25. During an observation/interview on 8/5/25 at 3:45 p.m., RN-B opened R92's locked medication drawer in R92's room. Located in a cup in R92's drawer revealed the following: - Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium) with R92's name and prescription number (Rx). Eye drops lacked boxed packaging and instructions. - Moxifloxacin Ophthalmic Solution 0.5% with R92's name and Rx number. Eye drops lacked boxed packaging and instructions. - Prednisolone Acetate Ophthalmic Suspension and lacked R92's name, Rx number, boxed packaging, and instructions. RN-B confirmed the above findings and stated eye drops should be in the boxed packaging labeled with resident's name, Rx number, and directions. R36 R36's Medication Review Report signed 8/4/25, included orders for Lantus Solo Star Subcutaneous solution Pen-injector 100 unit/ML (insulin Glargine) inject 8 units subcutaneously once a day for diabetes. R36's electronic medical record (eMAR) dated 7/1/25 to 8/5/25, identified R36 was currently receiving 8 units of Lantus insulin injection one time a day at bedtime. During an observation/interview on 8/5/25 at 3:33 p.m., trained medication aid (TMA)-C reviewed insulin pen with surveyor and confirmed the pen was not dated. TMA-C indicated TMA-C was aware pens were only good for 28 days after they were opened. TMA-C took the pen to		F0761				

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F0761 SS = E	Continued from page 18 registered nurse (RN)-F who confirmed the insulin pen was undated. RN-F discarded the insulin pen in the sharp's container. R40 R40's Medication Review Report signed 8/4/25, included orders for Lantus Solo Star Subcutaneous solution Pen-injector 100 unit/ML(insulin Glargine) inject 14 units subcutaneously once a day for diabetes. R40's current medication administration record (MAR) identified R40 was currently receiving 14 units of Lantus insulin injection at bedtime daily. R73 R73's Medication Review Report signed 6/11/25, included orders for Latanoprost Solution 0.005% one drop to each eye once per day for glaucoma. R73's MAR identified R73 was currently receiving Latanoprost Solution 0.005% one drop to each eye once per day. During an observation and interview on 8/5/25 at 3:33 p.m., registered nurse (RN)-D confirmed R40's insulin pen in the locked drawer was not dated and R73's Latanoprost Solution 0.005% eye drops had an expiration date of 7/11/25. RN removed the insulin pen from R40's locked medication drawer and the eye drops from R73's locked medication drawer and brought them to the medication room to be destroyed. RN-D verified Lantus insulin pen was good for 28 days and stated her expectation was R40's insulin pen would have been dated when it was opened. RN-A further stated her expectation was R73's eye drops were thrown away on or before the expiration date to ensure the medications were effective. R19 R19's Medication Review Report signed 7/16/25, included orders for Silicon Oil (Sil-Optho) prosthetic lubricant- one drop to left prosthetic eye twice a day for lubrication as needed. Artificial tear solution- instill one drop in right eye as needed for dry eye, and one drop in right eye five times a day for dry eye. Muro 128 ointment 5%- instill one application in right eye one time a day for corneal abrasion to right eye. During observation on 8/5/25 at 3:33 p.m., registered			F0761			

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F0761 SS = E	Continued from page 19 nurse (RN)-A confirmed R19 had a bottle of Sil-Optho not labeled, a bottle of Eye Relief not labeled, and a tube of Muro 5% not labeled. RN-A removed the medications from R19's medication locked drawer and brought to medication room, then indicated they would be destroyed. R10 R10's Medication Review Report signed 7/10/25, included order for Nitroglycerin Sublingual (below tongue) 0.4 milligram (MG)- give one tablet sublingually as needed for chest pain. Give one dose every five minutes for chest pain. Do not exceed three doses in 15 minutes. During observation on 8/5/25 at 3:44 p.m., RN-A confirmed R10 had two bottles of nitroglycerine, one with a label which included R10's name only and one not marked. RN-A stated they both should have R10's name and instructions attached. R13 R13's Medication Review Report signed 4/29/25, included orders for Breztri Aerosphere Inhalation Aerosol 160-9-4.8 microgram (MCG-ACT)- two puffs inhale orally two times a day for wheezing. Muro 128 ointment 5%- instill one drop in both eyes at bedtime for dry eye 1/4 strip in both eyes. During observation on 8/5/25 at 3:57 p.m., trained medication aide (TMA)-A indicated R13's two Brezti inhalers were not labeled. One was in her medication drawer, and one was on her bedside table. TMA-A stated there was a box for the inhaler with the label on it at one time, but it was not in R13's drawer anymore. R13 also had a Muro 5% eye ointment with no label. TMA-A indicated the Muro had a label, but it was not on it anymore. TMA-A also stated no expiration date was found on the Muro ointment. During a phone interview on 8/6/25 at 8:32 a.m., consultant pharmacist (CP)-A indicated all medications should have a pharmacy label with the resident's name and instructions. CP-A indicated if the medication was too small for a full label, she would expect the medication to be labeled with the resident's name and instructions to see electronic medication administration record (EMAR) for directions. CP-A stated if the medication was received in a box, the medication should be stored in the box which would contain the pharmacy label. CP-A stated it was important for medications to be labeled correctly to assure used correctly and for correct resident. CP-A		F0761				

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F0761 SS = E	Continued from page 20 indicated Xalatan/latanoprost eye drops expired 42 days or six weeks after opened. They should be labeled with date opened, and destroyed once expired. CP-A stated insulin pens should be dated when first used, and destroyed after manufactures recommended dates of how long the pens should be used, which was usually 28 days. CP-A indicated eye drops, and insulin pens should be dated when opened, and not used after expiration date per manufactures instructions. During interview on 8/6/25 at 9:14 a.m., director of nursing (DON) indicated her expectation was all medications would be labeled with resident's name, expiration date and directions for use. If the medication was not large enough for the full label, it should be kept in the box it came in. DON indicated the facility had labels they could use that had the resident's name and to refer to chart for direction of use. DON stated labels on medications were important to follow the rights of medication administration and safety. DON stated the facility had a shortened expiration date form, provided by pharmacy, which indicated which eye drops had shortened expiration dates after opened. DON stated her expectation was the eye drops were labeled when opened and disposed of when expired. DON stated insulin pens should also be dated when opened and disposed of when expired. DON indicated most insulin pens were to be disposed of after 28 days. DON stated it was important to dispose of medications after expiration as the medication may not be as effective after expired. The facility policy titled Medication Labeling And Storage revised 2/23, identified medications were stored in packaging, containers or other dispensing systems they were received. The policy identified medication labels included medication name, prescribed dose, strength, expiration date when applicable, resident's name, route of administration, and appropriate instructions and precautions. If medication containers had missing, incomplete, improper or incorrect labels, contact pharmacy for instructions regarding returning or destroying those items.		F0761				
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or		F0812	On 8/4/25, all expired or undated food items were discarded immediately. Refrigerators/freezers were cleaned and organized. Dietary Manager audited all food storage areas to ensure food was appropriately dated, and food was not expired.		09/03/2025	

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F0812 SS = E	Continued from page 21 considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food stored in the refrigerators and freezers were labeled, dated and discarded properly. This deficient practice had the potential to affect all 89 residents who received food from the refrigerators, freezers and the kitchen. Findings include: On 8/4/25 at 9:44 a.m., during the kitchen tour with the cook the following concerns were identified. Walk in cooler -half container of sour cream without notation of an opened date and an expiration date of 6/20/25. Fridge in kitchen -1/4 container of mustard with an expiration date of 7/28/25. -1/2 bottle of barbeque sauce without notation of an opened date and no expiration date. During an interview on 8/4/25 at 10:20 a.m., cook verified the above findings during the kitchen tour. Cook stated her expectation was all opened food should have been dated and thrown away on or before the expiration date to prevent food-borne illness. During an interview on 8/4/25 at 10:30 a.m. dietary			F0812	Continued from page 21 Policy Food Storage was reviewed. Dietary staff re-educated on this policy including expiration dates and dating of food. Dietary Manager/designee will audit refrigerators and freezers 3 times a week x 4 weeks, then weekly x 3 months. Results of audits are reported to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee determines if ongoing monitoring is required based on compliance trends. Date of Substantial Compliance 09/03/2025		

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F0812 SS = E	Continued from page 22 manager (DM) stated her expectation was all food should have been dated when it was opened and thrown away after the shelf life or the expiration date to prevent food-borne illness. Review of a facility policy titled Food Storage updated 3/23/25, identified leftover foods should be stored in covered containers or wrapped and clearly labeled, dated and monitored to assure that foods are consumed by their safe use by dates, or frozen.			F0812			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245463		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - SOUTH BLDG 3 B. WING		(X3) DATE SURVEY COMPLETED 08/05/2025	
NAME OF PROVIDER OR SUPPLIER Pioneer Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1131 SOUTH MABELLE AVENUE , FERGUS FALLS, Minnesota, 56537			
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/05/2025. At the time of this survey, Pioneer Care Center building 03 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:			K0000			08/05/2025

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 reverse for further 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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K0000	Continued from page 1 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was surveyed as two buildings. Building 03 is a 1-story building with no basement and is Type V (111) construction. Building 03 is fully sprinkler protected and has a complete fire alarm system including smoke detectors in the corridor, sleeping rooms and common areas. All hazardous areas have automatic fire detection. Building 03 is divided into 3 smoke compartments. Building 02 and 03 are separated by a 2-hour fire barrier. The facility has a licensed capacity of 105 beds and had a census of 90 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			
K0351 SS = D Bldg. 03	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes			K0351	A padlock was installed to the electrical disconnect box locking the handle in the on position ON position so it can't be turned off. This was completed 8/5/2025 by Brad Bushinger, Enviromental Director. Maintenace staff and Enviromental Director have the key and will monitor.		08/26/2025

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245463		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - SOUTH BLDG 3 B. WING		(X3) DATE SURVEY COMPLETED 08/05/2025	
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K0351 SS = D Bldg. 03	Continued from page 2 closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, and 9.7.1.1(1), and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 7.2.6.2.1. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 08/05/2025 at 12:03 PM, it was revealed by observation that the air compressor for the dry pipe sprinkler system in the building was wired to a switch that was not locked in the "ON" position preventing the power from being turned off to the air compressor. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0351			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 21, 2025

Administrator
Pioneer Care Center
1131 SOUTH MABELLE AVENUE
FERGUS FALLS, MN 56537

Re: State Nursing Home Licensing Orders

Event ID: 1D0D5F-H1

Dear Administrator:

The above facility survey was completed on August 6, 2025 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 one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
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20000	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 8/4/25-8/6/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000			08/27/2025	

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER Pioneer Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1131 SOUTH MABELLE AVENUE , FERGUS FALLS, Minnesota, 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	
20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		20000				
20510	Use of Restraints CFR(s): MN Rule 4658.0300 Subp. 2 Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the use of a low bed as a potential restraint for 1 of 1 resident (R32) reviewed for restraints.		20510	Corrected.		09/03/2025	

Minnesota State Department of Health

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20510	Continued from page 2 Findings include: R32's significant change Minimum Data Set (MDS) assessment dated 6/16/25, identified R32 had severe cognitive impairment and diagnosis of Parkinson's, hypertension (elevated blood pressure) and arthritis. R32 required extensive assistance for activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R32 had no impairment of upper or lower extremities, had a history of falls, and required a wheelchair for mobility. MDS indicated R32 did not use any restraints. R32's significant change Care Area Assessment (CAA) dated 6/24/25, identified R32 had severe cognitive impairment and was a fall risk and R32 did not use any restraints. Review of R32's quarterly fall assessment dated 5/29/25, identified R32 had balance problems when walking and standing and was a moderate risk for falls. Assessment did not identify the use of any restraints. Review of R32's current physician orders signed 6/17/25, did not identify an order for a restraint. R32's medical record lacked any evidence a restraint assessment had been completed. R32's care plan revised 7/25/25, identified R32 had a self - care deficit and was at risk for falls related to confusion, impaired balance and limited mobility. Identified 32 had a fall on 7/25/25 and directed staff to ensure R32's bed is in the lowest position at night for safety. Identified R32 transferred using a stand-up lift. R32's progress note dated 7/28/25 at 10:55 a.m., identified on 7/25/25 R32 was found on the floor next to her bed. Identified R32 had attempted to self-transfer from bed. Identified a new intervention after fall was to have bed in lowest position when R32 was in bed. During an observation on 8/4/25 at 6:49 p.m., R32's bed		20510				

Minnesota State Department of Health

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20510	Continued from page 3 was about 1 ft. off the ground and R32 was sitting at the edge of the bed leaning forward and was yelling " I can't get up come help me." Nursing assistant (NA)-A and NA-B entered R32's room and assisted R32 to lie back down in bed and boosted R32 up in the bed. During a joint interview on 8/4/25 at 6:56 p.m., nursing assistant (NA)-A stated R32 attempts to get out of bed on her own and had fallen. NA-A stated the latest intervention was to put R32's bed in the lowest position to keep R32 from getting up and falling. NA-B stated the low bed makes it really hard for R32 to stand up on her own. NA-A and NA-B stated R32 was able to stand on her own even though it was not always safe. NA-A and NA-B stated they were unsure if R32's low bed was a potential restraint. During an interview on 8/5/25 at 8:26 a.m., licensed practical nurse (LPN)-A stated R32 's bed is in lowest position because R32 has had falls trying to self transfer out of bed. LPN-A verified R32 was able to stand up on her own. LPN-A stated she did not feel putting R32's bed in lowest position was a restraint because even though R32 was able to stand on her own it was not safe for R32 to stand on her own. LPN-A verified R32's low bed was not assessed as a potential restraint. During an interview on 8/5/25 at 8:33 a.m., physical therapy assistant (PTA) stated R32 was able to stand up on her own and she should wait for help to stand up. PTA stated R32's bed is in the lowest position so that if R32 attempts to stand up on her own and falls it won't be so far to fall. PTA stated she did not think of the low bed as a potential restraint for R32 because R32 was not aware of the potential of falls when she stood on her own. During an interview on 8/5/25 at 10:08 a.m., director of nursing (DON) verified R32's care plan revealed R32 had falls attempting to self- transfer and the latest intervention was for 32's bed to be placed in the lowest position. DON verified a restraint assessment had not been completed prior to placing R32's bed in the lowest position. DON stated she had not thought of the low bed as a restraint for R32 because even though R32 was able to self transfer she was not always safe during self- transfers. DON further stated she could see how R32's low bed could be a potential restraint. DON stated her expectation was that a restraint		20510				

Minnesota State Department of Health

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20510	Continued from page 4 assessment would have been completed prior to placing R32's bed in the lowest position. Review of a facility policy titled Restraint Free Environment revised 2025, identified a physical restrain refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body such as placing a resident in a chair that prevents the resident from rising independently. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure restraint assessments were performed on all residents with low beds. Those assessments should occur upon admission, quarterly, yearly, with a significant change and periodically thereafter as needed. The facility could review policies and procedures, educate staff on changes, and perform audits periodically to ensure alarms are not used for staff convenience. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.		20510				
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded to include the use of safety alarms for 1 of 1 residents (R17) reviewed for MDS. Findings include R17's significant change in status MDS dated 6/27/25, identified R17 had medically complex conditions, hypertension, anxiety, and depression. R17 needed extensive assistance with activities of daily living (ADLs). R17 did not use a bed alarm, chair alarm, floor		20550	Corrected.		09/03/2025	

Minnesota State Department of Health

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20550	Continued from page 5 mat alarm, or motion sensor alarm. R17's care plan was revised on 7/25/24, revealing R17 had audible wheelchair and silent bed and recliner alarms. R17's signed orders dated 6/17/25, revealed R17 had orders to monitor the placement and function of the bed and recliner alarm, and the audible wheelchair alarm every shift for fall intervention; the order start date was 2/6/24. During an observation on 8/4/25 at 6:48 p.m., R17 was in the living room area next to the dining room, with a chair alarm on the back of the wheelchair. During an observation on 8/5/25 at 8:05 a.m., R17 was lying down in bed, the bed was low to the floor with a floor mat and a bed alarm attached to the bed. During an observation on 8/5/25 at 12:10 p.m., R17 was not in the room, but the alarm strip was on the bed. R17 was in a wheelchair, sitting in front of the television with an alarm on the back of the wheelchair. During an observation on 8/6/25 at 7:10 a.m., R17 was in a low bed with a bed alarm attached to the bed. During an interview on 8/5/25 at 12:15 p.m., registered nurse (RN)-E, verified R17 has had a bed alarm and a chair alarm since RN-E started working at the facility about a year ago. During an interview on 8/5/25 at 2:17 p.m., MDS coordinator verified the MDS was not coded for a bed alarm or a chair alarm. The MDS coordinator viewed the Kardex and the care plan and verified R17 did have a bed alarm and chair alarm and should have been coded on the MDS. The MDS coordinator indicated the process was to review the assessments, care plan, and care conference notes when completing an MDS. The MDS coordinator indicated at times she would perform a visual assessment on a resident, but did not have a visual assessment when completing R17's MDS. During an interview on 8/5/25 at 2:52 p.m., RN-F viewed R17's care plan and Kardex and verified R17 had a bed alarm and chair alarm and should have been coded on the MDS.		20550				

Minnesota State Department of Health

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20550	Continued from page 6 During an interview on 8/6/25 at 10:21 a.m., director of nursing (DON) expectation would be for the MDS coordinator to review the care plan. DON verified the bed alarm and chair alarm were located in R17's care plan. DON's expectation would be for the MDS to be coded correctly. Review of the facility policy titled Resident assessments dated October 2023, revealed information in the MDS assessment will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure policies are up to date, staff training has been completed, implemented and monitored to assure quarterly minimum data set (MDS) are completed accurately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20550				
20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure recommended splint or alternative devices were utilized to help prevent further contractures and stiffness for 1 of 1 residents (R11) reviewed for range of motion (ROM). Findings include: R11's annual Minimum Data Set (MDS) assessment dated		20895	Corrected		09/03/2025	

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20895	Continued from page 7 7/13/25, identified R11 had severe cognitive impairment and had diagnoses of cerebral palsy (irregular brain development that affects movement and posture), seizure disorder, and malnutrition. Indicated R11 required extensive assistance of staff for activities of daily living (ADLs) including transfers and toileting. R11's care plan revised 7/26/23, identified R11 had limited physical mobility related to the disease process. Additionally, R11 had the potential for skin impairment related to decreased mobility. R11's care planned interventions included: - Apply small towel roll in between left elbow and shoulder and small roll in left palm web space. - Left Hand Contractures: Place foam roll in palm of left hand between thumb and palm to prevent skin breakdown. Remove and check skin every two hours and as needed. R11's treatment administration record (TAR) dated 7/1/25 to 8/5/25, identified R11 was to apply a small towel roll in between left elbow and shoulder and small roll in left palm web space Monday, Wednesday, and Friday. R11's Kardex dated 8/5/25 revealed the following: - Left Hand Contractures: Place small towel/washcloth as resident will tolerate in left palm between thumb and palm every two hours and as needed. - Place small towel/ washcloth as resident will tolerate between left elbow and shoulder. Notify nurse if noted skin alternation. During an observation on 8/4/25 at 12:18 p.m., R11 was lying in bed with eyes closed. R11 left hand was tightly closed with thumb pressed against palm of hand and four fingers placed over thumb. Additionally, R11's left arm was bent up at the elbow. R11 was able to move right hand open and closed. R11 is non-verbal and unable to answer any questions. R11 did not have a washcloth or foam roll placed in R11's left hand and left elbow. During an observation on 8/4/25 3:30 p.m., R11 remained in a similar position as noted above. During an observation on 8/4/25 at 7:02 p.m., R11 was resting in bed with music playing. R11 had a gown on and was covered with a thin blanket. R11 did not have a washcloth or foam roll placed in R11's left hand and			20895			

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20895	Continued from page 8 left elbow. During an observation on 8/5/25 at 8:20 a.m., R11 was resting in bed covered with a blanket. R11 was listening to music with R11’s eyes closed. R11 did not have a washcloth or foam roll placed in R11’s left hand and left elbow. During an observation and interview on 8/5/25 to 9:47 a.m., registered nurse (RN)-E entered R11’s room to provide medications. RN-E stated R11 did not have a brace for R11’s left hand. RN-E further stated staff were to be doing range of motion (ROM) on R11’s upper extremities to help reduce further contractures. RN-E provided ROM on R11 after completing medication administration. RN-E completed ROM, cleaned up supplies, left R11’s room, and charted ROM in R11’s TAR. During an interview and observation on 8/5/25 at 11:06 a.m., rehabilitation director (RD) revealed passive range of motion (PROM) of R11’s upper extremities was an order from occupational therapy (OT). RD further revealed R11’s left hand was contracted when R11 was admitted to the facility and R11 could not use a brace. RD indicated OT ordered the use of a washcloth in place of a brace. RD further indicated R11 had an order to place a washcloth in the left hand and left elbow Monday, Wednesday, and Friday. RD reviewed R11’s care plan and stated another intervention was listed for staff to place a foam roll in R11’s left hand and monitor every two hours. RD confirmed the correct order should have been to place a washcloth in R11’s hand and elbow Monday, Wednesday, and Friday. RD entered R11’s room to evaluate R11’s left hand to see if contractors had gotten worse. RD stated there had not been much change in R11’s left hand and left arm. RD indicated R11 would still benefit from having a washcloth placed in R11’s hand and elbow as tolerated Monday, Wednesday, and Friday. During an interview on 8/5/25 at 11:22 a.m., registered nurse (RN)-F and RD reviewed R11’s orders and care plan. RN-F confirmed the current orders and care plan interventions for R11 and indicated RN-F was unaware what exact orders staff should have been following. RN-F indicated RN-F would contact the clinical coordinator to confirm the correct orders for R11. During a follow-up interview on 8/5/25 at 2:13 p.m., RN-F indicated the clinical coordinator stated R11 should have had the foam roll intervention removed from the care plan. RN-F further indicated the correct order		20895				

Minnesota State Department of Health

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20895	Continued from page 9 was currently listed on the TAR and staff should have been following the current order. During an interview on 8/5/25 at 2:33 p.m., director of nursing (DON) confirmed the above findings and stated she expected staff to follow the plan of care to ensure residents do not have a decline in care. DON further stated it is important residents continue to keep the highest level of ROM as possible. Facility policy titled restorative nursing services revised 7/17, resident will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitation services. Restorative goals may include, but are not limited to supporting and assisting the resident in: participating in the development and implementation of his/her plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures and ensure all residents with limitations in range of motion (ROM) receive services to maintain or improve ROM function. Nursing staff could be educated on the importance of providing services to residents with limited ROM based on assessed needs and as recommended. The DON or designee could develop a monitoring system to audit periodically and report the findings of those audits to the quality assurance performance improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20895				
21015	Dietary Staff Requirements- Sanitary conditi CFR(s): MN Rule 4658.0610 Subp. 7 Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food stored in the refrigerators and freezers were labeled, dated and discarded properly. This deficient practice had the potential to affect all 89 residents who received food from the refrigerators, freezers and the kitchen. Findings include:		21015	Corrected.		09/03/2025	

Minnesota State Department of Health

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21015	Continued from page 10 On 8/4/25 at 9:44 a.m., during the kitchen tour with the cook the following concerns were identified. Walk in cooler -half container of sour cream without notation of an opened date and an expiration date of 6/20/25. Fridge in kitchen -1/4 container of mustard with an expiration date of 7/28/25. -1/2 bottle of barbeque sauce without notation of an opened date and no expiration date. During an interview on 8/4/25 at 10:20 a.m., cook verified the above findings during the kitchen tour. Cook stated her expectation was all opened food should have been dated and thrown away on or before the expiration date to prevent food-borne illness. During an interview on 8/4/25 at 10:30 a.m. dietary manager (DM) stated her expectation was all food should have been dated when it was opened and thrown away after the shelf life or the expiration date to prevent food-borne illness. Review of a facility policy titled Food Storage updated 3/23/25, identified leftover foods should be stored in covered containers or wrapped and clearly labeled, dated and monitored to assure that foods are consumed by their safe use by dates, or frozen. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, could ensure food is dated when opened, and food is discarded of after the expiration date. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21015				
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive		21565	Corrected		09/03/2025	

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21565	Continued from page 11 resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper implementation of the self-administration of medication (SAM) assessments for 2 of 2 residents (R36, R1), reviewed for medication administration. Findings include: R36's quarterly Minimum Data Set (MDS) assessment dated 6/4/25, indicated R36 was cognitively intact and diagnoses of diabetes, heart failure, and arthritis and required the assistance of one staff with activities of daily living (ADL's) for transfers and toileting. R36's physician orders dated 8/4/25, revealed the following: - Lidocaine External Patch 4%, apply to back topically two times a day for pain. Apply at bedtime (HS) and remove at morning (AM). R36's electronic medical record (eMAR) dated 7/1/25 to 8/5/25, revealed nursing staff had applied and removed the lidocaine patch daily following physician's orders. R36's self-administration of medication (SAM) assessment dated 6/4/25, indicated R36 was able to self-administer medications after the nurse set-up R36's medications. During an observation on 8/05/25 at 3:45 p.m., trained medication aid (TMA)-C stated R36 was to have a lidocaine patch applied at HS. TMA-C confirmed R36's box of lidocaine patches were sitting out on R36's dresser in R36's room. TMA-C left the room after giving R36's medications, however, did not put R36's box of lidocaine patches away in the locked medication drawer. During an observation on 8/06/25 at 8:09 a.m., R36 continued to have an open box of lidocaine patches, containing three unopen patches, sitting on top of R36's dresser in R36's room. During an observation and interview on 8/06/2025 at 8:52 a.m., R36's lidocaine patches remained in the same position. R36 indicated she had a patch put on at HS and R36 removed the lidocaine patch independently in		21565				

Minnesota State Department of Health

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21565	Continued from page 12 the AM. During an interview on 8/06/25 at 8:32 a.m., pharmacy consultant (PC) stated R36 was to have one lidocaine patch on at a time and nursing staff should have only leave one patch out for R36 to apply. PC further stated it was important to follow the SAM assessments to ensure residents are appropriately using medications. During an interview on 8/06/2025 at 9:01 a.m., clinical coordinator (CC)-A confirmed R36's order for lidocaine patches. CC-A indicated R36 was not able to apply them independently but could remove them independently. CC-A revealed the lidocaine patches should have been put away in R36's drawer when they were not being used. CC-A entered R36's room and put the lidocaine patches away in R36's locked medication drawer. During an interview on 8/06/25 at 9:21 a.m., director of nursing (DON) confirmed the above findings and stated it was important for medication staff to put medications away in the appropriate location for safety reasons. DON further stated it was important for medication staff to return to the residents' room to ensure medications were taken properly. R1's significant change minimum data set (MDS) dated 6/12/25, revealed R1 had a mild cognitive impairment. R1 had a diagnosis of having an indwelling urinary catheter, heart failure, and hypertension. R1 needed extensive assistance for activities of daily living (ADLs). R1's signed orders dated 6/17/25, had an order for Clotrimazole ointment 1% (antifungal) for cutaneous candidiasis (skin infection), apply to the penis head twice a day, and Miconazole powder (antifungal) to affected red areas topically as needed when the current supply of nystatin powder (antifungal) is exhausted. R1's care plan revised on 6/6/25, revealed R1 is not able to self-administer medications. R1's self-administration of medication assessment dated 6/12/25, revealed R1 was not able to self-administer medications. During an observation and interview on 8/4/25 at 1:07 p.m., a tube of Clotrimazole cream 1% and Nystatin powder was sitting on the nightstand. R1 indicated that staff would leave the cream and powder on the nightstand for staff to apply. R1 indicated that if the medications were not left out on the nightstand, staff would not apply the cream and powder, as only one person can get out the cream and powder and apply it		21565				

Minnesota State Department of Health

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21565	Continued from page 13 when they are locked up. During an interview on 8/4/25 at 1:26 p.m., licensed practical nurse (LPN)-A verified R1 did not have an order to self-administer medication. LPN-A verified there was a tube of Clotrimazole cream 1% and Nystatin powder on R1 nightstand. LPN-A locked up the medications in the medication drawer. During an interview on 8:33 a.m., pharmacy consultant indicated Clotrimazole and Nystatin are both antifungal medications and should have a self-administered assessment done to ensure the resident knows how to correctly administer the medications. During an interview on 8/6/25 at 9:23 a.m., clinical coordinator manager (CCM)-A indicated medications applied by the nurse or trained medical assistant (TMA) should be in the medication drawer. CCM-A indicated that a self-administration assessment was important to ensure the resident understands how to administer a medication correctly. CCM-A indicated that locking a medication in a medication drawer is important to ensure the safety of residents and visitors. During an interview on 08/06/2025 at 10:23 a.m., director of nursing (DON) verified that creams and powders should be in a locked drawer unless the resident has a self-administration of medications order and was assessed to ensure they were safe to have the medications at bedside. Facility policy titled Self-Administration of Medications dated 2/21, the interdisciplinary team (IDT) assesses each resident's cognitive ability and physical abilities to determine whether self-administering of medications is safe and appropriate. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff		21565				

Minnesota State Department of Health

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21565	Continued from page 14 could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance.		21565				
21620	Labeling of Drugs CFR(s): MN Rule 4658.1345 Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled appropriately to include administration directions, insulin pens were dated and not expired and failed to dispose of expired eye drops per manufacturer recommendation's for 9 of 9 residents (R47, R69, R92, R36, R40, R73, R19, R10, R13) reviewed during medication storage and administration. Finding include R47's medication review report signed 7/15/25, included orders for Thera Tears (for dry eyes) solution 0.25%, install one drop in both eyes four times a day for dry eyes. During an observation and interview on 8/5/25 at 3:31 p.m., a bottle of Thera Tears 0.25% eye drops was in R47's medication drawer. The bottle had no name, label, or date opened. The directions on the bottle from the manufacturing company indicated to install 1-2 drops in the affected eye as needed. Registered nurse (RN)-B indicated the box the eye drops came in was thrown after it was verified with the EMAR. RN-B checked the EMAR and indicated R47 receives Thera Tears four times a day, which was different than what was written on the bottle. RN-B indicated staff would follow the orders on the MAR and not on the bottle. During an observation and interview on 8/06/2025 at 9:10 a.m., RN-C verified there was no name or directions on the R47 Thera Tears eye drop bottle. RN-C indicated the directions are on the EMAR and would		21620	Corrected.		09/03/2025	

Minnesota State Department of Health

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21620	Continued from page 15 follow the directions on the EMAR. RN-C indicated the family would bring R47's eye drops; that is why there is no name or label on the eye drop bottle. R69 R69's medication review report signed 7/22/25, included orders for latanoprost 0.005%, install one drop in both eyes one time a day for glaucoma. During an observation and interview on 8/5/25 at 3:34 p.m., R69 had a bottle of latanoprost (glaucoma) 0.005% eye drops in the medication drawer. There was no date of when the medication was opened, RN-B indicated the facility has a list of medications and when they expire on the medication cart from the pharmacy. RN-B verified the eye drops were open, and the EMAR indicated the eye drops expire 5/26. During an observation and interview on 8/06/2025 9:12 a.m., RN-C verified R69 latanoprost 0.005% eye drops had no date of when it was opened or when it expired on the eye drop bottle. RN-C indicated the process was to write on the eye drop when it was opened. RN-C indicated latanoprost normally expires in 28-40 days after being opened. RN-C indicated staff would write in the MAR when a medication expires. RN-C looked at the EMAR and showed the EMAR had the latanoprost expiring 5/26. During an interview on 8/6/25 at 9:23 a.m., clinical coordinator manager (CCM)-A indicated staff should date eye drops after opening. CCM-A was under the assumption that latanoprost eye drops expire 28 days after opening. CCM-A indicated staff should throw the eye drops if not dated when opened, and to order new eye drops from the pharmacy. CCM-A indicated it is important not to administer a medication when it has expired, to ensure the medication is working at its full strength. CCM-A checked with the pharmacy and confirmed the latanoprost eye drops were filled on 7/13/25, which indicates the medication had not expired. CCM-A indicated she would date the medication with the correct expiration date. CCM-A also provided a list of medications and expiration dates that the facility uses, and according to the list, latanoprost was good for six weeks after opening and being unrefrigerated. CCM-A also indicated the facility had labels with the resident names and room number for medications that were brought in by family and should have been applied to R47 eye drops. R92		21620				

Minnesota State Department of Health

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21620	Continued from page 16 R92's Medication Review Report signed undated, revealed the following: - Artificial Tears Ophthalmic Solution1.4% instill one drop in both eyes as needed for dry eyes four times a day (QID). - Artificial Tears Ophthalmic Solution 1.4% instill one drop in both eyes three times a day for cataract evaluation until 8/4/25. R92's eMAR dated 7/1/25 to 8/5/25, revealed the following: - Ketorolac Tromethamine Ophthalmic Solution 0/5% instill one drop in both eyes one time a day for cataracts for 14 days starting 7/10/25. - Ketorolac Tromethamine Ophthalmic Solution 0/5% instill one drop in both eyes one time a day for cataracts for 14 days starting 7/24/25. - Prednisolone Acetate Ophthalmic Suspension 1% instill one drop in both eyes one time a day for cataract surgery for 21 days starting 7/10/25. - Prednisolone Acetate Ophthalmic Suspension 1% instill one drop in both eyes one time a day for cataract surgery for 21 days starting 7/17/25. - Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium) instill one drop in right eye three times a day for dry eyes starting 7/11/25. - Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium) instill one drop in right eye as needed for dry eyes starting 7/11/25. - Moxifloxacin HCL Ophthalmic Solution 0.5% instill one drop in both eyes four times a day for cataract surgery for seven days starting 7/10/25. During an observation/interview on 8/5/25 at 3:45 p.m., RN-B opened R92's locked medication drawer in R92's room. Located in a cup in R92's drawer revealed the following: - Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium) with R92's name and prescription number (Rx). Eye drops lacked boxed packaging and instructions.		21620				

Minnesota State Department of Health

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21620	Continued from page 17 - Moxifloxacin Ophthalmic Solution 0.5% with R92's name and Rx number. Eye drops lacked boxed packaging and instructions. - Prednisolone Acetate Ophthalmic Suspension and lacked R92's name, Rx number, boxed packaging, and instructions. RN-B confirmed the above findings and stated eye drops should be in the boxed packaging labeled with resident's name, Rx number, and directions. R36 R36's Medication Review Report signed 8/4/25, included orders for Lantus Solo Star Subcutaneous solution Pen-injector 100 unit/ML (insulin Glargine) inject 8 units subcutaneously once a day for diabetes. R36's electronic medical record (eMAR) dated 7/1/25 to 8/5/25, identified R36 was currently receiving 8 units of Lantus insulin injection one time a day at bedtime. During an observation/interview on 8/5/25 at 3:33 p.m., trained medication aid (TMA)-C reviewed insulin pen with surveyor and confirmed the pen was not dated. TMA-C indicated TMA-C was aware pens were only good for 28 days after they were opened. TMA-C took the pen to registered nurse (RN)-F who confirmed the insulin pen was undated. RN-F discarded the insulin pen in the sharp's container. R40 R40's Medication Review Report signed 8/4/25, included orders for Lantus Solo Star Subcutaneous solution Pen-injector 100 unit/ML(insulin Glargine) inject 14 units subcutaneously once a day for diabetes. R40's current medication administration record (MAR) identified R40 was currently receiving 14 units of Lantus insulin injection at bedtime daily. R73 R73's Medication Review Report signed 6/11/25, included orders for Latanoprost Solution 0.005% one drop to each eye once per day for glaucoma.			21620			

Minnesota State Department of Health

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21620	Continued from page 18 R73's MAR identified R73 was currently receiving Latanoprost Solution 0.005% one drop to each eye once per day. During an observation and interview on 8/5/25 at 3:33 p.m., registered nurse (RN)-D confirmed R40's insulin pen in the locked drawer was not dated and R73's Latanoprost Solution 0.005% eye drops had an expiration date of 7/11/25. RN removed the insulin pen from R40's locked medication drawer and the eye drops from R73's locked medication drawer and brought them to the medication room to be destroyed. RN-D verified Lantus insulin pen was good for 28 days and stated her expectation was R40's insulin pen would have been dated when it was opened. RN-A further stated her expectation was R73's eye drops were thrown away on or before the expiration date to ensure the medications were effective. R19 R19's Medication Review Report signed 7/16/25, included orders for Silicon Oil (Sil-Optho) prosthetic lubricant- one drop to left prosthetic eye twice a day for lubrication as needed. Artificial tear solution- instill one drop in right eye as needed for dry eye, and one drop in right eye five times a day for dry eye. Muro 128 ointment 5%- instill one application in right eye one time a day for corneal abrasion to right eye. During observation on 8/5/25 at 3:33 p.m., registered nurse (RN)-A confirmed R19 had a bottle of Sil-Optho not labeled, a bottle of Eye Relief not labeled, and a tube of Muro 5% not labeled. RN-A removed the medications from R19's medication locked drawer and brought to medication room, then indicated they would be destroyed. R10 R10's Medication Review Report signed 7/10/25, included order for Nitroglycerin Sublingual (below tongue) 0.4 milligram (MG)- give one tablet sublingually as needed for chest pain. Give one dose every five minutes for chest pain. Do not exceed three doses in 15 minutes. During observation on 8/5/25 at 3:44 p.m., RN-A confirmed R10 had two bottles of nitroglycerine, one with a label which included R10's name only and one not marked. RN-A stated they both should have R10's name and instructions attached. R13		21620				

Minnesota State Department of Health

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21620	Continued from page 19 R13's Medication Review Report signed 4/29/25, included orders for Breztri Aerosphere Inhalation Aerosol 160-9-4.8 microgram (MCG-ACT)- two puffs inhale orally two times a day for wheezing. Muro 128 ointment 5%- instill one drop in both eyes at bedtime for dry eye 1/4 strip in both eyes. During observation on 8/5/25 at 3:57 p.m., trained medication aide (TMA)-A indicated R13's two Brezti inhalers were not labeled. One was in her medication drawer, and one was on her bedside table. TMA-A stated there was a box for the inhaler with the label on it at one time, but it was not in R13's drawer anymore. R13 also had a Muro 5% eye ointment with no label. TMA-A indicated the Muro had a label, but it was not on it anymore. TMA-A also stated no expiration date was found on the Muro ointment. During a phone interview on 8/6/25 at 8:32 a.m., consultant pharmacist (CP)-A indicated all medications should have a pharmacy label with the resident's name and instructions. CP-A indicated if the medication was too small for a full label, she would expect the medication to be labeled with the resident's name and instructions to see electronic medication administration record (EMAR) for directions. CP-A stated if the medication was received in a box, the medication should be stored in the box which would contain the pharmacy label. CP-A stated it was important for medications to be labeled correctly to assure used correctly and for correct resident. CP-A indicated Xalatan/latanoprost eye drops expired 42 days or six weeks after opened. They should be labeled with date opened, and destroyed once expired. CP-A stated insulin pens should be dated when first used, and destroyed after manufactures recommended dates of how long the pens should be used, which was usually 28 days. CP-A indicated eye drops, and insulin pens should be dated when opened, and not used after expiration date per manufactures instructions. During interview on 8/6/25 at 9:14 a.m., director of nursing (DON) indicated her expectation was all medications would be labeled with resident's name, expiration date and directions for use. If the medication was not large enough for the full label, it should be kept in the box it came in. DON indicated the facility had labels they could use that had the resident's name and to refer to chart for direction of use. DON stated labels on medications were important to follow the rights of medication administration and safety. DON stated the facility had a shortened expiration date form, provided by pharmacy, which		21620				

Minnesota State Department of Health

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21620	Continued from page 20 indicated which eye drops had shortened expiration dates after opened. DON stated her expectation was the eye drops were labeled when opened and disposed of when expired. DON stated insulin pens should also be dated when opened and disposed of when expired. DON indicated most insulin pens were to be disposed of after 28 days. DON stated it was important to dispose of medications after expiration as the medication may not be as effective after expired. The facility policy titled Medication Labeling And Storage revised 2/23, identified medications were stored in packaging, containers or other dispensing systems they were received. The policy identified medication labels included medication name, prescribed dose, strength, expiration date when applicable, resident's name, route of administration, and appropriate instructions and precautions. If medication containers had missing, incomplete, improper or incorrect labels, contact pharmacy for instructions regarding returning or destroying those items. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for consistent review of labeling of medications for accuracy. Nursing staff could be educated as necessary of the importance of labeling and dating medications properly when opened. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.		21620				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 2, 2026

Administrator
Pioneer Care Center
1131 SOUTH MABELLE AVENUE
FERGUS FALLS, MN 56537

RE: CCN: 245463
Cycle Start Date: August 6, 2025

Dear Administrator:

On September 10, 2025, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

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

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 2, 2026

Administrator
Pioneer Care Center
1131 SOUTH MABELLE AVENUE
FERGUS FALLS, MN 56537

Re: Reinspection Results
Event ID: 1D0D5F-H2

Dear Administrator:

On September 10, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 6, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

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

Email: sarah.lane@state.mn.us

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