Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 7, 2025

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

RE: CCN: 245463
Cycle Start Date: May 16, 2025

Dear Administrator:

On June 11, 2025, we notified you a remedy was imposed. On June 27, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 20, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 16, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 11, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 16, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 20, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 7, 2025

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

Re: Reinspection Results
Event ID: QQIX12

Dear Administrator:

On June 11, 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 May 16, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Electronically delivered
May 28, 2025

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

RE: CCN: 245463
Cycle Start Date: May 16, 2025

Dear Administrator:

On May 16, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 August 16, 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 November 16, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 28, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: QQIX11

Dear Administrator:

The above facility was surveyed on May 15, 2025 through May 16, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00443	A. BUILDING: ______ B. WING ______	C 05/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/15/25 and 5/16/25, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1	2 000		

identify the date when they will be completed.

The following complaint was reviewed:

H54634509C (MN00112985) with a licensing orders issued at 0830.

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 surveyor ' s 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 14-01, available at <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. The facility is enrolled in ePOC and therefore a signature is

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate supervision when a resident was brought outside onto the patio area and left there without supervision, and later became unresponsive for 1 of 1 resident (R1) reviewed for safety. Findings include: R1's Saint Louis University Mental Status	2 830	Corrected	6/7/25

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2 830	Continued From page 3 (SLUMS, screening test for dementia) examination dated 1/6/23, identified R1 had a mild neurocognitive disorder. R1's quarterly Minimum Data Set (MDS) dated 4/22/25, identified R1 had verbal behaviors one to three times a week, and rejection of care. She was dependent upon staff for toileting hygiene, personal hygiene, sit to stand, chair/bed to chair transfers, toilet transfers, and was unable to ambulate. R1 was frequently incontinent of bladder and occasionally continent of bowel. Medical diagnoses included arthritis, depression, psychotic disorder, macular degeneration, and epilepsy (seizure disorder). R1's care plan dated 3/18/25, identified R1 had impaired balance, limited mobility, and behaviors, and directed staff to provide total assistance of two for transfers with a lift, and encourage the use of bell to call for assistance. R1 did not ambulate. R1 required staff assist with wheelchair for longs distances, and she was independent with short distances. She had dementia with ineffective coping skills and delusional disorder (a serious mental health illness where a person cannot tell what is real and from what is imaginary, paranoid). She had impaired cognitive function/thought process and decision making. Staff were directed to cue, reorient, and supervise as needed. She required supervision with all decision making. She was at risk for falls related to gait/balance problems, and the care plan directed staff to provide call light within each, encourage her to use it when assistance was needed. She needed prompt response to all requests for assistance. R1's Nursing Assessment dated 4/22/25, identified she had periods of delusions and	2 830		

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2 830	Continued From page 4	2 830		

hallucinations, unsteady gait, poor balance, can stand and pivot only with help, and had moderate agitation (called out and used threatening language).

R1's progress note dated 5/11/25 through 5/13/25 identified:

- On 5/11/25 at 5:21 p.m. R1 was found outside at 4:30 p.m. unresponsive. R1 was assisted into the unit. Vital signs were as follows: blood pressure (BP) 168/89, pulse 116, respiration 22, temperature 99.8 degrees Fahrenheit (F), oxygen saturation (SaO2) 95% on room air. A cold washcloth was applied on her forehead and then she started mumbling. Placed call to 911 and requested for emergency medical service (EMS), family notified through her brother. Registered nurse (RN) charge nurse and RN care coordinator were notified as well.

-On 5/11/25 at 9:43 p.m. R1 returned from the emergency department (ED).

-On 5/12/25 at 4:28 p.m. Follow-up with staff working Sunday afternoon. R1 was assisted outside about 1:45 p.m. onto the short stay patio. Staff followed-up with resident two times from that time until 2:30 p.m. and offered her water. They also asked if she would like to come back inside, which she declined. Two staff offered to bring her in again about 4:00 p.m. and she declined at that time as well. She told them she did not want to come back in at that time.

-On 5/13/25 at 1:30 p.m. R1 required intravenous (IV) fluids (in the ED): sodium chloride 0.9% bolus on 5/11/25 for additional fluids intake for hydration needs. The need for fluids was determined by physical exam and/or diagnostic testing which

Minnesota Department of Health

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2 830	Continued From page 5	2 830		

had indicated: abnormal fluid loss, unstable vital signs (increased temperature) and abnormal labs such as BUN/creatinine, glucose, and potassium. R1 also received treatment for abnormal fluid loss, heat exposure, head exhaustion and hyperkalemia. Rehydration was reasonable and necessary.

R1's ED provider notes dated 5/11/25 at 6:34 p.m. indicated clinical impression: heat exposure, hyperkalemia (high potassium levels), heat exhaustion. She was found by staff at the nursing facility confused outside and quite confused upon EMS arrival. She was alert and oriented, though seemed to have some limited recall of recent events and may have some underlying dementia or other cognitive disorder. Her temperature was 100.1 orally, very warm to the touch with evidence of sunburn, suspected she was quite warmer earlier. Cooling measures were initiated prior to EMS arrival to facility, and mental status improved. She was given cool intravenous fluids and cooling packs were applied to the groin and axilla (under arms). Despite prolonged exposure she did not appear at this time to have suffered any untoward effects. Stable and discharged back to the nursing facility.

During an interview/observation on 5/15/25 at 2:03 p.m. R1 sat in her wheelchair in her room well groomed, fully dressed in t-shirt, zip-up long-sleeved jacket, shorts, socks, and tennis shoes. She stated unsure how long she had lived at the facility, and stated she had been there since fall to winter to spring and now it's summer, I think. She went outside every day and activities staff took her out. She stated she was tired today.

During an interview on 5/15/25 at 4:00 p.m. RN-A stated R1 pushed herself around the unit in the

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2 830	Continued From page 6 wheelchair with her feet. The resident patio area was fenced in, and staff entered a code on the pad located off to the left of the inside door. He had seen R1 outside both in front of the building, and in the patio area. R1's care planned did not identify interventions for her to go outside with or without anyone. Her cognition was affected at times, and she would not have been safe outside by herself when she was confused. She was unable to stand, walk, and/or transfer herself independently, and did not attempt to self-transfer. On 5/11/25, he administered medications to R1 between 8:00 a.m. and 9:00 a.m. while she was in her room. She ate breakfast in the dining room, and then went back to her room. At 12:00 p.m. until 12:45 p.m. she sat in dining room and ate lunch. He had gotten busy after that, took a break before 2:00 p.m. and returned to the floor. Nursing assistant (NA)-A had already given report to the oncoming NA-C. NA-B was scheduled for evening shift at 3:15 p.m. At 4:30 p.m. R1 was not in her room and was found out on the patio area by herself. He asked her, "Should we go inside?" She shook her head no. She was not responding appropriately and mumbled. When cued, she was unable to lift her feet. Foot pedals were placed on her wheelchair and she was pushed inside the building. Vital signs were taken at the nurse's station: blood pressure 165/89, heart rate was 115, temperature 99.8 degrees F., respirations 22, and SaO2 91%, and she was unable to respond. 911 was called. He placed a wet washcloth on her face and she started to wake up and talked a bit. EMS arrived, and once she was transferred to the gurney she woke up and became her normal self. He followed up with staff, and NA-C told him she had taken R1 out to the patio just before 2:00 p.m. and passed the information onto the evening shift NA-A. He	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7	2 830		

Continued From page 7

expected staff to inform the nurse, and he was not told about R1 being outside. NA-B hadn't informed him until 3:20 p.m. NA-A requested assistance to get R1 back into the building and R1 had refused. R1 was unable to identify how to get back into the building, she sat outside in the patio area from 3:20 p.m. until 4:30 p.m. unsupervised, in 90-degree weather, without access to water, and was not safe by herself.

During an observation on 5/15/25 at 4:20 p.m. the resident patio was in the short stay wing. A code pad was located inside on the left side of the door on the wall, at approximately eye level. The door had a large glass window with NO EXIT stamped on it. The door was unable to be opened without a code placed into the pad. There were four lawn chairs and a table against the inside of the metal white fencing, and a long wooden bench located up against the outside building wall. The patio could be visually seen from the main parking lot of the facility and from inside the building was a large window. No overhead protection from the sun was noted.

During an interview on 5/16/25 at 10:00 a.m. NA-A stated R1 refused to come back into building on 5/11/25. Staff were expected to check on residents inside the building every two hours, and if they were outside, they should be checked on every 30 minutes to one hour. NA-D brought R1 outside in the patio area around 1:45 p.m., she checked on her before 2:00 p.m. to see if she wanted to come back in and offered water, and R1 declined. The temperature outside was at least 80 degrees out and partly cloudy. R1 wore shorts, and a t-shirt. R1 did not have on sunscreen, a hat or sunglasses. She also had no access to water. She was unsure why they didn't leave something for her to drink. At 2:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 05/16/2025

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2 830	Continued From page 8 NA-C was informed R1 was outside on the patio, and how long she had been there. Staff were expected to check on her, they could have seen her through the window from inside the building. There was not way for R1 to alert us if she needed anything other than pound on the glass window, wave her arms or knock on the door. A code was needed to open the door from the outside to get back into the building. She would be unable to have pushed the door open, was heavy. There was a buzzer outside on the wall, but she would have most likely been unable to reach it from her wheelchair. During an interview on 5/16/25 at 10:26 a.m. NA-C stated she had received report from NA-A and was made aware R1 was outside on the patio, but was not informed how long it had been. Usually upstairs in the dementia unit a resident was brought outside to the patio area and staff were expected to stay with them, and 15 minutes later the resident was brought back into the facility, and not left alone. R1 was forgetful and confused at times. She had been informed staff attempted earlier to her back into the building, and R1 did not want to go back inside. At 4:00 p.m. she checked on R1 and asked her to come into the building and she refused. The temperature outside was hot, 90 degrees and sunny, and R1 had no protection from the sun. She should have not been placed outside by herself. NA-A stated NA-B planned on updating the nurse about R1's refusal to come inside, but was unable to locate him, it was an extremely busy day with many visitors. At about 4:30 p.m., R1 was in the hallway in her wheelchair unable to talk. They placed ice towels on her prior to EMS arrival. None of this should have happened and could have been worse.	2 830		

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	00443	A. BUILDING: ______ B. WING ______	C **05/16/2025**

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2 830	Continued From page 9 During an interview on 5/16/25 at 12:00 p.m. RN-B stated staff would be expected to check with the nurse on duty prior to a taking a resident outside and left by themselves. R1 was confused at times, especially one day last week, and may have not been able to let herself back into the building. During an interview on 5/16/25 at 2:26 p.m. the director of nursing (DON) stated staff brought R1 out to the patio, checked back and offered water, and offered to bring her back inside. She refused to come back into the building. Staff would have been expected to have notified RN-A, and they did not follow the facility process. RN-A should have been informed R1 was taken outside especially at shift change. R1 had a mental health diagnoses and an altered through process related to delusions. Staff would have expected to check on R1 at least every 15 to 30 minutes and under the circumstances, felt they checked on her appropriately. During an interview on 5/19/25 at 12:22 p.m. NA-B stated he did not receive report when he arrived at work on 5/11/25 at 3:05 p.m. He passed ice water, and R1 was not located in her room. He was unaware of her being out on the patio. She should have not been left alone outside. After 4:00 p.m., NA-C approached him and requested assistance with R1. He put in the code and opened the patio door, and held the door open while NA-C informed R1 it was time to come in for supper. R1 replied no, she was ok, and refused to go in. She wanted to sit outside longer. He told her they would come back in a while. He was unaware how long she had been outside. She was left out on the patio, and they planned on checking back with her later, before supper. R1 sat alone in the wheelchair, with	2 830		

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shorts and a t-shirt on, and without anything to drink. RN-A was unable to find R1 to administer medications, and then requested assistance with getting her into the building from the patio. A code was required to unlock the door to get back into facility, and he was unsure if R1 would have been able to reach the code pad since she was unable to stand up independently.

The facility policy Safety and Supervision of Residents dated 7/2017, directed resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessment needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. Resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.

SUGGESTED METHOD OF CORRECTION: The administrator or designee could update facility policies and procedures related to supervision of residents, train staff on these policies, and monitor with audits reviewed by the quality assurance and performance improvement committee.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

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F 000	INITIAL COMMENTS On 5/15/25 and 5/16/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H54634509C (MN00112985) with deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 689	R1 care plan was reviewed and updated	6/7/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/06/2025

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 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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F 689	Continued From page 1 review, the facility failed to provide adequate supervision when a resident was brought outside onto the patio area and left there without supervision, and later became unresponsive for 1 of 1 resident (R1) reviewed for safety. Findings include: R1's Saint Louis University Mental Status (SLUMS, screening test for dementia) examination dated 1/6/23, identified R1 had a mild neurocognitive disorder. R1's quarterly Minimum Data Set (MDS) dated 4/22/25, identified R1 had verbal behaviors one to three times a week, and rejection of care. She was dependent upon staff for toileting hygiene, personal hygiene, sit to stand, chair/bed to chair transfers, toilet transfers, and was unable to ambulate. R1 was frequently incontinent of bladder and occasionally continent of bowel. Medical diagnoses included arthritis, depression, psychotic disorder, macular degeneration, and epilepsy (seizure disorder). R1's care plan dated 3/18/25, identified R1 had impaired balance, limited mobility, and behaviors, and directed staff to provide total assistance of two for transfers with a lift, and encourage the use of bell to call for assistance. R1 did not ambulate. R1 required staff assist with wheelchair for longs distances, and she was independent with short distances. She had dementia with ineffective coping skills and delusional disorder (a serious mental health illness where a person cannot tell what is real and from what is imaginary, paranoid). She had impaired cognitive function/thought process and decision making. Staff were directed to cue, reorient, and supervise	F 689	to include directions for supervision when outdoors. All residents at Pioneer Care have the potential to be affected by this practice. All resident care plans were reviewed and updated to include directions for appropriate supervision when outdoors. Policy Activities was reviewed and updated to include Resident ability to be outside with or without supervision care planned based on RN assessment of resident cognition, functional status, and other clinical factors. All staff will be educated on this policy by 6/6/2025. The Director of Nursing or her designee will conduct weekly audits to ensure the Care Plans accurately reflect directions for supervision of residents when outdoors 4 audits per neighborhood for 4 weeks, then 4 audits per neighborhood every other week for 1 month, then 4 audits per neighborhood per month for 2 months- Results will be reported to the Quality Assurance Committee and further direction will be followed from this committee. Date of Substantial Compliance 6/7/2025	

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as needed. She required supervision with all decision making. She was at risk for falls related to gait/balance problems, and the care plan directed staff to provide call light within each, encourage her to use it when assistance was needed. She needed prompt response to all requests for assistance.

R1's Nursing Assessment dated 4/22/25, identified she had periods of delusions and hallucinations, unsteady gait, poor balance, can stand and pivot only with help, and had moderate agitation (called out and used threatening language).

R1's progress note dated 5/11/25 through 5/13/25 identified:

- On 5/11/25 at 5:21 p.m. R1 was found outside at 4:30 p.m. unresponsive. R1 was assisted into the unit. Vital signs were as follows: blood pressure (BP) 168/89, pulse 116, respiration 22, temperature 99.8 degrees Fahrenheit (F), oxygen saturation (SaO2) 95% on room air. A cold washcloth was applied on her forehead and then she started mumbling. Placed call to 911 and requested for emergency medical service (EMS), family notified through her brother. Registered nurse (RN) charge nurse and RN care coordinator were notified as well.

-On 5/11/25 at 9:43 p.m. R1 returned from the emergency department (ED).

-On 5/12/25 at 4:28 p.m. Follow-up with staff working Sunday afternoon. R1 was assisted outside about 1:45 p.m. onto the short stay patio. Staff followed-up with resident two times from that time until 2:30 p.m. and offered her water. They

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also asked if she would like to come back inside, which she declined. Two staff offered to bring her in again about 4:00 p.m. and she declined at that time as well. She told them she did not want to come back in at that time.

-On 5/13/25 at 1:30 p.m. R1 required intravenous (IV) fluids (in the ED): sodium chloride 0.9% bolus on 5/11/25 for additional fluids intake for hydration needs. The need for fluids was determined by physical exam and/or diagnostic testing which had indicated: abnormal fluid loss, unstable vital signs (increased temperature) and abnormal labs such as BUN/creatinine, glucose, and potassium. R1 also received treatment for abnormal fluid loss, heat exposure, head exhaustion and hyperkalemia. Rehydration was reasonable and necessary.

R1's ED provider notes dated 5/11/25 at 6:34 p.m. indicated clinical impression: heat exposure, hyperkalemia (high potassium levels), heat exhaustion. She was found by staff at the nursing facility confused outside and quite confused upon EMS arrival. She was alert and oriented, though seemed to have some limited recall of recent events and may have some underlying dementia or other cognitive disorder. Her temperature was 100.1 orally, very warm to the touch with evidence of sunburn, suspected she was quite warmer earlier. Cooling measures were initiated prior to EMS arrival to facility, and mental status improved. She was given cool intravenous fluids and cooling packs were applied to the groin and axilla (under arms). Despite prolonged exposure she did not appear at this time to have suffered any untoward effects. Stable and discharged back to the nursing facility.

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During an interview/observation on 5/15/25 at 2:03 p.m. R1 sat in her wheelchair in her room well groomed, fully dressed in t-shirt, zip-up long-sleeved jacket, shorts, socks, and tennis shoes. She stated unsure how long she had lived at the facility, and stated she had been there since fall to winter to spring and now it's summer, I think. She went outside every day and activities staff took her out. She stated she was tired today.

During an interview on 5/15/25 at 4:00 p.m. RN-A stated R1 pushed herself around the unit in the wheelchair with her feet. The resident patio area was fenced in, and staff entered a code on the pad located off to the left of the inside door. He had seen R1 outside both in front of the building, and in the patio area. R1's care planned did not identify interventions for her to go outside with or without anyone. Her cognition was affected at times, and she would not have been safe outside by herself when she was confused. She was unable to stand, walk, and/or transfer herself independently, and did not attempt to self-transfer. On 5/11/25, he administered medications to R1 between 8:00 a.m. and 9:00 a.m. while she was in her room. She ate breakfast in the dining room, and then went back to her room. At 12:00 p.m. until 12:45 p.m. she sat in dining room and ate lunch. He had gotten busy after that, took a break before 2:00 p.m. and returned to the floor. Nursing assistant (NA)-A had already given report to the oncoming NA-C. NA-B was scheduled for evening shift at 3:15 p.m. At 4:30 p.m. R1 was not in her room and was found out on the patio area by herself. He asked her, "Should we go inside?" She shook her head no. She was not responding appropriately and mumbled. When cued, she was unable to lift her feet. Foot pedals were placed on her

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wheelchair and she was pushed inside the building. Vital signs were taken at the nurse's station: blood pressure 165/89, heart rate was 115, temperature 99.8 degrees F., respirations 22, and SaO2 91%, and she was unable to respond. 911 was called. He placed a wet washcloth on her face and she started to wake up and talked a bit. EMS arrived, and once she was transferred to the gurney she woke up and became her normal self. He followed up with staff, and NA-C told him she had taken R1 out to the patio just before 2:00 p.m. and passed the information onto the evening shift NA-A. He expected staff to inform the nurse, and he was not told about R1 being outside. NA-B hadn't informed him until 3:20 p.m. NA-A requested assistance to get R1 back into the building and R1 had refused. R1 was unable to identify how to get back into the building, she sat outside in the patio area from 3:20 p.m. until 4:30 p.m. unsupervised, in 90-degree weather, without access to water, and was not safe by herself.

During an observation on 5/15/25 at 4:20 p.m. the resident patio was in the short stay wing. A code pad was located inside on the left side of the door on the wall, at approximately eye level. The door had a large glass window with NO EXIT stamped on it. The door was unable to be opened without a code placed into the pad. There were four lawn chairs and a table against the inside of the metal white fencing, and a long wooden bench located up against the outside building wall. The patio could be visually seen from the main parking lot of the facility and from inside the building was a large window. No overhead protection from the sun was noted.

During an interview on 5/16/25 at 10:00 a.m.

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NA-A stated R1 refused to come back into building on 5/11/25. Staff were expected to check on residents inside the building every two hours, and if they were outside, they should be checked on every 30 minutes to one hour. NA-D brought R1 outside in the patio area around 1:45 p.m., she checked on her before 2:00 p.m. to see if she wanted to come back in and offered water, and R1 declined. The temperature outside was at least 80 degrees out and partly cloudy. R1 wore shorts, and a t-shirt. R1 did not have on sunscreen, a hat or sunglasses. She also had no access to water. She was unsure why they didn't leave something for her to drink. At 2:00 p.m. NA-C was informed R1 was outside on the patio, and how long she had been there. Staff were expected to check on her, they could have seen her through the window from inside the building. There was not way for R1 to alert us if she needed anything other than pound on the glass window, wave her arms or knock on the door. A code was needed to open the door from the outside to get back into the building. She would be unable to have pushed the door open, was heavy. There was a buzzer outside on the wall, but she would have most likely been unable to reach it from her wheelchair.

During an interview on 5/16/25 at 10:26 a.m. NA-C stated she had received report from NA-A and was made aware R1 was outside on the patio, but was not informed how long it had been. Usually upstairs in the dementia unit a resident was brought outside to the patio area and staff were expected to stay with them, and 15 minutes later the resident was brought back into the facility, and not left alone. R1 was forgetful and confused at times. She had been informed staff attempted earlier to her back into the building,

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and R1 did not want to go back inside. At 4:00 p.m. she checked on R1 and asked her to come into the building and she refused. The temperature outside was hot, 90 degrees and sunny, and R1 had no protection from the sun. She should have not been placed outside by herself. NA-A stated NA-B planned on updating the nurse about R1's refusal to come inside, but was unable to locate him, it was an extremely busy day with many visitors. At about 4:30 p.m., R1 was in the hallway in her wheelchair unable to talk. They placed ice towels on her prior to EMS arrival. None of this should have happened and could have been worse.

During an interview on 5/16/25 at 12:00 p.m. RN-B stated staff would be expected to check with the nurse on duty prior to a taking a resident outside and left by themselves. R1 was confused at times, especially one day last week, and may have not been able to let herself back into the building.

During an interview on 5/16/25 at 2:26 p.m. the director of nursing (DON) stated staff brought R1 out to the patio, checked back and offered water, and offered to bring her back inside. She refused to come back into the building. Staff would have been expected to have notified RN-A, and they did not follow the facility process. RN-A should have been informed R1 was taken outside especially at shift change. R1 had a mental health diagnoses and an altered through process related to delusions. Staff would have expected to check on R1 at least every 15 to 30 minutes and under the circumstances, felt they checked on her appropriately.

During an interview on 5/19/25 at 12:22 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING ______ B. WING ______	C 05/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 NA-B stated he did not receive report when he arrived at work on 5/11/25 at 3:05 p.m. He passed ice water, and R1 was not located in her room. He was unaware of her being out on the patio. She should have not been left alone outside. After 4:00 p.m., NA-C approached him and requested assistance with R1. He put in the code and opened the patio door, and held the door open while NA-C informed R1 it was time to come in for supper. R1 replied no, she was ok, and refused to go in. She wanted to sit outside longer. He told her they would come back in a while. He was unaware how long she had been outside. She was left out on the patio, and they planned on checking back with her later, before supper. R1 sat alone in the wheelchair, with shorts and a t-shirt on, and without anything to drink. RN-A was unable to find R1 to administer medications, and then requested assistance with getting her into the building from the patio. A code was required to unlock the door to get back into facility, and he was unsure if R1 would have been able to reach the code pad since she was unable to stand up independently. The facility policy Safety and Supervision of Residents dated 7/2017, directed resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessment needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. Resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING ______ B. WING ______	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 689	Continued From page 9 is a change in the resident's condition.	F 689		