DEPARTMENT OF HEALTH

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 Therefore, the NATCEP prohibition is rescinded.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

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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Electronically delivered

July 7, 2025

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

Re: Reinspection Results
Event ID: 6XSI12

Dear Administrator:

On June 27, 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 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

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Federal Enforcement | Health Regulation Division
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Saint Paul, MN 55164-0900
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Electronically delivered

June 11, 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 28, 2025, we informed you that we may impose enforcement remedies.

On May 27, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 16, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 16, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 16, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 16, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Pioneer Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 16, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 16, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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

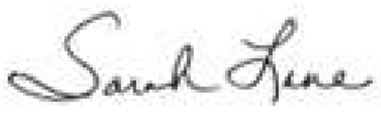
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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
June 11, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 6XSI11

Dear Administrator:

The above facility was surveyed on May 22, 2025 through May 27, 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
	245463	A. BUILDING _____ B. WING _____	C 05/27/2025

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 000	INITIAL COMMENTS On 5/22/25, 5/23/25, and 5/27/25, 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: H54635407C (MN00113168) As a result of the investigation, deficiencies were cited at F580, F610, F684 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		6/20/25

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

Electronically Signed | 06/18/2025

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.

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

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F 580	Continued From page 1 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F 580		

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

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F 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify a physician timely of a change in condition for 1 of 3 residents (R1) who had an injury of unknown origin related to bruising on her inner thigh. Findings include: R1's annual Minimum Date Set (MDS) on 4/24/25, identified R1 had severely impaired cognition, inattention (difficulty focusing, easily distractible, and difficulty keeping track of what was said), and disorganized thinking. Facility Resident Accident/Incident Report dated 5/17/25, completed by floor supervisor registered nurse (RN)-A identified date of incident 5/17/25, at 8:00 a.m. Staff noted R1 had eight areas of greenish colored bruising, dime to nickel sized, on inner knee/thighs which appeared to be fingerprint in size. Area on report labeled "Was it necessary to notify MD/GNP/PA?" was left blank, as was then name/date/time of MD/GNP/PA notified. Administrator and director of nursing (DON) notified on 5/17/25 at 9:45 a.m. R1's progress note dated 5/17/25 at 10:27 a.m., identified she had bruising to upper/inner thighs and inner left knee. The bruises were dark green in color, fingerprint sized and did not appear to cause pain when palpated. R1 was unable to indicate if she felt safe in the facility, if anybody had hurt her or if she remembered how she got the bruises. Progress note indicated resource manager was notified and appropriate actions were in place (those actions not described in progress note). Her granddaughter was contacted	F 580	R1's provider was notified of bruising via fax on 5/22/2025. All Residents at Pioneer Care have the potential to be affected by this practice. Residents Electronic Medical records were audited from 5/27/25 to present ensuring MD was notified of resident involved accidents, changes in resident mental, physical or psychosocial status, a need to alter resident treatment, or a need to transfer a resident. Policy Change in Resident Condition or Status was reviewed. Licensed Nurses will be educated on this policy by 6/20/2025. The Director of Nursing or her designee will conduct audits to ensure Electronic Medical Records reflect MD is appropriately notified of resident involved accidents, changes in resident mental, physical or psychosocial status, a need to alter resident treatment, or a need to transfer a resident. 4 audits weekly 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. The Committee will give further direction for follow up. Date of Substantial Compliance: 6/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 3	F 580		

and informed of the incident and had no questions/concerns at this time. Will continue to monitor and document as needed.

R1's progress note dated 5/19/25 at 1:34 p.m., Complete Skin Assessment: Healing bruises in inner thigh almost gone. No new concerns to report to provider.

R1's routine visit follow up visit by medical doctor/director (MD) on 5/20/25 at 9:55 a.m., lacked any mention of skin/bruising.

R1's progress note dated 5/22/25 at 11:49 a.m. Type: skin/wound note medical doctor (MD) updated via fax. (5 days later)

During an interview on 5/23/25 at 11:10 a.m. RN-A stated the provider should have been notified immediately when the bruises were discovered on 5/17/25 so they could have chosen to evaluate her or send her in for evaluation. The provider was notified via fax yesterday, (5/22/25).

During an interview on 5/23/25 at 2:42 p.m. DON stated the staff would be expected to have notified the provider right away after R1's bruises were found to see if he wanted a further medical evaluation completed and/or other interventions necessary depending on the situation.

During an interview on 5/27/25 at 8:32 a.m. MD stated he was not familiar with R1's incident that occurred on 5/17/25, regarding bruises. MD stated he did not believe it was included on the rounding form he received from the nurse when he saw her on 5/20/35, and no mention of bruises were identified on his visit notes. He would have wanted to be notified so that R1 could have been

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 05/27/2025

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

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F 580	Continued From page 4 examined, especially when there was a potential for alleged abuse. MD indicated the he would have completed the examination to verify if there were concerns for abuse. Certainty there would have been a possibility of sexual abuse especially if bruises were located close to the genital area, if not, rough handling and/or transfers with bruising would have been possible.	F 580		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review the facility failed to ensure an injury of unknown source was thoroughly investigated for 1 of 3 residents (R1) reviewed for abuse. Findings include:	F 610	R 1 a thorough investigation of the identified bruising from 5/17/2025 was completed by Pioneer Care Staff. On 5/22/2025, 5/23/2025 and 5/27/2025 an abbreviated survey and investigation was conducted by MDH.	6/20/25

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 05/27/2025

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 610	Continued From page 5 R1's annual Minimum Date Set (MDS) on 4/24/25, identified R1 had severely impaired cognition. Her medical diagnoses included Parkinson's (a movement disorder of the nervous system with symptoms that worsen over time such as tremors, slowed movements, rigid muscles, poor posture/balance, loss of blinking/smiling movements, speech changes, writing changes, nonmotor symptoms), dementia, and anxiety. She had impaired range of motion to bilateral lower extremities, unable to stand independently or walk. She required substantial to maximal assistance with personal hygiene, repositioning in bed, all transfers and dependent upon staff for toileting and oral hygiene, shower/bathe, dressing, and mobility in wheelchair. R1's care plan dated 5/19/25, identified impairment to skin integrity, activities of daily living (ADL) self-care deficit, and impaired communication. Staff were directed to anticipate and meet needs, use caution during transfers and bed mobility to prevent striking arms/legs/hands against any sharp or hard surfaces, assist of two staff for bed mobility and transfers with assist of one and PAL (patient assisted stand lift), monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, situations, and document. She was a vulnerable adult and staff were directed to monitor and report any suspected abuse or neglect following policy. R1's progress note dated 5/17/25 at 10:27 a.m., identified she had bruising to upper/inner thighs and inner left knee. The bruises were dark green in color, fingerprint sized and did not appear to cause pain when palpated. R1 was unable to	F 610	All residents at Pioneer Care have the potential to be affected, by this practice. All residents electronic medical records were reviewed from 5/27/25 to present for indications of Abuse Neglect, Mistreatment, and Misappropriation of Resident Property and if it existed - evidence of a thorough investigation. Policy Abuse Neglect, Mistreatment, and Misappropriation of Resident Property was reviewed. Licensed Nurses and Social Work Designee on this policy as well as Conducting an Investigation in a Skilled Nursing Facility by 6/20/2025. The Director of Nursing or her designee will conduct audits to ensure thorough investigations were completed for indications of Abuse Neglect, Mistreatment, and Misappropriation of Resident Property. 4 audits weekly 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. The Committee will give further direction for follow up. Date of Substantial Compliance: 6/20/2025	

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F 610	Continued From page 6 indicate if she felt safe in the facility, if anybody had hurt her or if she remembered how she got the bruises. Progress note indicated resource manager was notified and appropriate actions were in place (those actions not described in progress note). Her granddaughter was contacted and informed of the incident and had no questions/concerns at this time. Will continue to monitor and document as needed. R1's progress note dated 5/19/25 at 1:34 p.m., indicated skin assessment/observation of pubic area, buttocks, groin, and upper thighs: skin intact, warm, and dry. No new lesions, bruising or rashes noted. Chronic redness in groin, Nystatin applied. Healing bruises in inner thigh, almost gone. The state agency (SA) facility report dated 5/17/25, at 11:30 a.m. indicated no incident was observed related to bruises. Nurse caring for resident today observed greenish discoloration which appeared as bruising to residents inner knees and thighs. Size ranged from dime to nickel size. There were four small bruises in a straight line to the right inner thigh and four small bruises reported to left upper knees extending to upper thigh. Questionable if that may be related to required assist of one staff for ADLs (activity of daily living) including bathing, dressing, toileting, and transfers with a PAL lift, possible check and changed every two hours and R1's incontinent product. Observation of R1 identified she had very sensitive skin (abdominal folds/under breasts/inner thigh/groin/buttocks). Appeared to be at baseline with no changes in behaviors, participation, cognition, or mood. She continues to required assistance with bed mobility and repositioning. Previous skin assessments did not	F 610		

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F 610	Continued From page 7 reflect skin discolorations or bruising. Interviews with staff and investigation was ongoing. Review of the SA investigative report dated 5/23/25 at 4:05 p.m. no changes to her psychosocial wellbeing that would indicate abuse. Summary of interviews completed with staff identified no witnesses and those that worked with her reported increased difficulty with turning and repositioning, occasionally resistive to oral cares and adjustment to her pillow. She was not typically resistive when checked and changed, tried to help but was having more difficulty. Resident was checked and changed every two hours; bruising could have been related to process of changing her brief. No previous reports of bruising to her legs reported. Review of facility incident investigation staff interviews on 5/22/25, lacked evidence staff were asked questions related to observed or suspected abuse, concerns with aggressive cares, or other suspicious behavior by staff or residents. During an interview on 5/22/25 at 2:58 p.m. TMA-A stated R1 was not interview able, She became aware of the yellow/greenish bruises on R1, in the healing stages located and located on both her inner thighs on 5/17/25. TMA-s indicated she reported the bruises to the nurse and was present in the room while the nurse assessed her skin. She also stated R1 did not often resist or hold her legs together, she did become ridged at times but was then given time and space to relax. TMA-A confirmed she had not been interviewed by anyone related to the bruising or abuse.	F 610		

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F 610	Continued From page 8 During an interview on 5/22/25 at 3:17 p.m. TMA-B stated she first became aware of R1's bruises on 5/17/25 when the nurse and NA showed her the bruises. R1 had three or four bruises on both sides of her inner thighs, one on the outside of the right thigh, and one underneath each of her thighs, that were darker purple about the size of a penny. The nurse, another NA and her all thought they looked like fingerprints. TMA-B confirmed she had not been interviewed by anyone about this incident. During an interview on 5/23/25 at 2:42 p.m. director of nursing (DON) stated the facility investigation interviews with the staff included a total of three questions: had they noted any skin changes/alternations prior to incident, any trouble moving/repositioning her in the bed, and any difficulty with cares. The staff were not asked any questions about abuse and should have been. That would have helped identify if there was any abused that occurred. No abuse was determined with interviews and only an increase with repositioning was consistently identified. During an interview on 5/27/25 at 8:32 a.m. medical director (MD) stated the facility would have been expected to complete interviews with the staff that included questions about abuse. We would have wanted to know if she was being abused. If he would have been notified about the incident, an examination would have been completed, identified if things looked suspicious, and helped direct the investigation. Facility policy Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated 2/26/19, identified injuries of unknown origin was defined as the source of the injury was not	F 610		

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F 610	Continued From page 9 observed by any person, or source of the injury could not be explained by the resident; and the injury was suspicious because of the extent or locations of the injury (e.g., the injury was in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injuries over time. The investigation will consist of an interview with the person or persons reporting the incident, any witnesses to the incident, staff members having contact with the resident during the relevant periods or shifts of the alleged incident.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to assess and monitor bruises for 1 of 3 resident (R1) reviewed for injury of unknown origin. Findings include: R1's order dated 2/3/25 at 8:00 a.m. weekly bath day skin note. Monitor for changes, bruising, open areas. Notify nurse/general nurse practitioner (GNP) as needed. Every Monday for skin monitoring. Signed off as completed on	F 684	R1 bruises were assessed 5/26/2025. All residents residing at Pioneer Care have the potential to be affected by this practice. All residents electronic medical records from 5/27/2025 to present were reviewed to identify any resident with injuries not sufficiently being assessed and monitored. Policy Skin Assessment was reviewed, Licensed Nurses will be educated on this	6/20/25

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F 684	Continued From page 10 5/5/25, 5/12/25, and 5/19/25. R1's annual Minimum Date Set (MDS) on 4/24/25, identified R1 had severely impaired cognition, inattention (difficulty focusing, easily distractible, and difficulty keeping track of what was said), and disorganized thinking. Her medical diagnoses included Parkinson's (a movement disorder of the nervous system with symptoms that worsen over time such as tremors, slowed movements, rigid muscles, poor posture/balance, loss of blinking/smiling movements, speech changes, writing changes, nonmotor symptoms), dementia, and anxiety. She had impaired range of motion to bilateral lower extremities, unable to stand independently or walk. She required substantial to maximal assistance with personal hygiene, repositioning in bed, all transfers and dependent upon staff for toileting and oral hygiene, shower/bathe, dressing, and mobility in wheelchair. She was frequently incontinent of bladder and occasionally incontinent of bowel. Facility Resident Accident/Incident Report dated 5/17/25, completed by floor supervisor registered nurse (RN)-A identified date of incident 5/17/25 at 8:00 a.m. staff noted R1 had eight areas on greenish colored bruising, dime to nickel sized, on inner knee/thighs and appeared to be fingerprint in size. Notification to MD/GNP/PA and MD/GNP/PA was left blank and administrator and director of nursing (DON) were notified on 5/17/25. R1's progress note dated 5/17/25 at 10:27 a.m. identified she had bruising to upper/inner thighs and inner left knee. They were dark green in color. Bruises were fingerprint sized and did not appear to have cased pain when palpated. She	F 684	policy by 6/20/2025. The Director of Nursing or her designee will conduct audits to ensure injuries are appropriately assessed and monitored. 4 audits weekly 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. The Committee will give further direction for follow up. Date of Substantial Compliance: 6/20/2025	

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F 684	Continued From page 11 was unable to answer when asked if she felt safe in facility, if anybody had hurt her or if she remembered how she got the bruises. Resource manager was notified. Appropriate actions were in place (actions not identified). Her granddaughter was contacted and informed of incident and had no questions/concerns at that time. Will continue to monitor and document as needed. R1's order dated 5/18/25, monitor bruising to inner bilateral thighs for healing. Discontinue when healed. No directions specified for order. No progress notes noted on 5/18/25. R1's progress note dated 5/19/25 at 1:34 p.m., identified skin assessment/observation of pubic area, buttocks, groin, and upper thighs: skin intact, warm, and dry. No new lesions, bruising or rashes noted. Chronic redness in groin, Nystatin applied. Healing bruises in inner thigh, almost gone. R1's progress note dated 5/20/25 at 10:42 a.m. Type: appointment return/physician visit/medication change. No changes to plan. Updated family member. R1's progress note date 5/22/25 at 11:49 a.m. Type: Skin/wound note. MD updated via fax. R1's progress note date 5/22/25 at 4:55 p.m. received a fax order from MD concerning the bruising found on the resident. Continue to monitor. R1's record lacked monitoring of bruises on 5/18/25, 5/20/25-5/22/25, or until resolved.	F 684		

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F 684	Continued From page 12 During an interview on 5/23/25 at 11:00 a.m. registered nurse (RN)-A stated R1's progress notes written on 5/17/25, indicated appropriate actions were in place. The nurse providing cares and assigned to that unit would have been expected to monitor the bruising and document in the medical record/progress notes every shift. There was a nursing order to monitor the bruises but was unable to identify it had been placed in the TAR in electronic medical record. During an interview on 5/23/25 at 2:00 p.m., trained medication aide (TMA)-C stated he skin assessments usually would be identified and assigned through the resident's TAR (Treatment Administration Record) and he had not aware of anything for R1. During an interview on 5/23/25 at 2:10 p.m. RN-B stated she was not aware of R1's bruises were to be monitored and would confirmed that would have been important to monitor for any changes from the initial assessment on 5/17/25, such as more bruises, and whether they were healing or had a change in skin integrity. RN-B stated the order should have been to assess the bruises every shift, but the schedule (frequency) was not indicated in the order. She also verified the order was not located on the TAR and/or completed. Unless the nurse looked on every order they would have not known about the assessment and planned on adding it to the TAR. During an interview on 5/23/25 at 2:42 p.m. DON stated she would have expected the nurse to have placed the order into the TAR to ensure R1's bruises were getting monitored through healing. DON added, the nursing order was	F 684		

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F 684	Continued From page 13 missing the routine/frequency was not entered and therefore had not shown up on the TAR. The monitoring of the R1's bruises were not signed off as completed and would have needed to follow up with staff if they were assessed every shift. During an interview on 5/27/25 at 8:32 a.m. with medical doctor/director (MD) stated had not been notified of R1's incident on 5/17/25 but would have directed the nurses as to how often they should have monitored the bruise, adding bruises do not really change every shift and most likely daily would have been sufficient. Monitoring is important to watch how the bruises evolve, look different from one day to another, if new bruises popped up, which may have triggered continued concern and/or a possible hematoma (a closed wound bleeding outside the blood vessels that resulted in a collection of blood) that may have required more medical care.	F 684		

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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 5/22/25, 5/23/25, and 5/27/25, 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	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H54635407C (MN00113168) with no licensing orders issued. As a result of the investigation, licensing orders were issued at 0265 and 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	2 000		

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2 000	Continued From page 2 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 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		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;	2 265		6/20/25

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2 265	Continued From page 3 C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify a physician timely of a change in condition for 1 of 3 residents (R1) who had an injury of unknown origin related to bruising on her inner thigh. Findings include: R1's annual Minimum Date Set (MDS) on 4/24/25, identified R1 had severely impaired cognition, inattention (difficulty focusing, easily distractible, and difficulty keeping track of what was said), and disorganized thinking. Facility Resident Accident/Incident Report dated 5/17/25, completed by floor supervisor registered nurse (RN)-A identified date of incident 5/17/25, at 8:00 a.m. Staff noted R1 had eight areas of greenish colored bruising, dime to nickel sized, on inner knee/thighs which appeared to be fingerprint in size. Area on report labeled "Was it necessary to notify MD/GNP/PA?" was left blank, as was then name/date/time of MD/GNP/PA notified. Administrator and director of nursing (DON) notified on 5/17/25 at 9:45 a.m. R1's progress note dated 5/17/25 at 10:27 a.m.,	2 265	Corrected	

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	00443	A. BUILDING: _____ B. WING _____	C 05/27/2025

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2 265	Continued From page 4 identified she had bruising to upper/inner thighs and inner left knee. The bruises were dark green in color, fingerprint sized and did not appear to cause pain when palpated. R1 was unable to indicate if she felt safe in the facility, if anybody had hurt her or if she remembered how she got the bruises. Progress note indicated resource manager was notified and appropriate actions were in place (those actions not described in progress note). Her granddaughter was contacted and informed of the incident and had no questions/concerns at this time. Will continue to monitor and document as needed. R1's progress note dated 5/19/25 at 1:34 p.m., Complete Skin Assessment: Healing bruises in inner thigh almost gone. No new concerns to report to provider. R1's routine visit follow up visit by medical doctor/director (MD) on 5/20/25 at 9:55 a.m., lacked any mention of skin/bruising. R1's progress note dated 5/22/25 at 11:49 a.m. Type: skin/wound note medical doctor (MD) updated via fax. (5 days later) During an interview on 5/23/25 at 11:10 a.m. RN-A stated the provider should have been notified immediately when the bruises were discovered on 5/17/25 so they could have chosen to evaluate her or send her in for evaluation. The provider was notified via fax yesterday, (5/22/25). During an interview on 5/23/25 at 2:42 p.m. DON stated the staff would be expected to have notified the provider right away after R1's bruises were found to see if he wanted a further medical evaluation completed and/or other interventions necessary depending on the situation.	2 265		

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2 265	Continued From page 5 During an interview on 5/27/25 at 8:32 a.m. MD stated he was not familiar with R1's incident that occurred on 5/17/25, regarding bruises. MD stated he did not believe it was included on the rounding form he received from the nurse when he saw her on 5/20/35, and no mention of bruises were identified on his visit notes. He would have wanted to be notified so that R1 could have been examined, especially when there was a potential for alleged abuse. MD indicated the he would have completed the examination to verify if there were concerns for abuse. Certainty there would have been a possibility of sexual abuse especially if bruises were located close to the genital area, if not, rough handling and/or transfers with bruising would have been possible. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 265		
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	2 830		6/20/25

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2 830	Continued From page 6 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 interview and document review the facility failed to assess and monitor bruises for 1 of 3 resident (R1) reviewed for injury of unknown origin. Findings include: R1's order dated 2/3/25 at 8:00 a.m. weekly bath day skin note. Monitor for changes, bruising, open areas. Notify nurse/general nurse practitioner (GNP) as needed. Every Monday for skin monitoring. Signed off as completed on 5/5/25, 5/12/25, and 5/19/25. R1's annual Minimum Date Set (MDS) on 4/24/25, identified R1 had severely impaired cognition, inattention (difficulty focusing, easily distractible, and difficulty keeping track of what was said), and disorganized thinking. Her medical diagnoses included Parkinson's (a movement disorder of the nervous system with symptoms that worsen over time such as tremors, slowed movements, rigid muscles, poor posture/balance, loss of blinking/smiling movements, speech changes, writing changes, nonmotor symptoms), dementia, and anxiety. She had impaired range	2 830	Corrected	

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2 830	Continued From page 7 of motion to bilateral lower extremities, unable to stand independently or walk. She required substantial to maximal assistance with personal hygiene, repositioning in bed, all transfers and dependent upon staff for toileting and oral hygiene, shower/bathe, dressing, and mobility in wheelchair. She was frequently incontinent of bladder and occasionally incontinent of bowel. Facility Resident Accident/Incident Report dated 5/17/25, completed by floor supervisor registered nurse (RN)-A identified date of incident 5/17/25 at 8:00 a.m. staff noted R1 had eight areas on greenish colored bruising, dime to nickel sized, on inner knee/thighs and appeared to be fingerprint in size. Notification to MD/GNP/PA and MD/GNP/PA was left blank and administrator and director of nursing (DON) were notified on 5/17/25. R1's progress note dated 5/17/25 at 10:27 a.m. identified she had bruising to upper/inner thighs and inner left knee. They were dark green in color. Bruises were fingerprint sized and did not appear to have cased pain when palpated. She was unable to answer when asked if she felt safe in facility, if anybody had hurt her or if she remembered how she got the bruises. Resource manager was notified. Appropriate actions were in place (actions not identified). Her granddaughter was contacted and informed of incident and had no questions/concerns at that time. Will continue to monitor and document as needed. R1's order dated 5/18/25, monitor bruising to inner bilateral thighs for healing. Discontinue when healed. No directions specified for order. No progress notes noted on 5/18/25.	2 830		

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2 830	Continued From page 8 R1's progress note dated 5/19/25 at 1:34 p.m., identified skin assessment/observation of pubic area, buttocks, groin, and upper thighs: skin intact, warm, and dry. No new lesions, bruising or rashes noted. Chronic redness in groin, Nystatin applied. Healing bruises in inner thigh, almost gone. R1's progress note dated 5/20/25 at 10:42 a.m. Type: appointment return/physician visit/medication change. No changes to plan. Updated family member. R1's progress note date 5/22/25 at 11:49 a.m. Type: Skin/wound note. MD updated via fax. R1's progress note date 5/22/25 at 4:55 p.m. received a fax order from MD concerning the bruising found on the resident. Continue to monitor. R1's record lacked monitoring of bruises on 5/18/25, 5/20/25-5/22/25, or until resolved. During an interview on 5/23/25 at 11:00 a.m. registered nurse (RN)-A stated R1's progress notes written on 5/17/25, indicated appropriate actions were in place. The nurse providing cares and assigned to that unit would have been expected to monitor the bruising and document in the medical record/progress notes every shift. There was a nursing order to monitor the bruises but was unable to identify it had been placed in the TAR in electronic medical record. During an interview on 5/23/25 at 2:00 p.m., trained medication aide (TMA)-C stated he skin assessments usually would be identified and assigned through the resident's TAR (Treatment	2 830		

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2 830	Continued From page 9 Administration Record) and he had not aware of anything for R1. During an interview on 5/23/25 at 2:10 p.m. RN-B stated she was not aware of R1's bruises were to be monitored and would confirmed that would have been important to monitor for any changes from the initial assessment on 5/17/25, such as more bruises, and whether they were healing or had a change in skin integrity. RN-B stated the order should have been to assess the bruises every shift, but the schedule (frequency) was not indicated in the order. She also verified the order was not located on the TAR and/or completed. Unless the nurse looked on every order they would have not known about the assessment and planned on adding it to the TAR. During an interview on 5/23/25 at 2:42 p.m. DON stated she would have expected the nurse to have placed the order into the TAR to ensure R1's bruises were getting monitored through healing. DON added, the nursing order was missing the routine/frequency was not entered and therefore had not shown up on the TAR. The monitoring of the R1's bruises were not signed off as completed and would have needed to follow up with staff if they were assessed every shift. During an interview on 5/27/25 at 8:32 a.m. with medical doctor/director (MD) stated had not been notified of R1's incident on 5/17/25 but would have directed the nurses as to how often they should have monitored the bruise, adding bruises do not really change every shift and most likely daily would have been sufficient. Monitoring is important to watch how the bruises evolve, look different from one day to another, if new bruises popped up, which may have triggered continued concern and/or a possible hematoma (a closed	2 830		

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2 830	Continued From page 10 wound bleeding outside the blood vessels that resulted in a collection of blood) that may have required more medical care. SUGGEST METHOD OF CORRECTION: The administrator or designee could update policies related to skin monitoring and intervention and train staff on the updated policies. A monitoring program/audits could be established to assure ongoing assessment was effective and monitor the updated policies are being implemented by staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		