

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20076007M

Compliance Report#: HL20076008C

Date Concluded: March 9, 2021

Name, Address, and County of Licensee

Investigated:

Pioneer Home Inc. 1131 South Mabelle Ave Fergus Falls, MN 56537 Ottertail County Name, Address, and County of Housing with

Services location:

Pioneer Care Memory Cottage 521 Oak Street Breckenridge, MN 56520

Wilkin County

Facility Type: Home Care Provider

Investigator's Name:

Jana Wegener RN, Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):

It is alleged a facility staff member, the alleged perpetrator (AP), verbally and physically abused a client causing a skin tear to the client's arm.

Investigative Findings and Conclusion:

Abuse was substantiated. The facility and alleged perpetrator (AP) were responsible for the maltreatment. Multiple staff witnessed the AP over several months repeatedly verbally abuse the client by yelling, swearing at, and threatening to punch the client. The AP physically abused the client by punching him in the chest, pushing, kicking, and grabbing his arm causing a skin tear. The facility staff failed to protect the client and other vulnerable adults in the facility by allowing the AP to remain in the building and provide direct care for an additional six hours after staff witnessed the abuse.

The investigation included interviews with facility staff members, including administrative and nursing staff. The client's medical records, facility incidents, policy and procedures, and staff training were reviewed. In addition, law enforcement was contacted.

A review of client's medical record indicated the client had cognitive impairment with behaviors related to Alzheimer's disease and dementia and had the potential to be aggressive when feeling irritated or threatened. The client required assistance from others to make decisions, and frequently wandered around the facility independently.

The clients care plan interventions instructed staff to listen and respond with empathy, stand out of reach of the client, and encourage the client to take calm centering breaths. The care plan interventions also included removing the client from sources of distress and allow him to express his feelings towards the situation.

A review of the facility incident report indicated unlicensed staff reported to management that during the previous night shift she witnessed the AP physically and verbal abuse the client by hitting him in the chest, kicking him in the shin, repeatedly pushing him, and then grabbed his arm causing a skin tear. During the altercation, the unlicensed staff recorded the AP repeatedly yelling, swearing at, and threatening the client.

When interviewed the witnessed stated the AP was inpatient, short tempered, and verbally aggressive with the client(s) every night she worked with the AP over the last five to six months. The witness didn't report the ongoing, recurring verbal abuse because the AP "was not swearing" at the client. During the night of the incident, the client was trying to get a female client to walk with him. The AP yelled at the client in a loud aggressive tone, "She [female client] is not going anywhere with you." The client became agitated and hit the AP in the back of the head. The AP shoved the client backwards, kicked him in the shin, and hit him in the chest. The physical altercation between the AP and the client continued for approximately ten minutes until the AP grabbed the client's arm and caused a skin tear. When the client noticed his arm was bleeding, he backed away from the AP. The witness attempted to remove the client and told the AP to leave the client alone, but the AP continued "egging" on the client which caused the client to become more agitated. The witness stated she reported the abuse to management when the AP became physically abusive towards the client causing a skin tear.

A review of the witness audio recordings taken during the incident included five separate recordings varying in length from 19 to 49 seconds long. The AP was heard saying, "Oh god how I want to punch him [client], he is bringing out the old me", and repeatedly shouting at the client "Don't even think about it, no one wants you here, I will tackle you buddy, don't even think I won't!" The client was heard with a soft incoherent speech in the background. The AP responded in a loud voice at the client "what, what, what", repeating what the client had just softly said by stating in a loud mocking low tone "let her be" with a huffing noise, then shouting back at the client "You let her be"! The client's soft incoherent speech was heard again in the background, and the AP shouted at the client "She is not going anywhere with you, I am her boss, I will knock you out you stupid Fuck, don't even think about it tomboy, I can take your ass don't even think I can't!"

Review of the AP's personnel file indicated approximately six months prior to the physical and verbal altercation with the client, the AP was suspended for inappropriate verbal language toward another client because she felt irritated. After receiving verbal coaching the AP returned to work. There was no further documentation in the employees record regarding additional training or monitoring after the AP was disciplined for being irritated and using inappropriate language toward a client.

When interviewed staff stated she worked with AP on the overnight shifts and the AP raised her voice when speaking to the client. The AP would grab the clients arm and place her other arm behind his back and physically push the client against his will down the hallway towards his room. The client would get upset and start to swing at the AP and the AP would yell at the client "if you don't stop, I am going to punch you!" The staff member stated the verbal abuse and aggressive behavior between the AP and the client happened every night she worked with the AP. The unlicensed staff stated she never reported the ongoing verbal abuse to anyone at the facility.

When interviewed the facility nurse stated staff witnessed the AP hitting the client which caused a v shaped skin tear measuring 1.8 centimeters (cm) by 2 cm on the clients left forearm. The nurse stated she assessed the clients skin tear on his arm, however, she did not complete a full body assessment on the client to look for bruising or other injuries.

When interviewed facility administration stated the ongoing abuse of the client was not reported by staff and should have been. The night of the incident the witness should have called the nurse on call to come in and replace the AP for the remainder of her shift. The incident should have been immediately reported and investigated.

When interviewed the alleged perpetrator denied the allegations of abuse.

In conclusion, abuse was substantiated.

Abuse: Minnesota Statutes section 626.5572, subdivision 2

"Abuse" means:

- (a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
- (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224; A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
- (b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
- (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

- (2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
- (3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility: The AP no longer works at the facility. All staff reviewed the licensee reporting policies and procedure, and some staff reviewed the Dementia Management and Abuse Prevention Training.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc: The Office of Ombudsman for Long-Term Care Minnesota Board of Nursing Wilkin County Attorney Breckenridge Police Department Breckenridge City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		H20076	B. WING		C 02/05/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PIONEER	R HOME INC - CARE S	SUITES	TH SHERID. FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	D BE COMPLETE	
0 000	Initial Comments		0 000			
	In accordance with 144A.43 to 144A.48 been issued pursual Determination of whom corrected requires or requirements provious indicated below. Whom contains several iteration of the items will be compliance. INITIAL COMMENT On February 5, 202 of Health initiated a #HL20076008C/#H the investigation, the services under the The following correct #HL20076008C/#H	Minnesota Statutes, section 32, correction orders have ant to a survey. The ther a violation has been compliance with all ded at the Statute number then Minnesota Statute ms, failure to comply with any considered lack of TS: 11, the Minnesota Department in investigation of complaint HL20076007M. At the time of ere were #12 clients receiving comprehensive license. 12, the Minnesota Department in investigation of complaint investigation investigation investigation investiga		The Minnesota Department of Headocuments the State Licensing Coorders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Hom Providers. The assigned tag numbers appears in the far left column entity Prefix Tag." The state statute numbers the corresponding text of the state out of compliance are listed in the "Summary Statement of Deficiency column. This column also includes findings that are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the survey findings is the Time Period for Corrections and statute § 144A.474 8(c), the home care provider must document any action taken to come the correction order. A copy of the provider's records documenting the actions may be requested for follos surveys. The home care provider required to submit a plan of correct approval; please disregard the head the fourth column, which states "Pelan of Correction." The letter in the left column is use tracking purposes and reflects the and level issued pursuant to Minnes 144A.474, Subd. 11 (b).	e Care led "ID ber and statute les" state This as eyors' rection. I, Subd. Inply with ose w-up is not ction for ading of rovider's d for scope	
0 265 SS=I	144A.44, Subd. 1(a Plan/Accepted Star	, , ,	0 265			
Minnesota D	Subdivision 1.State epartment of Health	ment of rights. (a) A client who				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '		` ′	DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	, , ,	
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PIONEE	R HOME INC - CARE S	FERGUS	FALLS, MN	56537		
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0 265	in an assisted living chapter 144G has to (2) receive care and suitable and up-to-caccepted health care standards and personactive part in development and accepted standards health care practices C1, C2, and C3, restreatment and accepted standards health care practices C1, C2, and C3, restreatment and accepted to C1, C2, and C3, specific needs for the work with clients. The work with clients. The work with clients are from ULP-A processed at a light part of the control of a violation that has a violation tha	e services in the community or facility licensed under hese rights: d services according to a date plan, and subject to re, medical or nursing on-centered care, to take an oping, modifying, and and services; ent is not met as evidenced and record review, the rovide services according to sof medical, nursing, and es for three of three clients, viewed regarding staff ptable standards of practice. End ULP-A was verbally abusive and was not following the ene clients. ULP-A continued to this lead to actual harm for C1 ly and physically abused the e client receiving a skin tear to the clients.	0 265			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '			(3) DATE SURVEY COMPLETED	
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0 265	Continued From pa	ge 2	0 265			
	Findings include:					
	2017, and had diag neurological disorder of consciousness, of generalized arterios	the facility on January 13, noses including epilepsy (a er marked by episodes of loss or convulsions), dementia, and sclerosis (deposition of terial on their inner walls of				
	client had cognitive assistance with action dressing, bathing, be positioning, and per indicated C2 was undicated C3 was undicated C3 was undicated C3 was undicated C4 was undi	Industrial May 29, 2020, indicated the impairment and required ivities of daily living including led mobility, transfers, resonal hygiene. The care plan naware of her surroundings verbalize her needs at times.				
	investigation dated indicated C2 had be and unlicensed per yelled at C2, "Go to investigation indicated pending investigation in	lity incident report and internal May 4, 2020, at 2:00 a.m. een up several times that night sonal (ULP)-A swore and bed god damit!" The ted ULP-A was suspended on, and the facility filed a port with MAARC (the state				
	Written Warning, da ULP-I reported ULF and language toward indicated on June 1 the alleged incident	ent, Employee Warning Form, ated May 4, 2020, indicated P-A used inappropriate tone rds C2. The document 0, 2020, over a month after c, ULP-A was coached to reach she felt frustrated and was work.				
	a.m. registered nur	February 23, 2021, at 9:20 se clinical manager (RNCM)-Fowore at a client in the past.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	SUITES 1006 SOL	DRESS, CITY, S JTH SHERIDA FALLS, MN			
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0 265	Deing rude to C2. On February 24, 20 phone interview the (AA)-G stated on M C2 "go to bed god action. AA-G stated facility administration ULP-A within 30 days taff and casually a going with ULP-A. instructed to reach she was feeling frust not follow up with U frustrated, nor did stulpender to clients. AA-G stated the Marno audits of ULP-A' treatment of clients re-education or train AA-G stated the sar also reported ULP-A' treatment of clients re-education or train AA-G stated the sar also reported ULP-A' rough and laughed expressed pain. AA incident and it was agency and no furth C3 was admitted to 2019, with diagnosi disease, chronic par function, and major C3's care plan date C3 was cognitively assistance with ADI bathing, eating, personal could move independent and it was agency and move independent and it was agency and no furth C3 was admitted to 2019, with diagnosi disease, chronic paragraphs.	ge 3 ned, and denied swearing or 21, at 8:55 a.m. during a Administrative Assistant ay 4, 2020, ULP-A swore at damit", resulting in disciplinary d following the incident the on had planned to meet with ys. They interviewed other asked staff how things were AA-G indicated ULP-A was out to another staff person if strated. AA-G stated she did ILP-A to see if she has felt the specifically reach out to regarding ULP-A's treatment ted they did not monitor y 4, 2020 incident, completed s work performance and , and ULP-A received no ning following the incident. me night (May 4, 2020), staff A treated another client, C3, at the client when she a-G stated ULP-A denied the not reported to the state her investigation was done. the facility on October 23, s including Alzheimer's in syndrome, impaired visual depressive disorder. d October 23, 2019, indicated impaired and required staff L's including dressing, sonal hygiene, and transfers. ependently when in bed. The C3 was visually impaired and	0 265			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		l ` ′	(X3) DATE SURVEY COMPLETED	
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	entering, address C you are any why yo indicated C3 could with cares and instricalm tone. C3's progress note a.m. indicated on that 5:45 a.m. while shed she accidentally had no noted bruisi. A review of a hand	written note written by ULP-I				
	while providing care pushed C3's should her left forehead or at C3. ULP-A indication not funny and ULP-	and given to AA-G indicated es to C3 with ULP-A, ULP-A ders so hard and fast C3 hit is the wall, and ULP-A laughed ated she had told ULP-A it was A laughed and stated she was ng her head] was just so				
	indicated two staff [assisting C3 with personal content related two staff [assisting C3 with personal content content related two staff [assisting C3 with personal content	Report dated May 4, 2020, ULP-I and ULP-A] were ersonal hygiene cares in bed bumped her head on the eport lacked any of the initial mation provided by ULP-I's egarding ULP-A's rough g at C3, and had no evidence s completed.				
	a.m. ULP-I stated sabuse in May 2020 bed god damit", and personal hygiene calcients room unann	on February 19, 2021, at 11:00 stated she reported ULP-A for for yelling at a client "go to d also while she was providing ares to C3, ULP-A entered the ounced and abruptly shoved hard and fast it caused the				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
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	laughed at C3 and by was not funny and state hitting her head] was buring interview on a.m. AA-G stated stated ULP-A. She left a note for her restated ULP-A turned to hit her head on the laughed at C3 and she had no docume however, she recall over the phone. AA-re-education or coawith C3. AA-G stated happened, and only was one staff membad-G stated the alleged C3 happened the same called C3 happened c3 happened c3 happened c4 happ	on the wall. ULP-A started to ULP-I stated she told ULP-A it she was being mean. ULP-A ed she was sorry, but it [C3 is just so funny. February 24, 2021, at 8:55 he recalled the incident with e found about it when ULP-I egarding the incident. AA-G d C3 hard and fast causing C3 ne wall, and then ULP-A said it was funny. AA-G stated entation of an investigation, led talking to the staff involved -G stated ULP-A had no ching following the incident of two staff were involved so it bers word against another. Eged incident with ULP-A and ame night ULP-A received or swearing at C2 "go to bed"				
	a.m. RNCM-F state report regarding C3 RNCM-F stated she reported ULP-A pust causing her to hit he laughed at C3. RNC incident report she wall due to the position.	February 23, 2021, at 9:20 d she reviewed the incident hitting her head on the wall. was not aware ULP-I shed C3 over hard and fast er head on the wall and then CM-F stated based on the thought C3 hit her head on the tion of the bed. the facility July 11, 2017, with a Alzheimer's disease,				
	dementia with beha asthma.	vioral disturbances, and				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '			SURVEY LETED
		H20076	B. WING		02/0	5 5/2021
	PIONEER HOME INC - CARE SUITES		DRESS, CITY, S TH SHERID FALLS, MN			
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	indicated to Alzheimer had the potential to like he is being three interventions instructed encourage C1 to tal. The care plan interventions of the care plan intervention of the invention of the invention of the inverse of the care plan intervention of the invention of the inverse of the care plan intervention of the inverse of the care of the ca	sed September 7, 2020, impairment with behaviors r's disease and dementia, and be aggressive when feeling atened. C1's care plan oted staff to listen to C1 and thy, stand out of reach, and ke calm centering breaths. Ventions also included sources of distress, allow the sefelings towards the I his daughter. Port dated October 31, 2020, and ULP-B reported during the 30, 2020, around 2:00 a.m. A physically and verbally hit C1 in the chest, kicked eatedly pushed him, and then using a skin tear. During the ecorded five audio recordings are of ULP-A repeatedly yelling, reatening C1. I dated October 31, 2020, at differentiated the chest, pushed, and The progress note indicated the chest, pushed, and The progress note indicated the chest, and no occurrence. C1 had no incident, and no other injuries are completed on October 31, identified a v shaped skin centimeters (cm) by 2 cm on	0 265			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '		(X3) DATE COMP	SURVEY	
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NAME OF				TATE ZID CODE	1 02/0	.0,2021
NAME OF	PROVIDER OR SUPPLIER		JTH SHERIDA	STATE, ZIP CODE		
PIONEE	R HOME INC - CARE S	SUITES	FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	October 30, 2020, of ULP-A and C1. The recordings ranging ULP-A was heard in god how I want to pout the old me", and "Don't even think all will tackle you bud C1 was heard with the background; UL "What, what, what, what" softly said by stating mocking, low tone a be"! C1's soft incohin the background a going anywhere with	during the night shift of during the incident between ere were five separate from 19 to 49 seconds long. In the recordings saying "Ohe bunch him [C1], he is bringing different shouting at C1 cout it, no one wants you here, ldy, don't even think I won't"! a soft, incoherent speech in LP-A responded by shouting and repeating what C1 had g "Let her be" in a loud, and than shouted, "You let her erent speech was heard again and ULP-A shouted "She is not hyou, I am her boss, I will				
	about it tomboy; I can't"! ULP-E protect C1 during a The undated facility Maltreatment, including from October 30, 20 phone interviews w ULP-B's initial reporting investigation undated facility investigation undated facility investigation of what had happer incident occurred. Thad supporting evice with verbal inappropri	stupid Fuck, don't even think an take your ass don't even 3 was not heard intervening to ny of the recordings. Investigation of Suspected ded the internal incident report 020, and documentation of ith ULP-B, and ULP-A. It was made on 10/31/20, at ated ULP-A was suspended on. The summary of the estigation findings indicated had given two different stories hed and ULP-A denied the The summary identified ULP-B dence of the audio recordings oriateness and vulgar 01, and ULP-A was terminated 20.				
		February 18, 2021, at 4:45 ULP-A was routinely inpatient				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '		(X3) DATE COMP	SURVEY	
		H20076	B. WING		02/0) 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PIONEE	R HOME INC - CARE S	SUITES	TH SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 265	aggressive every nifive to six months. C1 stating things like to your room, and not your room, and not swearing at C1. 2020, at approximation get C2 to go with his C2 on the couch and was not going anywestated C1 became a back of the head, Ukicked him in the shocked him in the shocked and forth between approximately ten marm and caused a foulty. B stated when he backed away from ULP-B stated when he backed away from ULP-C1 on to agitate him was an unsafe situated ULP-B stated she was hurt at that poin C1 away from ULP-C1 on to agitate him was an unsafe situated ULP-B stated she was an unsafe situate	I with C1 and was verbally ght she worked over the last ULP-B stated ULP-A yelled at the get the hell out of here, go no body wants you here. In the order of C1 because ULP-A was ULP-B stated on October 31, tely 2:00 a.m. C1 was trying to m. ULP-A was sitting next to ad was yelling at C1 that C2 where with him [C1]. ULP-B agitated and hit ULP-A in the ILP-A shoved C1 backwards, hin, and hit him the chest. Thysical altercation continued ween C1 and ULP-A for minutes. ULP-A grabbed C1's five to six inch skin tear. C1 noticed his arm bleeding of ULP-A. ULP-B stated C1 and ULP-B stated C1 and ULP-B stated C1 and ULP-B stated C1 int, and when she tried to get the C1 and ULP-B stated C1 int as going to "knock his ass to do do the care if she "got fired." It id not report the physical and the following day after her shift think about calling a simediately when the physical. ULP-B stated ULP-A illity and worked her shift the only two staff in the ted she recorded and reported the nuller and physically because she wanted her	0 265			

Minnesota Department of Health

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	COMPI	
				_ c	;
	H20076	B. WING		02/0	5/2021
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, ST			
PIONEER HOME INC - CARE S	SUITES	FALLS, MN 5			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION (CROSS-REFERENCED TO THE APPROPERTION (CROSS-REFERENCED)	D BE	(X5) COMPLETE DATE
a.m. ULP-I stated slovernight shifts and ULP-A would also gother arm behind his him against his will droom. ULP-I stated to swing at ULP-A. didn't stop she would the verbal abuse and between ULP-A and she worked. ULP-I sulled up to the verbally ago but indicated she has reported the ongoing. During interview on a.m. RNCM-F stated day or night to report RNCM-F stated C1 tear on his arm follow not do a full body as or other injuries due. During interview on a.m. registered nursus stated she investigated that occurred. RNHI incident on May 4, 2 and ULP-I rolled C3 her head on the wal C3's bed was again the bed away from the AA-G and RNCM-F RNHD-E stated she allegation ULP-A has allegation ULP-A has laughed at C3. RNHULP-A was suspendent.	February 19, 2021, at 11:00 he worked with ULP-A on the ULP-A always yelled at C1. rab C1's arm, and put her is back and physically push down the hallway towards his C1 would get upset and start ULP-A would yell at C1 if he id punch him. ULP-I stated id aggressive behavior if C1 happened every night stated she considered gressive behavior abusive, and never thought about giverbal abuse. February 23, 2021, at 9:20 id staff should call any time int a fall, skin tear, or bruise, allowed her to look at the skin owing the incident, but she did seessment to look for bruising				

Minnesota Department of Health

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED	
		H20076	B. WING	B. WING		C 02/05/2021	
	PROVIDER OR SUPPLIER	SUITES 1006 SOL	DRESS, CITY, STALLS, MN 5	N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC)	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
0 265	was unaware of any ULP-A when she was incident with C2. UI 4, 2020, incident stabut indicated she the investigate the incident of feel comfortable waiting for someone county, and felt their regarding ULP-A's disciplinary action, allowed to return to felt there were some staff, and ULP-A de "her word against hashe was unaware souther word against hashe was unaware souther and utled to the suspended, and the ULP-B did not report of her shift. RN have called the RN should have come duties.	ding C3. RNHD-E stated she y other incidents involving as suspended following the LP-A stated following the May aff involved were interviewed, lought Ottertail County would dent. RNHD-E stated she did e with ULP-A at work and was to investigate from the y needed to make a decision suspension. ULP-A received verbal coaching, and was work. RNHD-E stated she to personality conflicts among enied the incident so it was the e personality conflicts among enied the incident so it was the er word". RNHD-E indicated taff had concerns regarding sing C1 routinely for the past LE stated following the ncident when ULP-B had rebally abuse C1, ULP-A was en terminated. RNHD-E stated of the abuse until the following A continued to work until the IHD-E stated ULP-B should on call, and the RN oncall in and relieved ULP-A of her	0 265				
	and Reviewing Incident of the section of the residence of the section of the residence of the section of the report. Section 2. in the report of the section of of	dents Involving Residents, 2014, instructed staff to h incidents involving a resident arm, and document incidents including staff response. It is staff to take emergency as sary and complete an incident indicated if the incident must are staff will do so as soon as the than 24 hours after the					

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		H20076	B. WING		02/05/2021	
	PROVIDER OR SUPPLIER	1006 SQU	DRESS, CITY, S	STATE, ZIP CODE AN		
PIONEE	R HOME INC - CARE S	FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	/= 4 6 1 1 5 == 1 6 1 = 1 1 6 1 1 1 1 6 = 5 = 5 = 5 = 5 = 5 1 1 1 1 1 1 1		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
0 265	Continued From pa	ge 11	0 265			
	immediately begin a indicates immediate prevent similar inciding additional. The reporting policy guidance for staff to abuse, how to recognished abuse, how to recognish to do competencies. No additional information and additional informations are also additional informations.	N or housing director would an investigation. Section 6. e actions should be taken to dents and implement actions staff training if necessary. It review by staff lacked to define the different types of gnize abuse, and specific if abuse occurred, or staff that in the different types of gnize abuse occurred, or staff that in the different types of gnize abuse occurred, or staff that in the different types of gnize abuse occurred, or staff that in the different types of gnize abuse occurred, or staff that in the different types of gnize abuse occurred, or staff that in the different types of gnize abuse occurred, or staff that in the different types of gnize abuse occurred.				
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment	0 325			
	receives home care in an assisted living chapter 144G has to (14) be free from planeglect, financial examples and the cover	ment of rights. (a) A client who e services in the community or facility licensed under hese rights: hysical and verbal abuse, eploitation, and all forms of ed under the Vulnerable Maltreatment of Minors Act;				
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interviews, and document ailed to ensure client one, (C1) reatment. 1, the Minnesota Department sued a determination that		No Plan of Correction (PoC) is recorded Please refer to the public maltreat report for details.	•	

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		` ′	COMPLETED	
			D WINC		C	
		H20076	B. WING		02/0	5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
PIONEE	R HOME INC - CARE S	SUITES	TH SHERIDAI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
0 325	Continued From pa	ge 12	0 325			
	preponderance of e occurred, and an in	e MDH concluded there was a vidence that maltreatment dividual staff person, and the sible for the maltreatment in				
0 805 SS=D		a) Reporting Maltrx of linors	0 805			
	adults and minors. must comply with re of maltreatment of the the requirements for maltreatment of vul 626.557. Each hom and implement a wi	maltreatment of vulnerable (a) All home care providers equirements for the reporting minors in section 626.556 and or the reporting of nerable adults in section le care provider must establish ritten procedure to ensure that ted maltreatment are reported.				
	Based on interview staff failed to immed suspected abuse for C3) reviewed regard Staff witnessed a compared abuse C1 over sever report it leading up. The facility staff individually staff member physically staff member to contreport the abuse una Additionally, the facility staff of Abuse Reporting Correport observing a corresport observing a corresponding contraction.	and record review, the facility diately report ongoing or two of three clients (C1, and ding allegations of abuse. Oworker repeatedly verbally eral months and failed to to C1 being physically abused icated they observed a staff abuse C1 and allowed the atinue working and did not atil the end of their work day. Eility failed to investigate and abuse to the Minnesota Adult enter (MAARC) when staff coworker treating C3 roughly ughing after hurting the client.				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP			
	H20076	B. WING		02/0	5/2021
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PIONEER HOME INC - CARE S	SUITES	JTH SHERIDA FALLS, MN 5			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
violation that did not safety but had the polient's health or safe cause serious injury was issued at an iso limited number of collimited number of state situation has occurred. The findings included dementia with beha asthma. C1's care plan revising indicated no cognitive related to Alzheimer had the potential to threatened. C1's care instructed staff to list empathy, stand out to take calm centering interventions also in sources of distress, feelings towards the daughter. C1's progress note 12:48 p.m. indicated a staff member were where the staff mempushed him, and king progress note indicated and stopped the alteroccurrence. C1 had stopped the alteroccurrence.	ed in a level two violation (a tharm a client's health or votential to have harmed a fety, but was not likely to y, impairment, or death), and clated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). E: the facility July 11, 2017, with Alzheimer's disease, vioral disturbances, and sed September 7, 2020, we impairment with behaviors r's disease and dementia. C1 be aggressive when he felt re plan interventions sten to C1 and respond with of reach, and encourage C1 ing breaths. The care plan included removing C1 from allow him to express his e situation, or call his dated October 31, 2020, at defacility staff reported C1 and re involved in an incident mber hit C1 in the chest, cked him in the shin. The lated C1 received a skin tear	0 805			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SUF				
		H20076	B. WING			C 05/2021
NAME OF	PROVIDER OR SUPPLIER	ςτρεετ ΔΓ	DRESS, CITY, S	TATE ZID CODE	<u> </u>	
NAIVIL OF	PROVIDER OR SUPPLIER		,			
PIONEE	R HOME INC - CARE S	SUITES	JTH SHERIDA FALLS, MN 5			
	CLIMANA DV CTA				FOTION	0.45
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 805	Continued From pa	ge 14	0 805			
	2020, at 12:08 p.m. tear measuring 1.8 the C1's left forearn					
	October 31, 2020, unlicensed personn administration staff October 30, 2020, a witnessed unlicense and verbally abused chest, kicking him is him, and then grable tear. During the alternation recordings or	at 7:30 a.m. indicated lel (ULP)-B reported to facility that during the night shift around 2:00 a.m. she led personal (ULP)-A physically d C1 by hitting him in the led his arm causing a skin lercation ULP-B recorded five her cellular phone of ULP-A swearing at, and threatening				
	obtained by ULP-B October 30, 2020, of five separate record seconds long. ULP- saying "Oh god how bringing out the old at C1 "Don't even th here, I will tackle yo won't"! The client w incoherent speech responded by shou and repeating what "Let her be" in a lou shouting back at Co incoherent speech background and UL anywhere with you, you out you stupid I tomboy I can take y	during the night shift of during the incident included dings each one 19 to 49. A was heard in the recordings of I want to punch him, he is me", and repeatedly shouting hink about it, no one wants you have buddy, don't even think I as heard with a soft in the background and ULP-A ting at C1 "What, what, what"! C1 had softly said by stating at mocking low tone then I "You let her be"! C1's soft was heard again in the LP-A shouted "She is not going I am her boss, I will knock Fuck, don't even think about it your ass don't even think I not heard intervening during				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SU COMPLE				
		H20076	B. WING			<i>5</i> /2021
	PROVIDER OR SUPPLIER	SUITES 1006 SOL	DRESS, CITY, STALLS, MN 5	N .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 805	"Investigation of Su included the internal documentation of punlicensed personn indicated ULP-B's in 10/31/20, at 7:30 a. suspended pending of the undated facili indicated ULP-A and different stories of videnied the incident identified ULP-B has audio recordings of inappropriate and unclassive her over the last five ULP-A yelled get the room, and no body stated she never reverbal abuse of C1 swearing at C1. UL 2020, at approximating get a female client is sat on the couch necessive	provided document titled spected Maltreatment", all incident report and hone interviews with sel (ULP)-B, and ULP-A and nitial report was made on m. and indicated ULP-A was ginvestigation. The summary ity investigation findings dulp-B had given two what had happened. ULP-A occurred. The summary disupporting evidence of the ULP-A being verbally sing vulgar language towards. February 18, 2021, at 4:45 ULP-A was routinely inpatient with C1 and had become every night she worked with e to six months. ULP-B stated e hell out of here, go to your wants you here to C1. ULP-B ported the ongoing recurring because ULP-A was not P-B stated on October 31, tely 2:00 a.m. C1 was trying to to go with him, while ULP-A ext to the client and yelled at was not going anywhere with C1 became agitated when and C1 hit ULP-A in the back shoved C1 backwards, kicked I hit him the chest. ULP-B altercation between ULP-A				
	approximately ten n	ninutes until ULP-A grabbed				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURV COMPLETED				
			A. BOILDING.			,
		H20076	B. WING		02/0	<i>,</i> 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
DIONEE	DUONE INO OADE	1006 SOU	TH SHERIDA	N .		
PIONEE	R HOME INC - CARE S	FERGUS	FALLS, MN 5	6537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 805	Continued From pa	ge 16	0 805			
	C1's arm and cause C1's arm. ULP-B stated she a from ULP-A, and U saying things to agi told ULP-A not to hi ULP-A stated I don ground or get fired immediately report that occurred that nafter her shift ender calling a supervisor stated ULP-A remainer shift because the building. ULP-B reported the verbal physically abusive the wanted her supervisor stated she had abustically abusive the stated she had abustically abustic	ed a five to six inch skin tea on ated when C1 noticed his arm acked away from ULP-A. attempted to remove C1 away LP-A kept "egging" C1 on tate him. ULP-B stated she at C1, and leave him alone and a't care if I knock his ass to the ULP-B stated she did not the physical and verbal abuse aight until the following day d, and did not think about for 911 immediately. ULP-B ined in the facility and worked ney were the only two staff in a stated she recorded and abuse when ULP-A became sowards C1 because she sor to believe her. ULP-B se training last year but out remember what to do in				
	phone interview UL ULP-A on the overry yelled at C1 and wo other arm behind him against his will room. ULP-I stated to swing at ULP-A a stop or she would proverbal abuse and and C1 happened e stated she consider aggressive behavious had never thought a verbal abuse. ULP-abused she would response to the consideration of the	P-I stated she worked with hight shifts and ULP-A always ould grab his arm and put her is back and physically push down the hallway towards his I C1 would get upset and start and ULP-A would yell at C1 to bunch him. ULP-I stated the ggressive behavior with ULP-A every night she worked. ULP-I red ULP-A's verbally or abusive, but indicated she about reporting the ongoing I stated if a client was being report it to her supervisor the were working. ULP-I indicated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	l ` ′	(X3) DATE SURVEY COMPLETED		
		H20076	B. WING			C 05/2021
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
PIONEE	R HOME INC - CARE S	SUITES	UTH SHERIDA FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
0 805	Continued From pa	ge 17	0 805			
		y on call staff available 24 days a week to report any				
	phone interview with manager (RNCM)-F day or night to report RNCM-F stated she 2021, at approximate was an altercation to and C1. RNCM-F ULP-A hitting C1 are arm. RNCM-F state	h registered nurse clinical stated staff can call any time at allegations of abuse. was called on October 31, tely 7:00 a.m. and told there that occurred between ULP-A stated ULP-B had witnessed a skin tear on his ed staff did not recognize the 1 and ULP-A abusive.				
	2019, with diagnosi disease, chronic pa	the facility on October 23, s including Alzheimer's in syndrome, impaired visual depressive disorder.				
	C3 was cognitively assistance with ADI eating, personal hyginsully impaired and knock on the clients	d October 23, 2019, indicated impaired and required staff L's including dressing, bathing giene, and transfers. C3 was a d staff were instructed to a door prior to entering, name, and tell the client who u are there.				
	a.m. indicated on M staff were rolling C3 incontinence cares,	the client hit her head on the note indicated C3 had no				
	ULP-I was providing	dated May 4, 2020, indicated g cares for C3. ULP-A came ssist. ULP-A pushed the				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20076	B. WING			C 05/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
PIONEE	R HOME INC - CARE S	SUITES	TH SHERIDA FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 805	Continued From pa	ge 18	0 805			
	her left forehead on after the C3's head it was not funny and am sorry but that was not fundicated two staff, assisting C3 with per and turned C3 onto accidentally bumper incident report lacked information of the instance	Report dated May 4, 2020, ULP-I and ULP-A, were ersonal hygiene cares in bed her side when the client d her head on the wall. The ed any of the initial internal acident provided by ULP-I's egarding ULP-A's rough				
	a.m. ULP-I stated shygiene cares to Cadidn't request assist room unannounced upper body so hard to roll into the wall a when C3 hit her head at C3. ULP-I stated funny and it was me sorry but that was justiced.	February 19, 2021, at 11:00 the was providing personal 3. Although ULP-I stated she tance, ULP-A entered C3's and abruptly shoved C3's and fast it caused the client and hit her head. ULP-I stated ad on the wall ULP-A laughed she told ULP-A it was not ean, ULP-A responded, "I amust so funny." ULP-I stated garding the incident and left it ssistance (AA-G).				
	a.m. AA-G stated Uthe alleged incident hard, resulting in the laughing at the client documentation of a however, she stated involved and ULP-A happened. AA-G stated	February 24, 2021, at 8:55 JLP-I left her a note regarding of ULP-A turning C3 fast and e client hitting her, and ULP-A nt. AA-G stated she had no n investigation being done; d she spoke to the staff A denied the incident tated there were only two staff oth had different story's so a				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1006 SOUTH SHERIDAN FERGUS FALLS, MN 56537 Discontinued From Bind	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	` '	(X3) DATE SURVEY COMPLETED		
PIONEER HOME INC - CARE SUITES SUMMARY STATEMENT OF DEFICIENCIES ID REPORT REACH CORRECTION RECOLLAR MN S6537			H20076	B. WING			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 0 805 Continued From page 19 vulnerable adult report was not made to MAARC. During interview on March 1, 2020, at 1:31 p.m. Registered Nurse Clinical Manager (RNCM)-F stated she reviewed the incident report regarding ULP-A and C3, but she was not aware ULP-I had initially reported the incident report regarding ULP-A. RNCM-F stated she did not recall interviewing staff regarding the information on the incident report because C3 had no injury on her head, and she thought it was an issue with the clients bed being positioned against the wall. During interview on February 24, 2021, at 11:26 a.m. Registered Nurse Housing Director (RNHD)-E stated she was responsible to review all incidents that occur in the facility. RNHD-E stated an internal investigation should be done to determine if maltreatment occurred, and based off those findings a report is made to MAARC. RNHD-E stated she recalled the incident on May 4, 2020, and indicated C3 accidentally bumped her head on the wall during carse. RNHD-E stated she had no knowledge of the allegation ULP-A treated C3 rough when she pushed her hard and fast causing her head to hit the wall and ULP-A laughed at the client. RNHD-E stated she though C3's bed was too close to the wall and needed to be moved. RNHD-E stated she would expect complete information to be included on the incident report, and the incident should be investigation, dated November 2014, indicated any staff who witnessed or suspected any form of maltreatment abuse must report the incident immediately to the registered nurse (RN)			SUITES 1006 SOU	TH SHERIDA	N		
vulnerable adult report was not made to MAARC. During interview on March 1, 2020, at 1:31 p.m. Registered Nurse Clinical Manager (RNCM)-F stated she reviewed the incident report regarding ULP-A and C3, but she was not aware ULP-I had initially reported the incident regarding C3 and ULP-A. RNCM-F stated she did not recall interviewing staff regarding the information on the incident report because C3 had not injury on her head, and she thought it was an issue with the clients bed being positioned against the wall. During interview on February 24, 2021, at 11:26 a.m. Registered Nurse Housing Director (RNHD)-E stated she was responsible to review all incidents that occur in the facility. RNHD-E stated an internal investigation should be done to determine if maltreatment occurred, and based off those findings a report is made to MAARC. RNHD-E stated she recalled the incident on May 4, 2020, and indicated C3 accidentally bumped her head on the wall during cares. RNHD-E stated she had no knowledge of the allegation ULP-A treated C3 rough when she pushed her hard and fast causing her head to hit the wall and ULP-A laughed at the client. RNHD-E stated she though C3's bed was too close to the wall and needed to be moved. RNHD-E stated she whould caybet information to be included on the incident report, and the incident should be investigated and reported to MAARC. The facility policy titled Vulnerable Adult Reporting and Investigation, dated November 2014, indicated any staff who witnessed or suspected any form of maltreatment abuse must report the incident immediately to the registered nurse (RN)	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE
Housing Director will complete an incident report.		During interview on Registered Nurse Contacted she reviewed JLP-A and C3, but nitially reported the JLP-A. RNCM-F stanced and she though clients bed being portional interview on a.m. Registered Nurse (all incidents that occasional and internal interview on the stated an internal interview on the stated an internal interview on the stated an internal interview on the stated and indicated she had no keeper complete information of the incident report, investigated and report of the facility policy tite and Investigation, dendicated any staff vary form of maltrean incident immediated in charge or the hours.	March 1, 2020, at 1:31 p.m. Clinical Manager (RNCM)-F of the incident report regarding she was not aware ULP-I had incident regarding C3 and ated she did not recall garding the information on the buse C3 had no injury on her got it was an issue with the positioned against the wall. February 24, 2021, at 11:26 rese Housing Director ne was responsible to review cur in the facility. RNHD-E exestigation should be done to atment occurred, and based report is made to MAARC. The recalled the incident on May red C3 accidentally bumped all during cares. RNHD-E exceeded the incident on the pushed her not head to hit the wall and the client. RNHD-E stated she would formation to be included on and the incident should be corted to MAARC. Iled Vulnerable Adult Reporting ated November 2014, who witnessed or suspected the tent abuse must report the year of the RN or large the RN or				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	H20076		B. WING		02/0	5/2021
					1 0210	3/202 I
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
PIONEER	R HOME INC - CARE S	SUITES	JTH SHERID. FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 805	O5 Continued From page 20		0 805	DEI IOIEITOI)		
	and Reviewing Incident of the incident must housing director or possible but no late	led Reporting Documenting dents Involving Residents, 2014, indicated staff would at report. Section 2. indicated be reported to MAARC, the staff would do so as soon as r than 24 hours after the diately begin an investigation.				
	No additional information was provided.					
	Time Period for cor	rection: Fourteen (14) days.				
	144A.479, Subd. 6(Prevention Plan	b) Individual Abuse	0 810			
	implement an individence of vulnerable minors; and state measures to be take abuse to that person or minors. For purp	e provider must develop and dual abuse prevention plan for nor or adult for whom home rovided by a home care shall contain an individualized ent of the person's see by another individual, erable adults or minors; the sing other vulnerable adults ements of the specific en to minimize the risk of n and other vulnerable adults oses of the abuse prevention e includes self-abuse.				
	by: Based on interview licensee failed to en prevention plans red of 3 clients, C1, C2,	and record review, the sure the individual abuse flected the current needs for 3 and C3, of abuse prevention d. The facility failed to				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		l ` ′	(X3) DATE SURVEY COMPLETED	
		H20076	B. WING		00/0	
		H20076	D. W		02/0	5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PIONEE	R HOME INC - CARE S	SUITES	JTH SHERIDA FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 810	Continued From pa	ge 21	0 810			
	prevention plans to vulnerability and/or specific measures to risk of abuse to the This practice results	ed in a level two violation (a				
	safety but had the position client's health or satisfied widespread scope (or represent a system)	t harm a client's health or otential to have harmed a fety), and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	e:				
	diagnoses included	the facility July 11, 2017, with Alzheimer's disease, vioral disturbances, and				
	indicated the client behaviors related to dementia, and had when he felt threate interventions instructions instructions encourage C1 to tall the care plan interventions care plan interventions.	had cognitive impairment with Alzheimer's disease and the potential to be aggressive ened. C1's care plan cted staff to listen to C1 and thy, stand out of reach, and ke calm centering breaths. Ventions also included sources of distress, allow him ngs towards the situation, ther.				
	2020, at 7:30 a.m. on October 30, 202 (ULP)-B witnessed	report dated October 31, indicated during the night shift 0, unlicensed personnel a coworker, ULP-A physically C1. ULP-A hit C1 in the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	l ` ′	(X3) DATE SURVEY COMPLETED	
		H20076	B. WING			C 05/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PIONEEI	R HOME INC - CARE S	SUITES	JTH SHERIDA			
		FERGUS	FALLS, MN 5			
(X4) ID PREFIX TAG	/= 4 O / 1 D == 1 O / 1 O / 1 O / 1 O = D = D = O = D = D D D O / 1 O / 1 O O		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 810	Continued From pa	ge 22	0 810			
	,	the shin, repeatedly pushed e clients arm causing a skin				
	admission) dated Jassessment for Vulothers, indicated Cand place. The asswas hard of hearing follow directions, an information consists vulnerability assess vulnerability requiring subsequent vulneration identify C1's vulneration consists and place. The assward of hearing follow directions, and information consists vulnerability assess vulnerability requiring subsequent vulnerations.	lity assessment (completed on uly 11, 2017, and titled Inerability, and Safety Risk for 1 was oriented to time, self, sessment also indicated C1 but was able to understand, and could give accurate ently. At the time of the sment, C1 had no areas of an intervention. There were no ability assessments completed erability leading up to, or ang, the October 30, 2020				
	assessment was up was oriented only to understand or give unable to follow dire medications for slee interventions staff or also indicated C1 w female client in the risk to other vulnerated C2 was admitted to 2017, and had diagoneurological disorder of consciousness, or generalized arterios	ep and agitation, and identified could utilize. The assessment as protective over another facility, and he may pose a able adults. The facility on January 13, noses including epilepsy (a er marked by episodes of loss or convulsions), dementia, and sclerosis (deposition of				
	blood vessels). C2's care plan date	terial on their inner walls of d May 29, 2020, indicated she airment and required				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20076	B. WING		02/0) 5/2021
	PROVIDER OR SUPPLIER	SUITES 1006 SOU	DRESS, CITY, ST ITH SHERIDA FALLS, MN 5	.N		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 810	dressing bathing, be positioning and per unaware of her surrunable to verbalize. C2's only vulnerability and indicated C2 was on the assessment al understand, follow information consists or neglect. The client vulnerability requiring there were no substant assessments compounderability leading following the May 4 verbally abused by A facility incident received abuse C2 with the client. ULP-A yield damit!" On February 9, 202 assessment was upassessment was contoriented, not abaccurate information.	ivities of daily living including ed mobility, transfers, sonal hygiene. C2 was roundings and at times was her needs. lity assessment (completed on anuary 13, 2017, Assessment d Safety Risk for Others, riented to time, self, and place. so indicated C2 was able to directions, give accurate ently, and could report abuse ent had no areas of any intervention at that time. sequent vulnerability eleted to identify C2's g up to or immediately, 2020 incident when C2 was				
	report abuse or neglindicated C2 did not was usually up want she fell asleep on the C3 was admitted to	glect. The assessment also it stay in her bed at night and idering around the facility until he couch or in a chair. The facility on October 23, is including Alzheimer's				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		H20076	B. WING		02/0	
		П20076			1 02/0	5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
PIONEER HOME INC - CARE SUITES		ITH SHERIDAI FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 810	Continued From pa	ge 24	0 810			
	· ·	in syndrome, impaired visual depressive disorder.				
	C3 was cognitively assistance with ADI bathing, eating personal could move indivas visually impaired knock on the door play name, and tell he are there. The care become physically a	d October 23, 2019, indicated impaired and required staff L's including dressing, onal hygiene, and transfers. ependently when in bed. C3 ed and instructed staff to prior to entering, address C3 er who you are and why you applied plan indicated C3 could aggressive with cares and peak to her in a calm tone.				
	admission dated No "Assessment for Vul Others", indicated Could was assessment also in understand and folloaccurate informationabuse or neglect and accurate and second and seco	ssessment completed on ovember 11, 2015, and titled alnerability, and Safety Risk for 23 was oriented to time, self, alk independently. The dicated C3 was able to ow directions, and give in consistently, could report indicated the client had no by requiring intervention at that				
	October 23, 2019 in person and place, wore glasses, and work to others and would subsequent vulnerate to identify C3's vulnerate	vulnerability assessment dated idicated C3 was oriented to used a wheelchair for mobility, was unable to communicate. dicated C3 was a potential risk I strike out. There were no ability assessments completed erability leading up to oring the May 4, 2020 incident.				
	phone interview UL	21, at 11:00 a.m. during a P-I stated stated while she onal hygiene cares to C3,				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` ,	(X3) DATE SURVEY COMPLETED	
	H20076	B. WING			C 05/2021	
NAME OF PROVIDER OR SUPPLIER PIONEER HOME INC - CARE S	DRESS, CITY, ST ITH SHERIDA FALLS, MN 5	.N				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
abruptly shoved C3 it caused her to roll ULP-I stated when ULP-A laughed at CULP-A that was not ULP-B responded of so funny. During a follow up it was responsible for assessments, and sadmission and return stated a quarterly a vulnerability re-asses changes. RNCM-F year ago and indicated questions in the quanties of the she did not review the was not aware of whe	room unannounced and 's upper body so hard and fast and hit her head on the wall. C3 hit her head in the wall c3. ULP-I stated she told funny it was mean, and oh I am sorry but that was just the roompleting client vulnerability stated they were done on rn from the hospital. RNCM-F ssessment may trigger a resement if the client had stated she had started about a stated when answering arterly assessments regarding prompt a vulnerability nswered based on her a last year. RNCM-F stated the previous assessment and hen a previous vulnerability red since the last assessment and hen a previous vulnerability red since the last assessment and hen a previous vulnerability red since the last assessment and hen a previous vulnerability than the quarterly prompts or rmination to complete one. Repondence on February 16, the Registered Nurse Housing on firmed the facility provided the red completed before and reatment incidents. In addition, and only admission and rebility assessment completed before and resting assessment completed ability assessment completed resting and only admission and rebility assessment completed ability assessment completed					

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Minnesota Department of Health

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	LETED
		H20076	B. WING		02/0	5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE	-	
DIONEE	R HOME INC - CARE S	1006 SOU	TH SHERID	AN		
PIONEER	T HOIVIE INC - CARE S	FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
0 810	Continued From pa	ge 26	0 810			
	Ongoing Nursing Asthe Comprehensive July 31, 2019, indicassessment of the susceptibility to malfor the clients individual identified speciminimize the risks of other vulnerable adclients would be reany time they return nursing home stay, experienced an inci-	d policy titled "Initial and seessment of Clients Under Licensed Agency", and dated ated indicated an initial clients vulnerability and streatment would be completed dual abuse prevention plan fic measures to be taken to of maltreatment to the client or ults. The policy indicated the assessed on an ongoing basis and from the hospital or had a change in condition, or dent.				
		rection: Fourteen (14) days.				
0 865 SS=G	Implementation & R Subd. 9.Service pla revisions to service	Revisions n, implementation, and plan. (a) No later than 14	0 865			
	first provided, a hor a current written set (b) The service plant include a signature home care provider client's representation the services to be must be revised, if review or reassessing. The provider must client about change	that home care services are me care provider shall finalize rvice plan. In and any revisions must or other authentication by the rand by the client or the reprovided. The service plan needed, based on client ment under subdivisions 7 and at provide information to the rest to the provider's fee for a contact the Office of the				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		H20076	B. WING		02/0	; 5/2021	
PIONEER HOME INC - CARE SUITES			DRESS, CITY, S JTH SHERID FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
0 865	Continued From pa	ge 27	0 865				
	Ombudsman for Lo	ng-Term Care.					
		provider must implement and required by the current					
	must be entered int	and revised service plan o the client's record, including in a client's fees when					
	` '	ome care services must be ent written service plan.					
	Based on interview licensee failed to implan for 2 of 3 client plans were reviewe completed according had specific, demended a specific, demended a specific, demended a specific, demended a specific addition that staff. This resulted member repeatedly service plan resulting addition, other staff service plan not being the service plan and the	and record review, the aplement the client's service as, C1 and C3, who's service as, C3's cares were not ag to the service plan, and C1 at a care related needs to at was not implemented by in harm for C1 when a staff failed to implement C1's ag in agitation for C1. In who repeatedly observed the ng followed failed to intervene ice plan was followed.					
	violation that harmed not including serious or a violation that has serious injury, impa- issued at a isolated number of clients a	ed in a level three violation (a ed a client's health or safety, injury, impairment, or death, as the potential to lead to irment, or death), and was scope (when one or a limited re affected or one or a limited involved or the situation has sionally).					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		H20076	B. WING			C 05/2021
	PROVIDER OR SUPPLIER	SUITES 1006 SOL	DRESS, CITY, ST JTH SHERIDA FALLS, MN 5	.N		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
0 865	Continued From pa	ige 28	0 865			
	Findings include:					
	diagnoses including	the facility July 11, 2017, with g Alzheimer's disease, avioral disturbances, and				
	indicated the client behaviors related to dementia. C1 had to when he felt threated listen to C1 and resort of the clients reach calm centering breatinterventions also in sources of distress	had cognitive impairment and a Alzheimer's disease and he potential to be aggressive ened. Staff were directed to spond with empathy, stand out, and encourage C1 to take aths. The care plant included removing C1 from allow him to express his e situation, and/or call his				
	12:48 p.m. indicate unlicensed personal incident. ULP-A hit and kicked C1 in the indicated C1 receivaltercation on his or	dated October 31, 2020, at d facility staff reported C1 and al (ULP)-A were involved in an C1 in the chest, pushed him, se shin. The progress note ed a skin tear and stopped the wn occurrence. C1 had no ncident, and no other injuries				
	p.m. unlicensed perwas routinely inpation C1, and was verbal worked over the last stated ULP-A yelled like, get the hell out body wants you her 31, 2020, at approximately approximately contact the state of the hell out body wants you her want	February 18, 2021, at 4:45 rsonal (ULP)-B stated ULP-A ent and short tempered with lly aggressive every night she at five to six months. ULP-B at C1 and would say things of here, go to your room, no re! ULP-B stated on October kimately 2:00 a.m. C1 was go with him. ULP-A was sitting				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20076	B. WING		1	C)5/2021
PIONEER HOME INC - CARE SUITES			DRESS, CITY, S JTH SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRICIENCY)	JLD BE	(X5) COMPLETE DATE
0 865	"She [C2] is not goi became agitated ar head. A review of the facil October 31, 2020, unlicensed personn administration that 30, 2020, around 2: physically and verbs the chest, kicking h pushing him, and the skin tear. During interview on a.m. ULP-I stated sovernight shifts and and would grab his his back, and physically and would get upset ULP-A would get upset ULP-A would get upset ULP-A worked with C3 was admitted to 2019, with diagnosi disease, chronic parfunction, and major C3's care plan date C3 was cognitively assistance with ADI bathing, eating and transfers, but could bed. The care plan impaired and instru	o C2 and was yelling at C1, ng anywhere with you!" C1 nd hit ULP-A in the back of the lity incident report dated at 7:30 a.m. indicated at 7:30 a.m. indicated lel (ULP)-B reported to facility during the night shift October 1:00 a.m. she witnessed ULP-A ally abuse C1 by hitting him in im in the shin, repeatedly nen grabbed his arm causing a February 19, 2021, at 11:00 he worked with ULP-A on the ULP-A always yelled at C1 arm, put her other arm behind cally push him against his will and start to swing at ULP-A. C1 if he didn't stop she would tated the verbal altercations d C1 happened every night				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20076	B. WING		02/0	
		П20076			02/0	5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PIONEER	R HOME INC - CARE S	SUITES	TH SHERID. FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
0 865	Continued From pa	ge 30	0 865			
	could become phys	are any why you are there. C3 ically aggressive with cares to speak in a calm tone.				
	a.m. indicated on Mostaff were rolling he	she accidentally hit her head				
	During interview on February 19, 2021, at 11:00 a.m. ULP-I stated she was providing personal hygiene cares to C3 when ULP-A entered the room unannounced and abruptly shoved C3's upper body so hard and fast it caused her to roll and hit her head on the wall. ULP-I stated when C3 hit her head in the wall ULP-A laughed at C3. ULP-I stated she told ULP-A that was not funny it was mean, and ULP-B responded oh I am sorry but that was just so funny.					
	No additional inform	nation was provided.				
	Time period for corr	rection: Seven (7) days.				
01187 SS=F	144D.065 Training	In Dementia Care Required	01187			
	144D.065 TRAININ REQUIRED.	G IN DEMENTIA CARE				
	registered under this program or special Alzheimer's disease advertises, markets establishment as prowith Alzheimer's disease whether in a segregical segregical and segregical segregical and segregical segregi	services establishment s chapter has a special care unit for residents with e or other dementias or s, or otherwise promotes the roviding services for persons sease or other dementias, gated or general unit, stablishment and of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE :		
		H20076	B. WING		02/0	; 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE	•	
		1006 SQL	JTH SHERIDA			
PIONEEI	R HOME INC - CARE S	FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01187	Continued From pa	ge 31	01187			
		anged home care provider wing training requirements:				
	least eight hours of specified under part hours of the employ have at least two hours employment therea (2) direct-care employment hours at least eight hours	loyees must have completed of initial training on topics				
	hours of the employ initial training is comprovide direct care employee on site weight hours of training dementia care and and assist if issues requirements under supervisor meeting (1), must be available new employee until complete. Direct-calleast two hours of the	agraph (b) within 160 working ment start date. Until this inplete, an employee must not unless there is another ho has completed the initial ing on topics related to who can act as a resource arise. A trainer of the paragraph (b), or a the requirements in clause ole for consultation with the training requirement is are employees must have at raining on topics related to 12 months of employment				
	maintenance, house staff, must have at training on topics sp within 160 working date, and must hav	provide direct care, including ekeeping, and food service least four hours of initial pecified under paragraph (b) hours of the employment start e at least two hours of training dementia care for each 12 nent thereafter; and				

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

	BUILDING:	(X3) DATE SURVEY COMPLETED	
H20076	WING	C 02/05/2021	
PIONEER HOME INC - CARE SUITES	SS, CITY, STATE, ZIP CODE SHERIDAN LS, MN 56537		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
(4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The establishment shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements of section 325F.72, subdivision 2, clause (4). (d) Housing with services establishments not included in paragraph (a) that provide assisted living services under chapter 144G must meet the following training requirements: (1) supervisors of direct-care staff must have at least four hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	1187		

IR0B11

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20076	B. WING		02/0	5/2021
	PROVIDER OR SUPPLIER	SUITES 1006 SOU	DRESS, CITY, ST ITH SHERIDA FALLS, MN 5	N		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01187	specified under par hours of the employ initial training is comprovide direct care employee on site w four hours of training dementia care and and assist if issues requirements under meeting the require clause (1), must be the new employee of complete. Direct-calleast two hours of the dementia for each of thereafter; (3) staff who do not maintenance, house staff, must have at training on topics so within 160 working date, and must have on topics related to months of employments of employments. (4) new employees requirements by propreviously complete past 18 months. This MN Requirements by: Based on interview licensee failed to en (A, B, and K) received.	of initial training on topics agraph (b) within 160 working ment start date. Until this inplete, an employee must not unless there is another ho has completed the initial ing on topics related to who can act as a resource arise. A trainer of the information paragraph (b) or supervisor ements under paragraph (a), available for consultation with until the training requirement is the employees must have at raining on topics related to 12 months of employment provide direct care, including ekeeping, and food service least four hours of initial becified under paragraph (b) hours of the employment start e at least two hours of training dementia care for each 12	01187			
	in accordance with	144D.065. This had the ll 12 clients residing in the				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20076	B. WING		02/0) 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE	, , , ,	
		1006 SQL	JTH SHERIDA			
PIONEE	R HOME INC - CARE S	FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01187	Continued From pa	ge 34	01187			
	facility.					
	This practice resulted violation that did not safety but had the particular client's health or safety widespread scope (or represent a system)	ed in a level two violation (a t harm a client's health or otential to have harmed a fety), and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	Findings include.					
	indicated she was had was terminated after physical and verbal November, 2020. Usindicated no require	nel (ULP)-A's personnel file nired on July 15, 2019. ULP-A er an alleged incident of abuse involving a client in JLP-A's employee record ed annual training for tia was completed during her				
	completed required related disorders tra	November 17, 2018, and Alzheimer's disease and aining on hire November 18, on May 22, 2019, and August ate).				
	completed required related disorders tra	n June 19, 2017, and Alzheimer's disease and aining on November 1, 2018, st 5, 2020 (3 months late).				
	she was in charge of required training an indicated it needed calendar year, and	21, at 8:55 a.m. AA-G stated of tracking and assigning d education to staff, and to be completed every was not aware it needed to be months of employment.				

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20076	B. WING		02/0	5/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
PIONEER	R HOME INC - CARE S	SUITES	TH SHERIDA FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01187	187 Continued From page 35 The undated facility provided policy and		01187			
	procedure titled "De Policy and Procedu "Categories of Emp of Training", indicate complete eight hour least 2 hours of den months of employm	ementia Program Disclosure re", indicated under section loyees Trained and Frequency ed direct care staff must sof initial training, and at nentia training for each 12 ent thereafter.				
	No additional inform					
	Time period for corr	ection: Fourteen (14) days.				
01190 SS=F	144A.4796, Subd. 6	Required Annual Training	01190			
	perform direct home at least eight hours months of employm obtained from the h source and must in	nnual training. (a) All staff that e care services must complete of annual training for each 12 ent. The training may be ome care provider or another clude topics relevant to the eare services. The annual e:				
	minors under section of vulnerable adults	ting of maltreatment of on 626.556 and maltreatment under section 626.557, able to the services provided;				
	(2) review of the ho 144A.44;	me care bill of rights in section				
	the home and implestandards including techniques; the need gloves, gowns, and of contaminated managements.	ementation of infection control a review of hand-washing ed for and use of protective masks; appropriate disposal aterials and equipment, such es, syringes, and razor				

Minnesota Department of Health

	I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´	E CONSTRUCTION	COMP	SURVEY
		H20076	B. WING		02/0) 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PIONEE	R HOME INC - CARE S	SUITES	TH SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01190	Continued From pa	ge 36	01190			
	disinfecting environ	reusable equipment; mental surfaces; and inicable diseases; and				
	procedures relating	to the provision of home care implement those policies and				
	annual training may providing services to Any training on hea subdivision must be research-based, ma	e topics listed in paragraph (a), also contain training on o clients with hearing loss. ring loss provided under this high quality and ay include online training, and g on one or more of the				
		of age-related hearing loss as itself, its prevalence, and to communication;				
		loss, such as increased itia, falls, hospitalizations,				
	that may enhance of involvement, included assistive listening dand tactile alerting of	ut strategies and technology communication and ing communication strategies, evices, hearing aids, visual devices, communication and closed captions.				
	by: Based on interview,	ent is not met as evidenced and record review, the sure four of four employees,				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	E SURVEY PLETED
		H20076	B. WING		l	C 05/2021
	PROVIDER OR SUPPLIER	1006 SO	DDRESS, CITY, STUTH SHERIDA	,		
PIONEE	R HOME INC - CARE S	FERGUS	FALLS, MN 5	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPR I ATE	(X5) COMPLETE DATE
01190	Continued From pa	ge 37	01190			
	ULP-L, reviewed fo minimum of eight h required topics for employment as req	al ULP-A, ULP-B, ULP-k, and received a ours of training to include the each twelve months of uired with records reviewed. The total to affect all 12 clients in the				
	violation that did no safety but had the position client's health or sa widespread scope or represent a system.	ed in a level two violation (a of harm a client's health or cotential to have harmed a fety), and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	e:				
	indicated she was he provide direct care alleged incident of particular, ULP-A was to 2020. ULP-A's empty	nel (ULP)-A's employee record nired on July 15, 2019, to to clients. Following an ohysical and verbal abuse to a erminated on November 2, oloyee record indicated ining was not completed nent.				
	provide direct care	n November 17, 2018, to to clients and completed ining on May 22, 2019, and 5 months late).				
	direct care to clients annual training on N	n June 19, 2017, to provide s and completed required November 5, 2018, May 9, er 4, 2020 (6 months late).				
		lly 2, 2018, to provide direct completed annual training on				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		H20076	B. WING		02/0) 5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
DIONEER	R HOME INC - CARE S	1006 SOU	TH SHERIDA	AN		
PIONELI	THOME INC - CARE	FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01190	Continued From page 38 July 16, 2019, and November 11, 2020 (4 months late).		01190			
	a.m. administrative was in charge of trataining and educat facility believed it not calendar year, and completed every 12. The facility policy and In-Service Training' indicated all home or required annual inservice annual inservice of employments of employmen					
	TIme period for cor	rection: Seven (7) days				
02015 SS=D	626.557, Subd. 3 T	iming of Report	02015			
	who has reason to is being or has been knowledge that a via a physical injury who explained shall import to the common entry vulnerable adult solutions admitted to a facility.	eport. (a) A mandated reporter believe that a vulnerable adult in maltreated, or who has ulnerable adult has sustained ich is not reasonably nediately report the information ry point. If an individual is a ely because the individual is y, a mandated reporter is not uspected maltreatment of the				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20076	B. WING		02/0) 5/2021	
	PROVIDER OR SUPPLIER	SUITES 1006 SOU	DRESS, CITY, S TH SHERIDA FALLS, MN		•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
02015	Continued From pa	ge 39	02015				
	individual that occu unless:	rred prior to admission,					
	another facility and	as admitted to the facility from the reporter has reason to ble adult was maltreated in the					
	that the individual is	ws or has reason to believe a vulnerable adult as defined subdivision 21, paragraph					
	(b) A person not required to report under the provisions of this section may voluntarily report as described above.						
	known or suspected	ection requires a report of maltreatment, if the reporter on to know that a report has ommon entry point.					
	·	ection shall preclude a eporting to a law enforcement					
	reason to believe the 626.5572, subdivision (5), occurred must subdivision. If the rebelieves that an invision according to the crisubdivision 17, para reporter or facility mentry point or direct	orter who knows or has at an error under section on 17, paragraph (c), clause make a report under this eporter or a facility, at any time estigation by a lead y will determine or should reported error was not neglect teria under section 626.5572, agraph (c), clause (5), the nay provide to the common ly to the lead investigative explaining how the event					

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		H20076	B. WING		I	C 05/2021
	PROVIDER OR SUPPLIER	SUITES 1006 SOL	DRESS, CITY, S JTH SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIECT (ACTION SHOT))	OULD BE	(X5) COMPLETE DATE
02015	subdivision 17, parallead investigative againformation when multiple the report under substitution. This MN Requirements by:	nder section 626.5572, agraph (c), clause (5). The gency shall consider this aking an initial disposition of bdivision 9c.	02015			
	staff failed to immed suspected abuse for C3) reviewed regard Staff witnessed a company abuse C1 over sever report it leading up by the staff member they observed the staff member they observed the staff member of their work day. In observing another staff members aroughly during care the client. The facility	and record review, the facility diately report ongoing or two of three clients (C1, and ding allegations of abuse. Oworker repeatedly verbally eral months and failed to to C1 being physically abused or. The facility staff indicated staff member physically abuse staff member to continue treport the abuse until the endot addition, staff report staff member treating C3 is and laughing after hurting ty failed to investigate and in to the Minnesota Adult Abuse MAARC).				
	violation that did no safety but had the position client's health or said cause serious injury was issued at an isolatical number of climited number of said continuation.	ed in a level two violation (a t harm a client's health or otential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally).				
	The findings include	e :				
	C1 was admitted to	the facility July 11, 2017, with				

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) O2015 Continued From page 41 diagnoses included Alzheimer's disease, dementia with behavioral disturbances, and asthma.		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	l ` ′	E SURVEY PLETED
PIONEER HOME INC - CARE SUITES 1006 SOUTH SHERIDAN FERGUS FALLS, MN 56537 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Deficiency Continued From page 41 diagnoses included Alzheimer's disease, dementia with behavioral disturbances, and asthma.			H20076	B. WING		l	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) O2015 Continued From page 41 diagnoses included Alzheimer's disease, dementia with behavioral disturbances, and asthma.			SUITES 1006 SO	UTH SHERIDA	N		
diagnoses included Alzheimer's disease, dementia with behavioral disturbances, and asthma.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
C1's care plan revised September 7, 2020, indicated he had cognitive impairment with behaviors related to Alzheimer's disease and dementia. C1 had the potential to be aggressive when he felt threatened. C1's care plan interventions instructed staff to listen to C1 and respond with empathy, stand out of reach, and encourage C1 to take calm centering breaths. The care plan interventions also included removing C1 from sources of distress, allow him to express his feelings towards the situation, or call his daughter. C1's progress note dated October 31, 2020, at 12:48 p.m. indicated facility staff reported C1 and a staff member were involved in an incident where the staff member hit C1 in the chest, pushed him, and kicked him in the shin. The progress note indicated C1 received a skin tear and stopped the altercation on his own occurrence. C1 had no recollection of the incident, and no other injuries were noted. C1's skin assessment completed on October 31, 2020, at 12:08 p.m. identified a v shaped skin tear measuring 1.8 centimeters (cm) by 2 cm on the C1's left forearm. A review of the facility incident report dated October 31, 2020, at 7:30 a.m. indicated unlicensed personnel (ULP)-B reported to facility administration staff that during the night shift October 30, 2020, around 2:00 a.m. she had witnessed unlicensed personal (ULP)-A physically	02015	diagnoses included dementia with beha asthma. C1's care plan revision indicated he had considered behaviors related to dementia. C1 had to when he felt threated interventions instructive respond with emparencourage C1 to tare the care plan interventions of the care plan interventions. C1's progress note 12:48 p.m. indicated a staff member were where the staff member were where the staff mempers and stopped the alto occurrence. C1 had incident, and no other c1's skin assessment 2020, at 12:08 p.m. tear measuring 1.8 the C1's left forearm. A review of the facilic October 31, 2020, unlicensed personnal administration staff October 30, 2020, at 2020, at 2020, at 2020, at 2020, and 2020, at 2020, at 2020, and 2020, at 2020, and 2020, at 2020,	Alzheimer's disease, avioral disturbances, and seed September 7, 2020, ognitive impairment with a Alzheimer's disease and the potential to be aggressive ened. C1's care plan acted staff to listen to C1 and thy, stand out of reach, and ke calm centering breaths. Eventions also included sources of distress, allow him the negs towards the situation, or dated October 31, 2020, at defacility staff reported C1 and the involved in an incident enter the complete of a skin tear ercation on his own dono recollection of the ner injuries were noted. The ated C1 received a skin tear ercation on his own dono recollection of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted. The atended the complete of the ner injuries were noted.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		H20076	B. WING	_	l	C 05/2021
	ROVIDER OR SUPPLIER	SUITES 1006 SOL	DRESS, CITY, STALLS, MN 5	N		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
	tear. During the alteraudio recordings or repeatedly yelling, seconds. C1. A review of the faciliobtained by ULP-B. October 30, 2020, of five separate record seconds long. ULP-saying "Oh god how bringing out the old at C1 "Don't even the here, I will tackle yowon't"! The client wincoherent speech responded by shour and repeating what "Let her be" in a low shouting back at Coincoherent speech background and UL anywhere with you, you out you stupid I tomboy I can take you out you stupid I tomboy I can take youn't"! ULP-B was rany of the recording "Investigation of Suincluded the internation of punlicensed personnindicated ULP-B's in October 31, 2020, a was suspended personnindicated personnindic	bed his arm causing a skin ercation ULP-B recorded five in her cellular phone of ULP-A swearing at, and threatening during the night shift of during the incident included dings each one 19 to 49 -A was heard in the recordings in a like in the properties of the background and ULP-A ting at C1 "What, what, what"! C1 had softly said by stating at mocking low tone then 1 "You let her be"! C1's soft was heard again in the LP-A shouted "She is not going I am her boss, I will knock Fuck, don't even think I wour ass don't even think I wour ass don't even think I mot heard intervening during				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
71101211	OF CONTRECTION	IDEITH IO/ (HONDER)	A. BUILDING:			
		H20076	B. WING		C 02/05/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIONEE	R HOME INC - CARE	SUITES 1006 SOL	JTH SHERIDA	AN		
PIONLLI	THOME INC - CARE	FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET	ΓΕ
02015	Continued From pa	ige 43	02015			
	summary identified evidence of the audience of	ncident occurred. The ULP-B had supporting dio recordings of ULP-A being ate and using vulgar language February 18, 2021, at 4:45				
	p.m. ULP-B stated and short tempered verbally aggressive her over the last fiv ULP-A yelled get the room, and no body stated she never reverbal abuse of C1 swearing at C1. UL 2020, at approximation	ULP-A was routinely inpatient with C1 and had become every night she worked with e to six months. ULP-B stated he hell out of here, go to your wants you here to C1. ULP-B eported the ongoing recurring because ULP-A was not P-B stated on October 31, ately 2:00 a.m. C1 was trying to				
	get a female client to go with him, while ULP-A sat on the couch next to the client and yelled at C1 the other client was not going anywhere with him. ULP-B stated C1 became agitated when ULP-A yelled at him and C1 hit ULP-A in the back of the head, ULP-A shoved C1 backwards, kicked him in the shin, and hit him the chest. ULP-B stated the physical altercation between ULP-A and C1 continued back and forth for					
	approximately ten r C1's arm and cause C1's arm. ULP-B st was bleeding he ba ULP-B stated she	minutes until ULP-A grabbed ed a five to six inch skin tea on tated when C1 noticed his arm acked away from ULP-A. attempted to remove C1 away				
	saying things to agi told ULP-A not to he and ULP-A stated to the ground or ge not immediately rep abuse that occurred day after her shift e	LP-A kept "egging" C1 on itate him. ULP-B stated she it C1, and to leave him alone "I don't care if I knock his ass t fired". ULP-B stated she did nort the physical and verbal d that night until the following ended, and did not think about or 911 immediately. ULP-B				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´´	CONSTRUCTION	(X3) DATE COMP	SURVEY
		H20076	B. WING		02/0) 5/2021
PIONEER HOME INC - CARE SUITES			DRESS, CITY, ST ITH SHERIDA FALLS, MN 5	N		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02015	her shift because the building. ULP-B reported the verbal physically abusive to wanted her supervisionated she had abuindicated she had abuindicated she did not those situations. On February 19, 20 phone interview ULULP-A on the overnyelled at C1 and woother arm behind him against his will room. ULP-I stated to swing at ULP-A astop or she would perbal abuse and and C1 happened estated she consider aggressive behavious had never thought a verbal abuse. ULP-abused she would rest day when they they had emergence hours a day, seven. On February 23, 20 phone interview with manager (RNCM)-February 24, 20 phone interview with manager (RNCM)-February 25, 20 phone interview with manager (RNCM	ined in the facility and worked bey were the only two staff in stated she recorded and abuse when ULP-A became owards C1 because she sors to believe her. ULP-B se training last year but of remember what to do in 21, at 11:00 a.m. during a P-I stated she worked with hight shifts and ULP-A always ould grab his arm and put her is back and physically push down the hallway towards his I C1 would get upset and start and ULP-A would yell at C1 to bunch him. ULP-I stated the ggressive behavior with ULP-A every night she worked. ULP-I red ULP-A's verbally red ULP-A's verbally rabusive, but indicated she about reporting the ongoing I stated if a client was being report it to her supervisor the were working. ULP-I indicated y on call staff available 24				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		. ,	(X3) DATE SURVEY COMPLETED	
		H20076	B. WING			C 05/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
PIONEE	R HOME INC - CARE S	SUITES	UTH SHERIDA FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
02015	Continued From pa	ge 45	02015			
	incident between C	1 and ULP-A were abusive.				
	2019, with diagnosi disease, chronic parfunction, and major C3's care plan date C3 was cognitively assistance with AD eating, personal hydrock on the clients	the facility on October 23, s including Alzheimer's in syndrome, impaired visual depressive disorder. Ind October 23, 2019, indicated impaired and required staff L's including dressing, bathing giene, and transfers. C3 was not staff were instructed to s door prior to entering, name, and tell the client who bu are there.				
	a.m. indicated on M staff were rolling C3 incontinence cares,	the client hit her head on the note indicated C3 had no				
	indicated ULP-I was ULP-A came into C pushed the clients s the client hit her left laughed after the C told ULP-A it was no	by ULP-I dated May 4, 2020, s providing cares for C3. 3's room to assist. ULP-A shoulders, "so hard and fast," t forehead on the wall. ULP-A 3's head hit the wall. ULP-I ot funny and ULP-A replied by but that was just so funny!"				
	indicated two staff, assisting C3 with per and turned C3 onto accidentally bumper incident report lacks information of the incident respective.	Report dated May 4, 2020, ULP-I and ULP-A, were ersonal hygiene cares in bed her side when the client d her head on the wall. The ed any of the initial internal ncident initially provided by n note regarding ULP-A's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		H20076	B. WING		1	C 05/2021
	PROVIDER OR SUPPLIER	SUITES 1006 SOL	JTH SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	ULD BE	(X5) COMPLETE DATE
02015	a.m. ULP-I stated shygiene cares to Cadidn't request assis room unannounced upper body so hard to roll into the wall a when C3 hit her heat C3. ULP-I stated funny and it was me sorry but that was justice where a note refor administrative a During interview on a.m. AA-G stated Uthe alleged incident hard, resulting in the laughing at the client documentation of a however, she stated involved and ULP-A happened. AA-G sinvolved and they be vulnerable adult republicated she reviewed ULP-A and C3, but initially reported the ULP-A. RNCM-F stated she reviewed ULP-A. RNCM-F stated and she thouse clients bed being possible and she thouse clients and she thouse clients and she thouse clients are considered and she thouse clients and she thouse clients are clients.	February 19, 2021, at 11:00 he was providing personal Although ULP-I stated she tance, ULP-A entered C3's and fast it caused the client and hit her head. ULP-I stated ad on the wall ULP-A laughed she told ULP-A it was not ean, ULP-A responded, "I amust so funny." ULP-I stated garding the incident and left it				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7 (17) L7 (17	A. BUILDING:					
		H20076	B. WING		02/0	; 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PIONEE	R HOME INC - CARE	SUITES	TH SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
02015	(RNHD)-E stated sall incidents that or stated an internal in determine if maltred off those findings a RNHD-E stated she 4, 2020, and indicated and the head on the wastated she had not ULP-A treated C3 in hard and fast causiful ULP-A laughed at though C3's bed waneeded to be move expect complete in the incident report, investigated and restricted any staff any form of maltred in charge or the housing Director who Housing Director who Housing Director who Housing Director who housing director or staff wor but no later than 24 immediately begin and restricted than 2	arse Housing Director the was responsible to review four in the facility. RNHD-E hvestigation should be done to atment occurred, and based report is made to MAARC. The recalled the incident on May ted C3 accidentally bumped all during cares. RNHD-E knowledge of the allegation rough when she pushed her ring her head to hit the wall and the client. RNHD-E stated she as too close to the wall and the d. RNHD-E stated she would formation to be included on and the incident should be ported to MAARC. Itled Vulnerable Adult Reporting thated November 2014, who witnessed or suspected atment abuse must report the thy to the registered nurse (RN) using director. The RN or rill complete an incident report. Itled Reporting Documenting dents Involving Residents, r 2014, indicated incident sidents with be reviewed by r. Staff would complete an ction 2. indicated if the sported to MAARC, the housing uld do so as soon as possible thours after the incident, and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20076	B. WING		02/0	5/2021
	PROVIDER OR SUPPLIER	SUITES 1006 SO	DDRESS, CITY, S UTH SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
02015	Continued From partial Time Period for Continued From partial Time Period From partial Time Period for Continued From partial Time Period From Period F	ge 48 rection: Fourteen (14) days.	02015			