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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Care Center	1131 South Mabelle Avenue Fergus Falls, MN 56537

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide adequate supervision when a resident was brought outside onto the patio area and left there without supervision, and later became unresponsive for 1 of 1 resident (R1) reviewed for safety. Findings include: R1's St. Louis University Mental Status (SLUMS, screening test for dementia) examination dated 1/6/23, identified R1 had a mild neurocognitive disorder. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had verbal behaviors one to three times a week, and rejection of care. She was dependent upon staff for toileting hygiene, personal hygiene, sit to stand, chair/bed to chair transfers, toilet transfers, and was unable to ambulate. R1 was frequently incontinent of bladder and occasionally continent of bowel. Medical diagnoses included arthritis, depression, psychotic disorder, macular degeneration, and epilepsy (seizure disorder). R1's care plan dated 3/18/25, identified R1 had impaired balance, limited mobility, and behaviors, and directed staff to provide total assistance of two for transfers with a lift, and encourage the use of bell to call for assistance. R1 did not ambulate. R1 required staff assist with wheelchair for longs distances, and she was independent with short distances. She had dementia with ineffective coping skills and delusional disorder (a serious mental health illness where a person cannot tell what is real and from what is imaginary, paranoid). She had impaired cognitive function/thought process and decision making. Staff were directed to cue, reorient, and supervise as needed. She required supervision with all decision making. She was at risk for falls related to gait/balance problems, and the care plan directed staff to provide call light within each, encourage her to use it when assistance was needed. She needed prompt response to all requests for assistance. R1's Nursing assessment dated [DATE], identified she had periods of delusions and hallucinations, unsteady gait, poor balance, can stand and pivot only with help, and had moderate agitation (called out and used threatening language). R1's progress note dated 5/11/25 through 5/13/25 identified: (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 5/11/25 at 5:21 p.m. R1 was found outside at 4:30 p.m. unresponsive. R1 was assisted into the unit. Vital signs were as follows: blood pressure (BP) 168/89, pulse 116, respiration 22, temperature 99.8 degrees Fahrenheit (F), oxygen saturation (SaO2) 95% on room air. A cold washcloth was applied on her forehead and then she started mumbling. Placed call to 911 and requested for emergency medical service (EMS), family notified through her brother. Registered nurse (RN) charge nurse and RN care coordinator were notified as well. -On 5/11/25 at 9:43 p.m. R1 returned from the emergency department (ED). -On 5/12/25 at 4:28 p.m. Follow-up with staff working Sunday afternoon. R1 was assisted outside about 1:45 p.m. onto the short stay patio. Staff followed-up with resident two times from that time until 2:30 p.m. and offered her water. They also asked if she would like to come back inside, which she declined. Two staff offered to bring her in again about 4:00 p.m. and she declined at that time as well. She told them she did not want to come back in at that time. -On 5/13/25 at 1:30 p.m. R1 required intravenous (IV) fluids (in the ED): sodium chloride 0.9% bolus on 5/11/25 for additional fluids intake for hydration needs. The need for fluids was determined by physical exam and/or diagnostic testing which had indicated: abnormal fluid loss, unstable vital signs (increased temperature) and abnormal labs such as BUN/creatinine, glucose, and potassium. R1 also received treatment for abnormal fluid loss, heat exposure, head exhaustion and hyperkalemia. Rehydration was reasonable and necessary. R1's ED provider notes dated 5/11/25 at 6:34 p.m. indicated clinical impression: heat exposure, hyperkalemia (high potassium levels), heat exhaustion. She was found by staff at the nursing facility confused outside and quite confused upon EMS arrival. She was alert and oriented, though seemed to have some limited recall of recent events and may have some underlying dementia or other cognitive disorder. Her temperature was 100.1 orally, very warm to the touch with evidence of sunburn, suspected she was quite warmer earlier. Cooling measures were initiated prior to EMS arrival to facility, and mental status improved. She was given cool intravenous fluids and cooling packs were applied to the groin and axilla (under arms). Despite prolonged exposure she did not appear at this time to have suffered any untoward effects. Stable and discharged back to the nursing facility. During an interview/observation on 5/15/25 at 2:03 p.m. R1 sat in her wheelchair in her room well groomed, fully dressed in t-shirt, zip-up long-sleeved jacket, shorts, socks, and tennis shoes. She stated unsure how long she had lived at the facility, and stated she had been there since fall to winter to spring and now it's summer, I think. She went outside every day and activities staff took her out. She stated she was tired today. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/25 at 4:00 p.m. RN-A stated R1 pushed herself around the unit in the wheelchair with her feet. The resident patio area was fenced in, and staff entered a code on the pad located off to the left of the inside door. He had seen R1 outside both in front of the building, and in the patio area. R1's care planned did not identify interventions for her to go outside with or without anyone. Her cognition was affected at times, and she would not have been safe outside by herself when she was confused. She was unable to stand, walk, and/or transfer herself independently, and did not attempt to self-transfer. On 5/11/25, he administered medications to R1 between 8:00 a.m. and 9:00 a.m. while she was in her room. She ate breakfast in the dining room, and then went back to her room. At 12:00 p.m. until 12:45 p.m. she sat in dining room and ate lunch. He had gotten busy after that, took a break before 2:00 p.m. and returned to the floor. Nursing assistant (NA)-A had already given report to the oncoming NA-C. NA-B was scheduled for evening shift at 3:15 p.m. At 4:30 p.m. R1 was not in her room and was found out on the patio area by herself. He asked her, Should we go inside? She shook her head no. She was not responding appropriately and mumbled. When cued, she was unable to lift her feet. Foot pedals were placed on her wheelchair and she was pushed inside the building. Vital signs were taken at the nurse's station: blood pressure 165/89, heart rate was 115, temperature 99.8 degrees F., respirations 22, and SaO2 91%, and she was unable to respond. 911 was called. He placed a wet washcloth on her face and she started to wake up and talked a bit. EMS arrived, and once she was transferred to the gurney she woke up and became her normal self. He followed up with staff, and NA-C told him she had taken R1 out to the patio just before 2:00 p.m. and passed the information onto the evening shift NA-A. He expected staff to inform the nurse, and he was not told about R1 being outside. NA-B hadn't informed him until 3:20 p.m. NA-A requested assistance to get R1 back into the building and R1 had refused. R1 was unable to identify how to get back into the building, she sat outside in the patio area from 3:20 p.m. until 4:30 p.m. unsupervised, in 90-degree weather, without access to water, and was not safe by herself. During an observation on 5/15/25 at 4:20 p.m. the resident patio was in the short stay wing. A code pad was located inside on the left side of the door on the wall, at approximately eye level. The door had a large glass window with NO EXIT stamped on it. The door was unable to be opened without a code placed into the pad. There were four lawn chairs and a table against the inside of the metal white fencing, and a long wooden bench located up against the outside building wall. The patio could be visually seen from the main parking lot of the facility and from inside the building was a large window. No overhead protection from the sun was noted. During an interview on 5/16/25 at 10:00 a.m. NA-A stated R1 refused to come back into building on 5/11/25. Staff were expected to check on residents inside the building every two hours, and if they were outside, they should be checked on every 30 minutes to one hour. NA-D brought R1 outside in the patio area around 1:45 p.m., she checked on her before 2:00 p.m. to see if she wanted to come back in and offered water, and R1 declined. The temperature outside was at least 80 degrees out and partly cloudy. R1 wore shorts, and a t-shirt. R1 did not have on sunscreen, a hat or sunglasses. She also had no access to water. She was unsure why they didn't leave something for her to drink. At 2:00 p.m. NA-C was informed R1 was outside on the patio, and how long she had been there. Staff were expected to check on her, they could have seen her through the window from inside the building. There was not way for R1 to alert us if she needed anything other than pound on the glass window, wave her arms or knock on the door. A code was needed to open the door from the outside to get back into the building. She would be unable to have pushed the door open, was heavy. There was a buzzer outside on the wall, but she would have most likely been unable to reach it from her wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/25 at 10:26 a.m. NA-C stated she had received report from NA-A and was made aware R1 was outside on the patio, but was not informed how long it had been. Usually upstairs in the dementia unit a resident was brought outside to the patio area and staff were expected to stay with them, and 15 minutes later the resident was brought back into the facility, and not left alone. R1 was forgetful and confused at times. She had been informed staff attempted earlier to her back into the building, and R1 did not want to go back inside. At 4:00 p.m. she checked on R1 and asked her to come into the building and she refused. The temperature outside was hot, 90 degrees and sunny, and R1 had no protection from the sun. She should have not been placed outside by herself. NA-A stated NA-B planned on updating the nurse about R1's refusal to come inside, but was unable to locate him, it was an extremely busy day with many visitors. At about 4:30 p.m., R1 was in the hallway in her wheelchair unable to talk. They placed ice towels on her prior to EMS arrival. None of this should have happened and could have been worse. During an interview on 5/16/25 at 12:00 p.m. RN-B stated staff would be expected to check with the nurse on duty prior to a taking a resident outside and left by themselves. R1 was confused at times, especially one day last week, and may have not been able to let herself back into the building. During an interview on 5/16/25 at 2:26 p.m. the director of nursing (DON) stated staff brought R1 out to the patio, checked back and offered water, and offered to bring her back inside. She refused to come back into the building. Staff would have been expected to have notified RN-A, and they did not follow the facility process. RN-A should have been informed R1 was taken outside especially at shift change. R1 had a mental health diagnoses and an altered through process related to delusions. Staff would have expected to check on R1 at least every 15 to 30 minutes and under the circumstances, felt they checked on her appropriately. During an interview on 5/19/25 at 12:22 p.m. NA-B stated he did not receive report when he arrived at work on 5/11/25 at 3:05 p.m. He passed ice water, and R1 was not located in her room. He was unaware of her being out on the patio. She should have not been left alone outside. After 4:00 p.m., NA-C approached him and requested assistance with R1. He put in the code and opened the patio door, and held the door open while NA-C informed R1 it was time to come in for supper. R1 replied no, she was ok, and refused to go in. She wanted to sit outside longer. He told her they would come back in a while. He was unaware how long she had been outside. She was left out on the patio, and they planned on checking back with her later, before supper. R1 sat alone in the wheelchair, with shorts and a t-shirt on, and without anything to drink. RN-A was unable to find R1 to administer medications, and then requested assistance with getting her into the building from the patio. A code was required to unlock the door to get back into facility, and he was unsure if R1 would have been able to reach the code pad since she was unable to stand up independently. The facility policy Safety and Supervision of Residents dated 7/2017, directed resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessment needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. Resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.