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	05/27/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and document review, the facility failed to notify a physician timely of a change in condition for 1 of 3 residents (R1) who had an injury of unknown origin related to bruising on her inner thigh. Findings include: R1's annual Minimum Date Set (MDS) on 4/24/25, identified R1 had severely impaired cognition, inattention (difficulty focusing, easily distractible, and difficulty keeping track of what was said), and disorganized thinking. Facility Resident Accident/Incident Report dated 5/17/25, completed by floor supervisor registered nurse (RN)-A identified date of incident 5/17/25, at 8:00 a.m. Staff noted R1 had eight areas of greenish colored bruising, dime to nickel sized, on inner knee/thighs which appeared to be fingerprint in size. Area on report labeled Was it necessary to notify MD/GNP/PA? was left blank, as was then name/date/time of MD/GNP/PA notified. Administrator and director of nursing (DON) notified on 5/17/25 at 9:45 a.m. R1's progress note dated 5/17/25 at 10:27 a.m., identified she had bruising to upper/inner thighs and inner left knee. The bruises were dark green in color, fingerprint sized and did not appear to cause pain when palpated. R1 was unable to indicate if she felt safe in the facility, if anybody had hurt her or if she remembered how she got the bruises. Progress note indicated resource manager was notified and appropriate actions were in place (those actions not described in progress note). Her granddaughter was contacted and informed of the incident and had no questions/concerns at this time. Will continue to monitor and document as needed. R1's progress note dated 5/19/25 at 1:34 p.m., Complete Skin Assessment: Healing bruises in inner thigh almost gone. No new concerns to report to provider. R1's routine visit follow up visit by medical doctor/director (MD) on 5/20/25 at 9:55 a.m., lacked any mention of skin/bruising. R1's progress note dated 5/22/25 at 11:49 a.m. Type: skin/wound note medical doctor (MD) updated via fax. (5 days later) (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/25 at 11:10 a.m. RN-A stated the provider should have been notified immediately when the bruises were discovered on 5/17/25 so they could have chosen to evaluate her or send her in for evaluation. The provider was notified via fax yesterday, (5/22/25). During an interview on 5/23/25 at 2:42 p.m. DON stated the staff would be expected to have notified the provider right away after R1's bruises were found to see if he wanted a further medical evaluation completed and/or other interventions necessary depending on the situation. During an interview on 5/27/25 at 8:32 a.m. MD stated he was not familiar with R1's incident that occurred on 5/17/25, regarding bruises. MD stated he did not believe it was included on the rounding form he received from the nurse when he saw her on 5/20/35, and no mention of bruises were identified on his visit notes. He would have wanted to be notified so that R1 could have been examined, especially when there was a potential for alleged abuse. MD indicated the he would have completed the examination to verify if there were concerns for abuse. Certainty there would have been a possibility of sexual abuse especially if bruises were located close to the genital area, if not, rough handling and/or transfers with bruising would have been possible.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observations, interviews and document review the facility failed to ensure an injury of unknown source was thoroughly investigated for 1 of 3 residents (R1) reviewed for abuse. Findings include: R1's annual Minimum Date Set (MDS) on 4/24/25, identified R1 had severely impaired cognition. Her medical diagnoses included Parkinson's (a movement disorder of the nervous system with symptoms that worsen over time such as tremors, slowed movements, rigid muscles, poor posture/balance, loss of blinking/smiling movements, speech changes, writing changes, nonmotor symptoms), dementia, and anxiety. She had impaired range of motion to bilateral lower extremities, unable to stand independently or walk. She required substantial to maximal assistance with personal hygiene, repositioning in bed, all transfers and dependent upon staff for toileting and oral hygiene, shower/bathe, dressing, and mobility in wheelchair. R1's care plan dated 5/19/25, identified impairment to skin integrity, activities of daily living (ADL) self-care deficit, and impaired communication. Staff were directed to anticipate and meet needs, use caution during transfers and bed mobility to prevent striking arms/legs/hands against any sharp or hard surfaces, assist of two staff for bed mobility and transfers with assist of one and PAL (patient assisted stand lift), monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, situations, and document. She was a vulnerable adult and staff were directed to monitor and report any suspected abuse or neglect following policy. R1's progress note dated 5/17/25 at 10:27 a.m., identified she had bruising to upper/inner thighs and inner left knee. The bruises were dark green in color, fingerprint sized and did not appear to cause pain when palpated. R1 was unable to indicate if she felt safe in the facility, if anybody had hurt her or if she remembered how she got the bruises. Progress note indicated resource manager was notified and appropriate actions were in place (those actions not described in progress note). Her granddaughter was contacted and informed of the incident and had no questions/concerns at this time. Will continue to monitor and document as needed. R1's progress note dated 5/19/25 at 1:34 p.m., indicated skin assessment/observation of pubic area, buttocks, groin, and upper thighs: skin intact, warm, and dry. No new lesions, bruising or rashes noted. Chronic redness in groin, Nystatin applied. Healing bruises in inner thigh, almost gone. The state agency (SA) facility report dated 5/17/25, at 11:30 a.m. indicated no incident was observed related to bruises. Nurse caring for resident today observed greenish discoloration which appeared as bruising to residents inner knees and thighs. Size ranged from dime to nickel size. There were four small bruises in a straight line to the right inner thigh and four small bruises reported to left upper knees extending to upper thigh. Questionable if that may be related to required assist of one staff for ADLs (activity of daily living) including bathing, dressing, toileting, and transfers with a PAL lift, possible check and changed every two hours and R1's incontinent product. Observation of R1 identified she had very sensitive skin (abdominal folds/under breasts/inner thigh/groin/buttocks). Appeared to be at baseline with no changes in behaviors, participation, cognition, or mood. She continues to required assistance with bed mobility and repositioning. Previous skin assessments did not reflect skin discolorations or bruising. Interviews with staff and investigation was ongoing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the SA investigative report dated 5/23/25 at 4:05 p.m. no changes to her psychosocial wellbeing that would indicate abuse. Summary of interviews completed with staff identified no witnesses and those that worked with her reported increased difficulty with turning and repositioning, occasionally resistive to oral cares and adjustment to her pillow. She was not typically resistive when checked and changed, tried to help but was having more difficulty. Resident was checked and changed every two hours; bruising could have been related to process of changing her brief. No previous reports of bruising to her legs reported. Review of facility incident investigation staff interviews on 5/22/25, lacked evidence staff were asked questions related to observed or suspected abuse, concerns with aggressive cares, or other suspicious behavior by staff or residents. During an interview on 5/22/25 at 2:58 p.m. TMA-A stated R1 was not interview able, She became aware of the yellow/greenish bruises on R1, in the healing stages located and located on both her inner thighs on 5/17/25. TMA-s indicated she reported the bruises to the nurse and was present in the room while the nurse assessed her skin. She also stated R1 did not often resist or hold her legs together, she did become ridged at times but was then given time and space to relax. TMA-A confirmed she had not been interviewed by anyone related to the bruising or abuse. During an interview on 5/22/25 at 3:17 p.m. TMA-B stated she first became aware of R1's bruises on 5/17/25 when the nurse and NA showed her the bruises. R1 had three or four bruises on both sides of her inner thighs, one on the outside of the right thigh, and one underneath each of her thighs, that were darker purple about the size of a penny. The nurse, another NA and her all thought they looked like fingerprints. TMA-B confirmed she had not been interviewed by anyone about this incident. During an interview on 5/23/25 at 2:42 p.m. director of nursing (DON) stated the facility investigation interviews with the staff included a total of three questions: had they noted any skin changes/alternations prior to incident, any trouble moving/repositioning her in the bed, and any difficulty with cares. The staff were not asked any questions about abuse and should have been. That would have helped identify if there was any abused that occurred. No abuse was determined with interviews and only an increase with repositioning was consistently identified. During an interview on 5/27/25 at 8:32 a.m. medical director (MD) stated the facility would have been expected to complete interviews with the staff that included questions about abuse. We would have wanted to know if she was being abused. If he would have been notified about the incident, an examination would have been completed, identified if things looked suspicious, and helped direct the investigation. Facility policy Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated 2/26/19, identified injuries of unknown origin was defined as the source of the injury was not observed by any person, or source of the injury could not be explained by the resident; and the injury was suspicious because of the extent or locations of the injury (e.g., the injury was in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injuries over time. The investigation will consist of an interview with the person or persons reporting the incident, any witnesses to the incident, staff members having contact with the resident during the relevant periods or shifts of the alleged incident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and document review the facility failed to assess and monitor bruises for 1 of 3 resident (R1) reviewed for injury of unknown origin. Findings include: R1's order dated 2/3/25 at 8:00 a.m. weekly bath day skin note. Monitor for changes, bruising, open areas. Notify nurse/general nurse practitioner (GNP) as needed. Every Monday for skin monitoring. Signed off as completed on 5/5/25, 5/12/25, and 5/19/25. R1's annual Minimum Date Set (MDS) on 4/24/25, identified R1 had severely impaired cognition, inattention (difficulty focusing, easily distractible, and difficulty keeping track of what was said), and disorganized thinking. Her medical diagnoses included Parkinson's (a movement disorder of the nervous system with symptoms that worsen over time such as tremors, slowed movements, rigid muscles, poor posture/balance, loss of blinking/smiling movements, speech changes, writing changes, nonmotor symptoms), dementia, and anxiety. She had impaired range of motion to bilateral lower extremities, unable to stand independently or walk. She required substantial to maximal assistance with personal hygiene, repositioning in bed, all transfers and dependent upon staff for toileting and oral hygiene, shower/bathe, dressing, and mobility in wheelchair. She was frequently incontinent of bladder and occasionally incontinent of bowel. Facility Resident Accident/Incident Report dated 5/17/25, completed by floor supervisor registered nurse (RN)-A identified date of incident 5/17/25 at 8:00 a.m. staff noted R1 had eight areas on greenish colored bruising, dime to nickel sized, on inner knee/thighs and appeared to be fingerprint in size. Notification to MD/GNP/PA and MD/GNP/PA was left blank and administrator and director of nursing (DON) were notified on 5/17/25. R1's progress note dated 5/17/25 at 10:27 a.m. identified she had bruising to upper/inner thighs and inner left knee. They were dark green in color. Bruises were fingerprint sized and did not appear to have cased pain when palpated. She was unable to answer when asked if she felt safe in facility, if anybody had hurt her or if she remembered how she got the bruises. Resource manager was notified. Appropriate actions were in place (actions not identified). Her granddaughter was contacted and informed of incident and had no questions/concerns at that time. Will continue to monitor and document as needed. R1's order dated 5/18/25, monitor bruising to inner bilateral thighs for healing. Discontinue when healed. No directions specified for order. No progress notes noted on 5/18/25. R1's progress note dated 5/19/25 at 1:34 p.m., identified skin assessment/observation of pubic area, buttocks, groin, and upper thighs: skin intact, warm, and dry. No new lesions, bruising or rashes noted. Chronic redness in groin, Nystatin applied. Healing bruises in inner thigh, almost gone. R1's progress note dated 5/20/25 at 10:42 a.m. Type: appointment return/physician visit/medication change. No changes to plan. Updated family member. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress note date 5/22/25 at 11:49 a.m. Type: Skin/wound note. MD updated via fax. R1's progress note date 5/22/25 at 4:55 p.m. received a fax order from MD concerning the bruising found on the resident. Continue to monitor. R1's record lacked monitoring of bruises on 5/18/25, 5/20/25-5/22/25, or until resolved. During an interview on 5/23/25 at 11:00 a.m. registered nurse (RN)-A stated R1's progress notes written on 5/17/25, indicated appropriate actions were in place. The nurse providing cares and assigned to that unit would have been expected to monitor the bruising and document in the medical record/progress notes every shift. There was a nursing order to monitor the bruises but was unable to identify it had been placed in the TAR in electronic medical record. During an interview on 5/23/25 at 2:00 p.m., trained medication aide (TMA)-C stated he skin assessments usually would be identified and assigned through the resident's TAR (Treatment Administration Record) and he had not aware of anything for R1. During an interview on 5/23/25 at 2:10 p.m. RN-B stated she was not aware of R1's bruises were to be monitored and would confirmed that would have been important to monitor for any changes from the initial assessment on 5/17/25, such as more bruises, and whether they were healing or had a change in skin integrity. RN-B stated the order should have been to assess the bruises every shift, but the schedule (frequency) was not indicated in the order. She also verified the order was not located on the TAR and/or completed. Unless the nurse looked on every order they would have not known about the assessment and planned on adding it to the TAR. During an interview on 5/23/25 at 2:42 p.m. DON stated she would have expected the nurse to have placed the order into the TAR to ensure R1's bruises were getting monitored through healing. DON added, the nursing order was missing the routine/frequency was not entered and therefore had not shown up on the TAR. The monitoring of the R1's bruises were not signed off as completed and would have needed to follow up with staff if they were assessed every shift. During an interview on 5/27/25 at 8:32 a.m. with medical doctor/director (MD) stated had not been notified of R1's incident on 5/17/25 but would have directed the nurses as to how often they should have monitored the bruise, adding bruises do not really change every shift and most likely daily would have been sufficient. Monitoring is important to watch how the bruises evolve, look different from one day to another, if new bruises popped up, which may have triggered continued concern and/or a possible hematoma (a closed wound bleeding outside the blood vessels that resulted in a collection of blood) that may have required more medical care.