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	07/24/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview and document review, the facility failed to ensure nebulizer medication was administered safely for 1 of 1 resident (R28) who was observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Findings Include: R28's admission Minimum Data Set (MDS) dated [DATE], identified R28 was cognitively intact and had diagnoses which included: chronic obstructive pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed airflow from the lungs), heart failure and anxiety disorder. Indicated R28 required partial/moderate assistance with upper body dressing, transfers, and hygiene. R28's care plan revised 6/27/24, identified R28 had activities of daily living (ADL) self-care performance deficit and required assistance for dressing, personal hygiene and transfers. R28 had potential for respiratory status/difficulty breathing related to COPD and interventions included administer medication/puffers as ordered. R28's care plan lacked self administration of medication interventions. R28's Medication Review Report signed 7/8/24, included orders for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligrams (MG)/3 milliliters (ML) (a bronchodiator medication that helps relax muscles in airway to increase air flow) one unit inhale orally four times a day for COPD. R28's Medication Review Report lacked an order to self-administer medication. R28's medical record lacked documentation of a self-administration medication (SAM) assessment completed. During an observation and interview on 7/23/24 at 8:36 a.m., trained medication aide (TMA)-A indicated R28 was probably done with her nebulizer medication, entered R28's room, unhooked the nebulizer mask and cup from the nebulizer machine, rinsed it in the sink and set it on a paper towel to dry. At 8:41 a.m., TMA-A indicated he planned to set up R28's nebulizer around lunch time and R28 would administer it herself after set up. (continued on next page)

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

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	07/24/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/23/24 at 11:30 a.m., TMA-A entered R28's room, removed a vial of R28's Ipratropium-Albuterol Inhalation Solution from a locked medication drawer, opened the vial and poured it into the nebulizer cup. TMA attached the mask to the tubing on the nebulizer machine and handed the nebulizer to R28. TMA-A turned on the nebulizer machine, sanitized hands and exited R28's room. At 11:33 a.m., TMA-A was at the nursing desk. TMA-A indicated he thought R28 had been assessed to be safe to self administer medications. TMA-A reviewed R28's electronic medical record and verified it lacked a SAM for R28 to self-administer medications. TMA-A stated his usual practice was to set up R28's nebulizer, leave the room and R28 would administer the medication and shut it off when done. At 11:35 a.m., R28 continued to be self-administering her nebulizer in her room while no other staff member was present. During an interview on 7/23/24 at 3:34 p.m., unit manager registered nurse (RN)-A confirmed R28 did not have a SAM assessment, or an order for self administration of medications, which included the nebulizer. RN-A indicated the usual process was to complete a SAM assessment and if it was determined the resident was appropriate to self-administer medications, it should have been added to care plan. In addition, an order should have been obtained and it should have been identified on the resident's electronic health record banner. RN-A stated it was important to complete the SAM and obtain orders to assure medications were administered appropriately and would not cause harm. During an interview on 7/23/24 at 4:11 p.m., director of nursing (DON) indicated the facility's usual process was for licensed staff to complete a SAM and obtain an order for self-administration if the SAM determined the resident was safe to self- administer meds. DON expected staff to re-evaluate quarterly and when a significant change occurred. DON verified an order for self-administration of meds should have been obtained and should have been documented in the resident's care plan and electronic record banner. DON indicated it was important to complete the process to assure the resident received the medications as prescribed by their provider. During an interview on 7/23/24 at 5:03 p.m., R28 confirmed all nursing staff set up her nebulizer medications and did not remain with her while she self-administered the nebulized medication. R28 stated no one had discussed self-administering her nebulizer medication with her and she just automatically completed the task. During a telephone interview on 7/23/24 at 5:19 p.m., pharmacy consultant (PC)-A indicated it was her expectation the facility would have completed a SAM assessment and obtained an order for R28 to self administer her nebulizer medication. PC-A indicated for nebulized medication, the facility needed to assure the resident would keep the nebulizer mask in place and not remove it before the medication administration was completed. The facility policy titled Self-Administration Of Medications revised 2/21, identified residents had the right to self-administer medications if the interdisciplinary (IDT) team had determined that it was clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the IDT team assessed each resident's cognitive and physical abilities to determine whether self-administration medications was safe and clinically appropriate for that resident. If deemed safe and appropriate for a resident to self-administer medications, this would have been documented in the medical record and the care plan.

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	07/24/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 2 residents (R75) who required assistance with hygiene, and was reviewed for activities of daily living (ADL). Findings Include: R75's quarterly Minimum Data Set (MDS) dated [DATE], identified R75 was severely cognitively impaired, with diagnoses which included dementia, coronary artery disease (CAD), and hypertension. Indicated R75 required substantial/maximal assistance with shower/bathing, and partial/moderate assistance with upper and lower body dressing. Identified R75 was independent with personal hygiene. R75's care plan revised 6/28/24, identified R75 had an ADL self-care performance deficit related to confusion, fatigue and impaired balance. R75 required assistance of one staff for dressing, bathing, and personal hygiene. R75's interventions identified R75 preferred no facial hair. During an observation and interview on 7/22/24 at 9:48 a.m., R75 was dressed in street clothes and seated in her recliner chair in her room. R75 had multiple white facial hairs approximately one quarter inch long across both cheeks, chin and around her mouth. R75 had a couple of approximately half inch long white facial hairs on her chin. R75 rubbed her chin and indicated she was unable to take them off by rubbing them. During an observation on 7/23/24 at 9:16 a.m., R75 was seated in her chair in her room and dressed in street clothes. R75 was looking for a pen to complete her word search puzzle book. R75 continued to have multiple white facial hairs approximately one quarter inch long across both cheeks, chin and around her mouth. R75 had a couple of approximately half inch long white facial hairs on her chin. During an interview on 7/23/24 at 9:18 a.m., nursing assistant (NA)-B stated she had not assisted R75 that morning with cares however, had noticed R75 had a large amount of facial hair present. NA-B indicated her usual practice when she observed R75 with facial hair, was to ask her if she could remove the hair and then remove it. NA-B stated it was important to assist R75 to remove facial hair to maintain her dignity. During an interview on 7/23/24 at 9:32 a.m., NA-C confirmed assisting R75 with ADL cares that morning and another day earlier that week. NA-C indicated the usual practice was to assist residents to remove facial hair when observed. NA-C had not looked closely at R75 that morning to check for facial hair however, should have done so. NA-C indicated it was important to assist residents with facial hair removal, as most of the female residents did not want any facial hair present. During an interview on 7/23/24 at 10:32 a.m., clinical manager registered nurse (RN)-A indicated the facility's usual practice was to ask residents or family members if the resident wished to have facial hair removed. RN-A stated if a resident wished to have facial hair removed, it was her expectation that staff checked for the presence of facial hair and asked them daily if they want it removed, as it was important to maintain dignity. (continued on next page)

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	07/24/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/23/24 at 10:39 a.m., director of nursing (DON) stated the facility's usual practice was for staff to offer to remove the resident's facial hair daily when present with morning cares. If a resident refused the offer, DON expected staff to document it. DON stated the resident's facial hair preference would have been identified on the resident's care plan. DON indicated it was important to assist residents to remove facial hair if they were unable to complete the task themselves to maintain dignity, to promote confidence and to have pride in their appearance. During a telephone interview on 7/23/24 at 10:48 a.m., family member (FM)-A stated R75 did not want to have any facial hair present and expected it to be removed. The facility policy titled Shaving The Resident revised 2/18, identified the purpose was to promote cleanliness and to provide skin care. The policy instructed to review the resident's care plan to assess for any special needs of the resident. The policy instructed to notify the supervisor if the resident refused the procedure.

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	07/24/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620 Based on observation, interview and document review, the facility failed to comprehensively assess, monitor, develop and implement interventions to promote healing for 1 of 3 residents (R38) reviewed for a current, facility acquired, stage two pressure ulcer. Stage two pressure ulcer; partial-thickness skin loss with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Findings include: R38's significant change of status assessment (SCSA) Minimum Data Set (MDS) dated [DATE], identified R38 had diagnoses which included dementia, aphasia (loss or impairment to use or comprehend language), cerebral infarction (brain lesion in which a cluster of brain cells die when they don't get enough blood), congestive heart failure, chronic respiratory failure and dependence on supplemental oxygen. Indicated R38 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, toileting, dressing, personal hygiene and bathing. Identified R38 was at risk for developing pressure ulcers. The MDS lacked documentation of R38 having a pressure ulcer. R38's SCSA care area assessment worksheet (CAA) dated 7/9/24, identified R38 required extensive assistance with bed mobility, had a pressure reducing mattress on his bed and no noted skin issues. Identified R38 demonstrated a steady decline over the past several months and spent more time in bed. R38's care plan revised 2/3/24, identified R38 had potential impairment of skin integrity. R38's care plan lacked documentation of a current pressure ulcer. Furthermore, R38's care plan indicated R38 had shortness of breath related to diagnosis of chronic respiratory failure and received oxygen via nasal cannula continuously. R38's care plan lacked documentation of interventions to prevent pressure ulcers related to oxygen tubing. R38's Braden scale (tool used to determine risk for pressure ulcer development) dated 7/16/24, identified R38 was at moderate risk for pressure ulcer development due to the following risk factors; slightly limited sensory perception, very moist skin, was chairfast, slightly limited mobility and very poor nutrition. In addition, friction and shearing were a potential problem for R38 who required moderate to maximum assistance with moving. R38's nursing respiratory assessment dated [DATE], identified R38 had oxygen continuously via nasal cannula and would not experience discomfort or altered quality of life related to respiratory status. R38's nursing assessment dated [DATE], identified R38 had no skin concerns. Skin remained intact. Cushion applicators present behind ears. (continued on next page)

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	07/24/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38's progress note weekly skin assessment dated [DATE], identified R38 continued to have skin breakdown behind left ear from nasal cannula tubing. Skin protector applicator was placed on nasal cannula tubing and a treatment to monitor R38's ear until healed was setup by nursing. The note lacked a description of the breakdown and the type of treatment initiated by nursing staff. R38's progress note weekly skin assessment dated [DATE], identified R38 had no skin alterations. R38's progress note weekly skin assessment dated [DATE], identified R38 had no skin alterations. R38's progress notes lacked assessment of the pressure ulcer including measurements, interventions implemented to promote healing and prevent further breakdown and weekly monitoring of the ulcer to determine if it was healing or worsening. R38's nursing assistant (NA) care guide/Kardex printed 7/24/24, indicated R38 had oxygen via nasal cannula continuously. The Kardex lacked documentation of the presence of a pressure ulcer. During an observation on 7/23/24 at 3:04 p.m., R38 was laying in bed with the nasal cannula on and foam protectors on oxygen tubing behind bilateral ears. A Band-Aid was observed to be on the back of R38's left ear. During an observation and interview on 7/23/24 at 3:25 p.m., registered nurse (RN)-B stated she was unaware R38 had a Band-Aid to the back of his ear and was unaware that R38 had a pressure ulcer present on the back of the left ear. RN-B removed the Band-Aid and stated the Band-Aid did not look new. RN-B stated the Band-Aid had dried blood on it, no odor, and no drainage noted to the area on back of the left ear. RN-B confirmed there had been no initial assessment of the pressure ulcer on the back of R38's left ear or any measurements of the pressure ulcer documented in the electronic medical record (EMR). At 4:04 p.m., RN-B measured the pressure ulcer of R38's left ear at 0.5 centimeters (cm) long by 0.5 cm wide and was round. RN-B verified the pressure ulcer was located in the middle of the back of R38's left ear and stated the first layer of the skin was gone. The wound bed was red and no drainage was observed. RN-B confirmed it was important to assess and measure a pressure ulcer to determine if the pressure ulcer was improving or worsening and to implement interventions to assist with healing. RN-B stated there was a wound checklist at the nurses' station for nurses to complete when a new pressure ulcer was identified on a resident. During an interview on 7/24/24 at 12:31 p.m., licensed practical nurse (LPN)-A verified the progress note on 7/23/24. LPN-A stated she did not observe a Band-Aid behind R38's left ear during the weekly skin assessment documented on 7/23/24 at 1:51 p.m. LPN-A stated R38 had some redness behind both ears however there were no open areas present. During an interview on 7/24/24 at 12:35 p.m., RN-A stated she was unaware of a skin concern behind R38's left ear prior to last evening on 7/23/24. RN-A confirmed R38 had developed a stage two pressure ulcer to the back of his left ear from the oxygen tubing. RN-A stated the expectation of nursing staff was to complete a wound checklist when a new pressure ulcer was identified and verified the following steps of the wound checklist: -measure wound and describe. -start initial treatment (barrier cream, dressing, monitoring schedule). (continued on next page)

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	07/24/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-notify the following; resident, resident representative, dietary, therapy, doctor, care coordinator. -implement new interventions (start tissue tolerance, air mattress, heel boots, etc.). -update care plan. -document. -once completed turn wound assessment into care coordinator. RN-A confirmed the progress note on 7/9/24, should have had a wound checklist completed. RN-A verified it was important to complete the wound checklist sheet to determine objectively if the pressure ulcer on the back of R38's ear was healing or worsening and if the right treatment had been implemented. During an interview on 7/24/24 at 1:15 p.m., RN-C verified the progress note on 7/9/24. RN-C stated R38 had a scabbed area to the back of his left ear and RN-C stated the scab was not a new concern. During an interview on 7/24/24 at 12:46 p.m., R38's doctor verified he was not aware of R38 having a pressure ulcer prior to last evening on 7/23/24. R38's doctor confirmed he would expect the facility to update him timely when a pressure ulcer developed and stated it was important to provide the resident with treatment, prevent infection and promote proper healing. During an interview on 7/24/24 at 1:23 p.m., the director of nursing (DON) verified she was not aware R38 had a pressure ulcer prior to last evening on 7/23/24. The DON confirmed R38's care plan lacked documentation about the development of the pressure ulcer to his left ear. The DON stated the expectation of nursing staff was for them to complete a wound checklist whenever a pressure ulcer developed, complete weekly monitoring, updating the care plan, the doctor and provide interventions. The DON verified it was important to complete the wound checklist to ensure a resident's pressure ulcer was healing and not worsening and ensure the interventions in place were effective. Review of the facility policy titled Skin Assessment, undated, identified it was the policy of the facility to complete weekly skin checks and quarterly skin assessments. Indicated it was the facility's procedure once a pressure injury was identified, that assessment and treatments, which included pressure relieving and nutritional interventions, would be implemented, care planned and monitored to promote healing. Review of the facility policy titled Documentation of Wound Treatments, undated, identified a pressure ulcer would be assessed including response to treatment, change in condition and changes in treatment. Pressure ulcers would be monitored for progression of wound healing and care plans would be reviewed and modified as appropriate.