

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Pioneer Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 200 N Oregon St Dillon, MT 59725	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35356</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure an ongoing systemic approach was utilized for managing a resident with a known history of elopement attempts, by failing to ensure the resident was evaluated timely and as needed throughout his stay, for future elopement prevention as the resident continued to attempt to elope; and the facility failed to ensure staff were made aware of the resident's risk for elopement and process utilized for residents who were an elopement risk, and resident #1 eloped, sustained an injury, and was hospitalized for monitoring, for 1 (#1) of 12 sampled residents. Findings include:</p> <p>During an interview on 8/26/24 at 11:15 a.m., staff members A and B stated resident #1 was sitting in the dining room with his wife, having his morning coffee before breakfast, at approximately 8:20 a.m. Staff noticed the resident was not at his dining room table while serving breakfast, at approximately 9:00 a.m. Staff immediately alerted other staff and started to look for resident #1. Resident #1 was not found in the courtyard outside the dining room or in the building. Facility leadership was immediately notified, and a search on foot occurred. At approximately 10:00 a.m., a staff member alerted staff member A that their car had been stolen (from facility parking lot), and the staff member had left the keys in the car. The facility staff believed resident #1 had taken the car. Resident #1 was found at approximately 10:00 p.m. The vehicle he had taken from the facility parking lot, was rolled onto the passenger side, and the resident was not wearing a seatbelt. The resident was immediately transported to the hospital with complaints of neck pain. The resident was then admitted to the hospital over the weekend to monitor elevated troponin levels (a troponin test measures the levels of troponin T or troponin I proteins in the blood). These proteins are released when the heart muscle has been damaged, such as what occurs with a heart attack. The more damage there is to the heart, the greater the amount of troponin T and I there will be in the blood) which was believed to have occurred during the wreckage of the vehicle. Staff members A and B stated the dining room door did not alarm, and staff believed resident #1 had removed his Wander guard from his walker, which resulted in the dining room door not alarming, when he left the building.</p> <p>During an interview on 8/26/24 at 11:30 a.m., staff member D stated the dining room door did not lock until 9:00 p.m. The dining room door exits into a courtyard which has a patio and gazebo, but the yard is not secured. Staff member D stated, the dining room door should alarm if a resident with a Wander guard attempts to exit the door. The door would not alarm if the resident was not wearing a Wander guard. Staff member D stated the residents who utilize the unsecured courtyard were not always supervised.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 275124	If continuation sheet Page 1 of 4

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation at 12:15 p.m., the dining room door was not locked. Upon exiting the dining room door, the egress opens onto a patio and a sidewalk which leads into an enclosed grassed courtyard with a gazebo at the center. The courtyard is enclosed with a chain-link fence. The gate off the side of the courtyard, which leads to where staff and visitors park, was not secured.</p> <p>During an observation on 8/26/24 at 1:45 p.m., a resident without a Wander guard alarm went outside through the dining room door. The door did not alarm. The resident held the door open for resident #11 so she could go outside. The Wander guard alarm sounded, and staff turned off the alarm. Resident #11 went outside and attended the garden.</p> <p>1. Failed to Ensure the Resident at Risk of Elopement was Evaluated Timely:</p> <p>A review of resident #1's nursing Progress Notes Reflected the following:</p> <ul style="list-style-type: none"> - On 8/11/24 at 6:30 p.m., Note Text: Resident witnessed to be walking out of his room screaming at his wife that they are leaving, all their clothes and belongings packed into bags stacked up onto his walker and he stated, We are leaving. This nurse walked with resident down hallways trying to redirect him back to his room, but patient refused and continued onto the common day room at 100/200 hall. He presented to the front door and re-directed to the chair in the front room. The other nurse called his son and phone was handed over to resident. - On 8/12/24 at 7:18 p.m., Note Text: Resident found 2 blocks away by another staff member Resident stated he was waiting for the Bus. Notified Resident nurse that he is outside and refusing to come back in. This elopement was not reported. A new elopement assessment was not completed after this elopement. - On 8/15/24 at 9:40 a.m., Note Text: resident is convinced he is going to leave the facility today, has been packing things out of his closet. piled up a bunch of clothes on top of his walker then tried to sit on it. he slipped off the walker and fell to floor. fall was unwitnessed. neuro checks started. increased confusion noted. [sic] - On 8/16/24 at 6:33 p.m., Note Text: resident is convinced he is going to leave the facility today. Resident has packed things out of his closet. He has piled up his clothes on top of his walker and attempted to leave his room. Resident was re-directed, clothes taken off of his walker and walked to the dining room for dinner. - On 8/16/24 at 1:14 p.m., Late Entry Note Text: Discussed with IDT about resident and his wife rooming together and the possibility of separating them because they are known to [NAME]. Followed up with resident and asked why he is wanting to leave facility. He stated he is just looking for something to do. Asked if he would like to move rooms. Resident chuckled and stated no. Will follow up with POA. - On 8/16/24 at 8:10 a.m., Late Entry Note Text: Resident is an elopement risk r/t dementia diagnosis and poor safety awareness. Wander guard issued as intervention. - On 8/17/24 at 7:10 a.m., Late Entry Note Text: Resident witnessed by this nurse to have bags on his walker and stating he was leaving the facility, resident was re-directed by this nurse back to his room, walker was unloaded in his room and resident laid back in bed. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- On 8/17/24 at 8:25 a.m., Late Entry Note Text: This nurse was passing medications to a resident in the dining room prior to breakfast. [Resident #1] was not in his regular dinning chair awaiting his breakfast tray, this nurse looked around the dining room, in the resident's room/bathroom, in the 100/200 halls and asked CNAs and other nurses if they had seen [Resident #1], everyone had denied at this time, resident is a smoker and goes to designated smoking area often, resident was not found in smoking area and back gate out of designated smoking area opened. Code Yellow called over the walkie talkie. Administration notified, and POA next of kin notified at this time. [sic]</p> <p>A review of resident #1's Social Services Behavior Notes, reflected the following:</p> <p>- Effective Date: 8/13/24 at 8:10 a.m., with a Created Date of 8/17/24 at 5:27 p.m., Resident is an elopement risk r/t [related to] dementia diagnosis and poor safety awareness. Wander guard issued as intervention.</p> <p>- Effective Date: 8/13/24 at 9:43 a.m., with a Created Date of 8/19/24 at 9:47 a.m., Resident removed wander guard from person. Resident has a sitting walker with a lift seat for storage area. Wander guard was taken and placed inside his walker to prevent further tampering. Resident does not open storage area.</p> <p>A review of resident #1's Elopement Risk Assessments showed an elopement assessment was completed on admit on 7/8/24 and a second elopement assessment was completed on 8/21/24 after the resident's second and final elopement. There was no elopement assessment completed after the resident's elopement on 8/12/24. A Wander guard was not placed on the resident until 8/13/24. Social Service documentation showed the resident continued to remove his Wanderguard bracelet. No additional interventions were implemented to prevent further tampering of the bracelet by the resident.</p> <p>A review of the resident #1's IDT notes failed to show an IDT meeting was held to review the resident's elopement on 8/12/24.</p> <p>A review of resident #1's Medication Administration Record for July and August 2024 reflected the Wanderguard was applied to the left ankle due to poor safety awareness, with a start date of 8/19/24 at 6:00 p.m. This entry was after the second elopement on 8/17/24.</p> <p>A review of resident #1's Treatment Administration Record for July and August 2024, reflected staff were to check the Wanderguard nightly for proper functioning, with a starting date of 8/20/24. This entry was after the second elopement on 8/17/24.</p> <p>A review of resident #1's KARDEX failed to show the resident was an elopement risk and failed to show he had a Wanderguard in place.</p> <p>2. Failed to Ensure Staff were Made Aware of the Resident's Risk for Elopement:</p> <p>During an interview on 8/26/24 at 11:00 p.m., staff member B stated she had implemented a form which identifies all the residents and has the term alarm next to any resident who is an elopement risk and wears a Wanderguard. She stated before the elopement of resident #1, there would be a notation on the treatment record or the Kardex for the aides.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/26/24 at 12:47 a.m., staff members F and G stated the nurses would let them know who wears a Wanderguard and was an elopement risk. She stated if they could not see the Wanderguard or were not sure if a resident was an elopement risk, she would ask the nurse or would have to log onto the computer and thought it might be on the Kardex.</p> <p>During an interview and observation on 8/26/24 at 1:00 p.m., staff member N stated she was not sure how to tell if a resident was at risk for wandering or elopement. She stated she would look for a Wanderguard and if could not see one, she might check the treatment record. Staff member N was only able to identify one of the three residents in the dining room who were elopement risks.</p> <p>During an interview on 8/26/24 at 1:15 p.m., staff member H stated they were not sure how to tell if a resident was a high risk for elopement. She stated hopefully it was shared during report. She stated she was not sure if it was on the treatment record or not but would check. She stated she was not aware of the form which identified the residents with alarms.</p> <p>A review of a facility's policy and procedure, titled Elopements and Wandering Residents, with no date, reflected:</p> <p>. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.</p> <p>4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering</p> <p>a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team.</p> <p>b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan.</p> <p>c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.</p> <p>d. Adequate supervision will be provided to help prevent accidents or elopements.</p> <p>e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly.</p> <p>f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff .</p>		