STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275124	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Care and Rehabilitation	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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 45448 Based on interview and record review, the facility failed to crush medications as ordered by the physician, for 1 (#1) of 5 sampled residents with a diagnosis of difficulty swallowing. This resulted in the resident being transferred to the emergency department and hospitalized for aspiration pneumonia. Findings include: During an interview on 12/4/24 at 2:37 p.m., staff member G said resident #1 was at risk for choking and the resident eats in the dining room. She had never witnessed resident #1 to have problems with swallowing but the resident has her food cut up into small bites. During an interview and record review on 12/5/24 at 7:50 a.m., staff member D said she was a travel nurse and had received education on medication administration and abuse by her travel company, prior to starting her 13-week contract. Staff member D said the facility provided information on each resident and their preferences, in a binder, at the nurse's station. Staff member D provided a document, labeled with the resident's name, the hall, and the room number, and how each resident takes their medications. This included the code status, primary physician name, and any notes that are specific to the resident. Review of the document showed resident #1's medication was to be given whole. Staff member D said she had not checked the specific medication order but followed the information on the document. Staff member D said resident #1 has difficulty swallowing and eats in the dining room where she could be observed. During an interview on 12/5/24 at 8:15 a.m., staff member E said she was familiar with resident #1 and her medications were administered whole, not crushed. Staff member E said she had not checked the medication order. She said she had not given resident #1 her medications crushed, and if she had crushed the medications, resident #1 would probably refuse to take them. During an interview on 12/5/24 at 10:29 a.m., staff member B said the facility did not currently have a DON, but had a clinical nurse resource filling the position until a replacement was found. Staff member B said it was her expectation that staff document any interventions offered or refused by a resident within the medical record. (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

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 12/05/2024
NAME OF PROVIDER OR SUPPLIER Pioneer Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 200 N Oregon St Dillon, MT 59725	

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/5/24 at 11:00 a.m., staff member H said on the night of 11/24/24, she had received report from the previous nurse that resident #1 had been off during the day. Later that night, she went into resident #1's room to dispense her medications, she was sleeping. Staff member H had asked resident #1 if she was wanting to go into the ED for evaluation and resident #1 refused and said she wanted her medication. Staff member H said resident #1 was awake and alert, she dispensed the medication to resident #1 in applesauce or something, and resident #1 seemed to have swallowed them without difficulty. Shortly after taking the medications, resident #1 began to cough and became unresponsive. Staff member H then tried to take out as many pills as she could get out of resident #1's mouth but was aware she had not gotten all the pills out. Staff member H said after attempting to contact the physician and the resident's daughter, without success, she contacted emergency medical services. Resident #1 had remained unresponsive. Staff member H said she was aware resident #1 had a history of difficulty swallowing and had been noted to choke on day shift. She had not seen the resident choke before this incident. Staff member H said she had listened to resident #1's lungs after her coughing episode, and the lungs sounded terrible (not clear). Staff member H said she was not aware of resident #1 had an order to crush her medication. She said resident #1 was not compliant with pureed food, so she did not think resident #1 would be compliant with crushed medication. She had never attempted to give her crushed medications. During an interview on 12/5/24 at 11:54 a.m., staff member J said resident #1 was very independent. Staff member J said resident #1 would not take her medication crushed. When asked if staff member J had documented resident #1's refusal of crushed medication, staff member J smiled and shrugged her shoulders, she did not provide and answer. During and interview on 12/5/24 at 12:09 p.m., staff member I said resident #1 was at the assistive table, she requires assistance at every meal. Staff member I said she had witnessed resident #1 choking on liquids, but the resident was able to clear her lungs. Staff member I said she had not seen an incident where she believed resident #1 had aspirated. Staff member I said she had not received a report of resident #1 had any difficulty with swallowing food or pills. Record review of resident #1's electronic medical record health status note, dated 11/25/24 at 1:31 a.m., showed: Resident coughed after pills were taken, LPN got out any pills that were visible in mouth at the time. Resident then became lethargic and not responsive. Review of a facility document, Order Recap Report, dated 1/1/24 through 12/31/24, showed resident #1 had airway clearance therapy ordered as needed and three times a day for increased secretions, order date 10/1/24 and an end date of 11/24/24; May crush all crushable medications and open capsules until contraindicated, order date 7/29/24 and an end date of 11/24/24. 11/24/24 was the date resident #1 was admitted to the hospital for aspiration pneumonia. Review of resident #1's care plan, with a print date of 12/4/24, showed a diagnosis of Dysphagia, oropharyngeal phase, and pneumonia due to other specified infectious organisms. Review of a facility Emergency Provider Note, dated 11/25/24, showed: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	. presents to the ED for evaluation of hypoxia and altered mental status.patient is nonverbal at time of initial assessment.per facility report she has been not herself for 2 days, but claimed she was awake when they gave her her nightly meds . . On EMS arrival patient was on her baseline nasal cannula at 5 L through a concentrator, satting 82% . On presentation to the ED she will blink her eyes on command but is not responding verbally and has very weak attempts at motor responses to verbal stimuli. . RT at bedside, managing high flow and administering DuoNeb treatments, was performing oropharyngeal suctioning and continues to get chunks of partially dissolved pills and possibly food from pt's oropharynx after she coughs . [sic] Review of a facility H&P, dated 11/25/24, showed: . A/P: 1. Severe sepsis 2. Acute on chronic respiratory failure, hypoxia 3. Aspiration PNA . -Food and pill material evident in ED with suctioning - CXR with B/L PNA findings .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45448 Based on observation, interview, and record review, the facility failed to ensure a staff member adhered to proper infection control procedures while assisting a resident with drink service, for 1 (#4) of 5 sampled residents. This deficient practice had the potential to spread infectious pathogens between residents. Findings include: During an observation and interview on 12/4/24 at 12:01 p.m., a resident was observed removing ice with a spoon from her drinking container. The resident was placing ice cubes into a cup full of coffee. Staff member C was observed to be assisting the resident with removing the ice and placing it into the clear coffee cup. The lid on the coffee cup was replaced by staff member C, and the coffee cup was handed to another resident, resident #4. Staff member C stated she had not realized she had cross contaminated the coffee for resident #4. During an interview on 12/4/24 at 2:37 p.m., staff member G stated she performed weekly audits with staff during the serving of meals. Staff member G said it was not acceptable practice to assist residents with the sharing of ice cubes. She had not seen this occur while doing her weekly audits. Review of a facility policy, Food Safety Requirements, not dated, showed: . 5. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination .