

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 12/31/2025
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 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>Based on interview and record review, the facility failed to provide necessary services and supervision to prevent a resident with dementia from continuing to enter other residents' rooms after an altercation with injury. The failure increased the risk for emotional distress and physical injury for 1 (#3) of 8 sampled residents and placed other residents at elevated risk for physical or verbal altercations. Findings include: Review of a facility-reported event, submitted to the State Survey Agency on 11/14/25, showed resident #3 entered resident #4's room and a physical altercation occurred when resident #4 attempted to redirect resident #3 out of the room. Resident #4 sustained minor injuries. During an interview on 12/30/25 at 1:22 p.m., staff member C stated resident #3 had been known to wander into other residents' rooms since he arrived at the facility. Staff member C stated resident #3 would not remember where his room was and would think another resident was in his room. Staff member C stated resident #3's room was now part of the new secured memory care wing which was opened on 12/22/25. During an interview on 12/30/25 at 2:18 p.m., staff member B stated resident #3 was placed on 1-to-1 observation from 11/15/25 to 12/1/25 and on fifteen-minute checks from 12/1/25 to 12/22/25 when his wing was converted to a secured unit. During an interview on 12/31/25 at 9:38 a.m., staff member D stated resident #3 does continue to wander into other rooms since being in the secured unit, but had not had any other conflicts that I know of. Staff member D stated the staff usually can redirect him out of other residents' rooms. Review of resident #3's nursing progress note, dated 12/3/25, showed, Resident was attempting to enter other resident's rooms but, was redirected by staff. He was aggressive. [sic] Review of resident #3's nursing progress note, dated 12/12/25, showed, Resident wandering at 6 am, up and down halls, went in to another residents room and sat in his w/c, he got up and resident returned and shut his door to keep him out and he was banging on the door. As he walked away he said 'I should kick his Ass'. Very aggressive this am. [sic] Review of an SBAR note, dated 12/21/25, showed, Resident (#3) wandering in and out of other residents' rooms. [sic] Review of resident #3's nursing progress note, dated 12/28/25, showed, (Resident #3) was wandering in and out of other Residents rooms. He was taking their personal items etc. He picked a glass vase and I tried to get it from him and staff assisted me in getting the glass vase from him. Staff redirected him to his room to eat his dinner when he picked up his plate and took it to (room number) and dumped his food down the toilet. He began to dump other items like deodorant and toothbrushes down the toilet. Staff had to intervene and assisted him to his room. [sic] Review of a facility policy titled Dementia Care, dated 2025, showed, It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, psychological well-being. Resident #3 continued to wander into other residents' rooms while on fifteen-minute checks and while residing on the secured memory care unit. The facility failed to consistently ensure the resident had adequate supervision as to prevent the resident from entering other resident rooms, placing resident #3 and other residents at risk for verbal or physical altercations.</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
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