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	06/04/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain potentially hazardous foods at safe temperatures during holding and distribution for residents receiving meals prepared by the facility's kitchen. The failure increased the risk of foodborne illness for all residents receiving food from the kitchen. Findings include:During observations of breakfast and lunch meal service, for trays being taken to resident rooms, on 6/2/26 and 6/3/26, it was noted that meal trays were not transported in insulated dietary carts to keep meals warm. The trays were either carried from the kitchen to the residents' rooms or were placed on an uninsulated open metal cart and then delivered to the rooms. Each cart contained three to four meal trays. On each tray, the plates were covered with reusable insulated plastic covers. No insulated bottom covers or warming bases were used. Several plate covers on resident meal trays were observed to be poorly seated on the plates, resulting in air gaps between the plate and cover.During an observation on 6/2/26 at 8:20 a.m., a breakfast tray delivered to the dining room was observed. A waffle from the tray was temperature tested at the surveyor's request, and the temperature reading was 78 degrees Fahrenheit.During meal tray preparation observations on 6/2/26 from 8:22 a.m. through 8:44 a.m., the tray line steam table was observed to have and hold waffles, sausage, bacon, toast, and Cream-of-Wheat cereal. At no time during the observation were lids present on the steam table pans covering the foods, while staff members E and F prepared resident meal trays. At 8:24 a.m., staff member F removed the toast from the steam table and placed it on a plate. The toast on the plate was not covered until 8:35 a.m., which was 11 minutes after being removed from the heated steam table. At 8:38 a.m., a sausage patty removed from the steam table was temperature tested at the surveyor's request, and the temperature was 108 degrees Fahrenheit. After temperature testing, the steam table trays were still not covered with lids, although the food was not being held at safe temperatures. During an interview on 6/2/26 at 8:41 a.m., staff member F stated she did not know what the food holding temperature should be for the steam table, and she did not routinely monitor holding temperatures within the steam table.During an interview on 6/2/26 at 8:45 a.m., staff member D stated all dietary staff had received ServSafe food service training approximately two years ago and were due for a refresher course this year. Staff member D stated the facility had an insulated cart for transferring food; however, the trays did not fit well with the insulated lids. Therefore, the staff chose to use the standard metal cart to deliver meals to the rooms. This process did not allow for the meals to be maintained at safe temperatures.During an interview on 6/3/26 at 10:48 a.m., staff member D stated the dietary staff had not been routinely temperature-checking foods held in the steam table or foods served on resident trays. Staff member D stated hot foods should be maintained at safe temperatures from cooking through meal delivery, and that foods on the steam table were intended to remain hot while resident trays were prepared and served.Review of a facility document titled Record of Food Temperatures, revised 1/15/26, showed: . 2. Hot foods will be held at 135 degrees Fahrenheit or greater. 5. Food containers will be kept covered to retain heat and prevent environmental contaminants from entering food.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275124	A. Building B. Wing	06/04/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to establish and communicate an effective process for submitting anonymous grievances for 2 (#s 13 and 27) of 34 sampled and supplemental residents. The failure impeded residents' ability to exercise their right to voice grievances by failing to communicate how and where anonymous grievances could be submitted. Findings include:During an observation on 6/3/26 at 4:02 p.m., the Social Services office was observed. The office had no identifying signage showing it was the Social Services office, and no grievance forms or grievance drop box were located outside the office for resident use.During an observation on 6/4/26 at 7:54 a.m., a wall-mounted file basket containing new grievance forms and an informational grievance poster was observed on the wall across from the nursing station. The instructions directed residents, guests, and employees to place a completed grievance form in the Social Services box, but did not identify the location of the Social Services box or explain how residents could submit grievances anonymously.During an interview on 6/4/26 at 7:58 a.m., resident #27 stated she did not know how to file a grievance anonymously and stated she would submit her grievances to someone in upper management.During an observation and interview on 6/4/26 at 8:00 a.m., staff member C stated residents could place anonymous grievances in a locked box near the nursing station and pointed to two gray, unmarked boxes mounted on the wall. Staff member C stated he was aware there was no identification outside the Social Services office, and the facility was ordering signage for the office.During an interview on 6/4/26 at 8:05 a.m., staff member B stated she reviewed the grievance policy with newly admitted residents, and then quarterly thereafter, so residents would know where to submit grievances. When asked how residents would know to place anonymous grievances in the two unmarked boxes near the nursing station, staff member B stated, Good point, we can put some signs up by the boxes.During an interview on 6/4/26 at 8:08 a.m., staff member M stated the two gray, unmarked boxes near the nurse's station were used for nothing.During an interview on 6/4/26 at 8:39 a.m., resident #13 stated he did not know how to file a grievance anonymously.Review of the facility policy titled Grievance Policy, dated 1/15/26, showed grievances could be submitted anonymously; however, the policy did not describe the process for submitting an anonymous grievance.

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	06/04/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record review, the facility failed to ensure beds and belongings were kept a safe distance away from baseboard heaters, and the facility staff were informed of the risk the heaters posed due to fire/injury, for 7 (#s 8, 28, 39, 55, 60, 64, and 71) of 7 resident rooms sampled for heater hazards. Findings include:During an observation on 6/1/26 at 1:25 p.m., resident #64 was in his bed. His bed was against the wall and baseboard heater unit. A four-wheel walker was folded and sitting against the baseboard heater unit with clothing hanging off of it. During an observation on 6/1/26 at 1:28 p.m., resident #60's bed was against the baseboard heater unit. During an observation on 6/1/26 at 1:29 p.m., resident #71's bed was against the baseboard heater unit. During an observation on 6/1/26 at 1:30 p.m., resident #39's bed was against the baseboard heater unit. During an observation and interview on 6/2/26 at 4:25 p.m., staff member O stated the beds should be at least four inches away from the baseboard heater units. Staff member O stated half the building was water baseboard heaters, and the other half of the building was electric baseboard heaters. Staff member O stated it was more important the beds and personal items be away from the electric baseboard heaters because they get much hotter. Staff member O stated the Fire Department had warned the facility about the beds and personal items touching the heaters was a fire hazard. The following temperatures were found during a walk-thru with staff member O, using the facility's temperature gun. Staff member O stated the temperature gun readings were accurate: - Resident #8's room had the cover of the water baseboard heater falling off, with curtains and bed against the heater. The temperature of the heater unit was 82 degrees Fahrenheit. - Resident #55's room had the bed and dresser against the electric baseboard heater. The temperature of the heater unit was 98 degrees Fahrenheit. - Resident #28's room had the dresser and cords against the electric baseboard heater. The temperature of the heater unit was 100 degrees Fahrenheit. During an interview on 6/2/26 at 4:45 p.m., staff member P stated she did not know of any requirements for beds and belongings to be kept away from the heaters in the resident's rooms. Review of the facility's policy, HVAC system, no date, showed: 2a. All furniture and resident belongings ensured to be kept at least 4 inches from any fixed room heating units.

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	06/04/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to ensure proper hand hygiene when moving between wounds during cares for 1 (#8); failed to ensure hand hygiene was performed during meal service for 2 (#14 and 54); failed to ensure linens were handled to prevent contamination between clean linens and dirty linens for 1 (#8); failed to use clean dishes during meal service for 1 (#2); and failed to clean equipment after use with resident for 1(#8) of 34 sampled and supplemental residents. These deficient practices placed residents at risk for the spread of infections. Findings include:During an observation on 6/2/26 at 8:10 a.m., staff member G was serving breakfast drinks to residents in the memory unit. Staff member G removed a coffee cup from the cupboard and started scratching a crusted substance off the side and top edge of the coffee cup. Staff member G then poured coffee into the cup and served resident #2 the coffee. During an observation on 6/2/26 at 8:18 a.m., staff member H was repeatedly touching and adjusting her hair while setting up resident trays, serving the trays, and then starting the setup of the next tray without hand hygiene being performed. Staff member H then cut up resident #54's waffles and took the bacon off her plate, handing it to her. Staff member H then placed her hands in her pockets and stood next to the table. Staff member H noticed a resident did not have a tray and went to the cart and grabbed her tray. Staff member H then set up the tray for resident #14 after her hands were in her pockets and hand hygiene was not performed. During an observation on 6/2/26 at 12:33 p.m., staff member J went to resident #8's room to complete a brief change. Resident #8 was lying in bed on a draw sheet and a bed pad. No sheets covering the mattress were on the bed. Resident #8 had a large bowel movement in the bed. Staff member J pulled a pillow out from under the resident's legs, which had fecal matter on it, and placed it at the top of the mattress. The mattress had fecal matter present. Staff member J removed the soiled pad and draw sheet, placing a new pad under resident #8. Staff member J then cleansed resident #8 further to remove all fecal matter. Resident #8 stated he wanted a shower. Staff member J stated he could shower. Staff member L entered the room with linens for the bed and stood over the bedding covered in fecal matter, which was at the end of the bed. Staff member L allowed the clean linens to come into contact with the dirty linens and placed them on the wheelchair at the end of the bed. A new pillow was placed on the trash can. The peri-wipes staff member J had on the bed while cleaning the fecal matter from resident #8 was placed on the pile of clean linens at the foot of the bed. Staff member J noticed the fecal matter on the pillow and wiped it off with a cleansing wipe, leaving some fecal matter still on the pillow. The pillow was then placed on the pile of clean linens with the wipe's container. Staff member J then placed the Hoyer sling under resident #8. Resident #8 was lifted using the mechanical lift and moved to the shower chair. The Hoyer lift was then lowered, and resident #8's sling was removed from the Hoyer and placed in the hallway. Resident #8 was taken to the shower. Staff member H began remaking resident #8's bed. Staff member H took the pillow with fecal matter on it, placed a pillowcase on the pillow, covering the fecal matter, and put it on the bed. Staff member H picked up an open box of Kleenex from the floor, placed it on the bedside table, and left the room. The Hoyer lift remained in the hallway, uncleaned. Staff members J, L, and H failed to keep clean linens from coming in contact with dirty items and items with fecal matter on them, and failed to maintain a clean environment related to infection control hazards. During an observation on 6/2/26 at 2:08 p.m., staff member L was assessing resident #8's wounds after his shower. Staff member L moved from resident #8's left buttock wound to his left ankle, to his left knee wound, touching and cleansing each wound. Staff member L did not remove the soiled gloves and perform hand hygiene between the care of the wounds, potentially cross contaminating the wounds. During an interview on 6/3/26 at 11:22 a.m., staff member B stated the CNAs should have communicated with each other in an attempt to prevent the cross-contamination of linens during resident #8's toileting and ADL care, and the bed's linen change. Staff member B stated the linens were changed after this surveyor reported the observation of the soiled linens being placed on the bed (continued on next page)

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	06/04/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of resident #8. Staff member B stated that staff should practice hand hygiene after touching hair when serving food. Review of the facility's policy, Infection Prevention and Control Program, no date, showed: . 12. Linens: b. Clean linen shall be separated from soiled linen at all times. Review of the facility policy, Clean Dressing Change, dated 1/15/26, showed: . 3. Each wound will be treated individually.

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	06/04/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record review, the facility failed to ensure showers and grooming were provided for 1 (#71) of 34 sampled and supplemental residents. This deficient practice resulted in resident #71 not being offered a shower or grooming seven times during the month of May 2026, placing resident #71 at risk of infections and compromised the resident's right to maintain personal hygiene and dignity. Findings include:During an observation and interview on 6/1/26 at 2:44 p.m., resident #71 was in his bed, resting. Resident #71 was disheveled with greasy, messy hair, an unkept beard with food in it, and a strong body odor. Resident #71 stated he did not get his two showers a week, as scheduled. Resident #71 stated he refused once when the staff came while he was sleeping, and the staff did not offer an alternate shower time. Resident #71 stated he had not been offered shaving, so his brother would shave him when he came to visit. Resident #71 stated he had requested the staff trim his nails, but no one had. Resident #71's nails were longer than 1/4 inch and yellow and brown in color, with dirt under his nails. During an interview on 6/3/26 at 11:37 a.m., staff member B stated someone changed the schedule in the computer or the shower sheet and should not have. Staff member B stated the change caused resident #71 to miss his showers over the past month. Staff member B stated records indicated resident #71 refused one shower, and one shower was given from May 6th to May 31st, 2026. Review of the facility's policy, Resident Showers, dated 1/15/26, showed: - . 1. Residents will be provided showers/bed bath as per request or as facility schedule (2 times a week) or protocols and based upon resident safety or requests.

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	06/04/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure a PASARR Level I was completed for 1 (#3) of 34 sampled and supplemental residents. This deficient practice resulted in resident #3 not receiving potentially needed mental health services. Findings include: Review of resident #3's PASARR Level I showed that resident #3 was approved for a 29-day convalescent stay. The approval letter rationale included that the approval was supposed to expire 29 days after admission. After the 29 days, a new Level 1 would need to be completed and submitted for resident #3 if the resident remained in the building. During an interview on 6/3/26 at 4:36 p.m., staff member B stated the facility failed to complete the follow-up PASARR and was going to complete one. Staff member B stated the lines (understanding of the process) were unclear on whose duty it was to follow up on the Level screenings. Review of the facility's policy, Resident Assessment-Coordination with PASARR Program, no date, showed: . 5. If a resident who was not screened due to an exception above and resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate designated authority for Level II PASARR evaluation and determination. [sic]

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	06/04/2026

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interviews and record review, the facility failed to ensure all physician orders were signed and dated for 1 (#29) of 34 sampled and supplemental residents. This deficient practice placed residents at risk of medication errors. Findings include:Review of resident #29's Psychiatry Follow-up Visit, dated 4/27/26, showed resident #29's risperidone medication was discontinued after a gradual dose reduction was completed, and the resident did not display aggression in the last three weeks. Review of resident #29's EHR medication list, dated 6/3/26, showed resident #29 was actively receiving risperidone 0.125 mg beginning 3/7/26. During an interview on 6/3/26 at 4:42 p.m., staff member B stated the Psychiatric Nurse Practitioner emailed her verbal orders and she could not find an order to discontinue the risperidone for resident #29. Staff member B stated she has been trying to get the Psychiatric Nurse Practitioner to comply with proper ordering of the medication process for a while now. Staff member B stated that the Psychiatric Nurse Practitioner emailed notes to the nurses, and the nurse transcribed them into orders. Staff member B stated the Psychiatric Nurse Practitioner was not following ordering protocols, and when she brought this up to her, the Psychiatric Nurse Practitioner removed staff member B from the emails and continued to email the other nurses. Staff member B stated she was not aware that the Psychiatric Nurse Practitioner was still emailing the nurses and was now going to get the Medical Director involved to work toward having the Psychiatric Nurse Practitioner follow compliance requirements. The Psychiatric Nurse Practitioner was not available for an interview due to vacation. Review of the facility's policy, Consulting Physician/Practitioner Orders, not dated, showed instructions reflecting that physician orders could be received in writing, via fax, or via telephone. The policy did not include receiving orders by email for controlled substances.