

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Benefis Senior Services - Eastview		STREET ADDRESS, CITY, STATE, ZIP CODE 2621 15th Ave S Great Falls, MT 59405	

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 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>50245</p> <p>Based on interview and record review, the facility failed to identify, address, and obtain necessary services for the behavioral health care needs; failed to develop and implement person-centered care plans that included and supported the behavioral health care needs; and develop individualized interventions related to the resident's diagnosed conditions, for 2 (#s 13 and 71) of 5 sampled residents. Findings include:</p> <p>Review of a Facility Reported Event, initially reported 9/30/24, showed:</p> <p>Resident #13 was in an altercation with resident #71. In this altercation, both resident #71 and resident #13 had hit one another. The reported findings showed the residents were initially friends, and resident #71 would follow resident #13 around, but due to resident #71's developmental delay, resident #13 lost patience with resident #71, and acted out against him.</p> <p>Review of the PASARR Level 1, dated 11/13/23, showed an updated PASARR Level 1 was not completed for resident #71, after his convalescent stay. Resident #71 had previously had a PASARR Level 2 completed on a previous stay due to the diagnoses: Microencephaly and History of Developmental Delay.</p> <p>Review of resident #71's Care Plan, with a start date of 2/19/24, showed no updates or new interventions were made concerning altercations with residents, redirection after a physical interaction with another resident occurred (specifically resident #13), or interventions specific to resident #71's diagnoses.</p> <p>Review of resident #71's EHR showed no notes from social services or behavioral health services.</p> <p>During an interview on 10/8/24 at 4:09 p.m., resident #71 stated the residents did have an altercation, but resident #71 stated he felt safe in the facility and around resident #13. Resident #71 stated resident #13 was disruptive to him at times, but overall he did not have a problem with her other than the one to one interaction where she started hitting him.</p> <p>During an interview on 10/9/24 at 8:29 a.m., NF2 stated the facility does not communicate with her very well or often enough about events that occur with resident #71. NF2 stated, Any time they do have an issue, they get defensive. I leave feeling like I brought it up, so I am the one at fault, and this has even gone up to the [upper management].</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
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #13's EHR showed the following diagnoses: bipolar disorder, neurocognitive deficit, post-traumatic stress disorder (PTSD), schizophrenia, depression, anxiety and a history of a traumatic brain injury (TBI).</p> <p>Review of resident #13's Care Plan, with a start date of 2/10/24, showed no updates or new interventions were made concerning altercations with residents or redirection after an interaction with another resident occurred (specifically resident #71). Resident #13's Care Plan showed: . [Resident #13] will have her psychosocial needs met as needed. Social services will follow up with resident #13 as needed .</p> <p>During an interview on 10/9/24 at 2:05 p.m., staff member A stated resident #71 and resident #13 were not being followed by social services or behavioral health services.</p> <p>A phone call and message was made on 10/9/24 at 1:29 p.m. to staff member H, social services, but no return phone call was received by the end of the survey.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>50245</p> <p>Based on observation, interview, and record review, the facility failed to individualize interventions for the dementia residents residing in the memory care unit; failed to assess the efficacy of the wanderguard intervention placed on each resident after an elopement; and failed to follow protocol when obtaining the verbal consent for the wanderguards for 3 (#s 7, 110, and 400) of 3 residents sampled for elopement concerns. Findings include:</p> <p>Review of two Facility Reported Events, initially reported on 8/29/24 and 9/2/24, showed:</p> <ul style="list-style-type: none"> - Resident #110 eloped from the facility on 8/29/24 by following an environmental services staff member out of the memory care locked unit, and was found on the facility campus. - Review of the Facility Reported Event, dated 9/2/24, showed resident #400, who resided on the dementia unit, eloped from the facility by following a staff member out of the activity room, and staff were not watching the activity room door to ensure the dementia resident was safe, when she attended an activity off the secured dementia unit. <p>1. During an observation on 10/7/24 at 3:26 p.m., resident #7 was pleasantly confused in the memory care unit and was noted to have a wanderguard to her left ankle.</p> <p>During an interview on 10/8/24 at 3:00 p.m., NF1 stated they were not notified of the wanderguard placement on resident #7. NF1 stated they did not recall giving verbal consent for the wanderguard to be placed, and NF1.</p> <p>Review of resident #7's wanderguard consent showed NF1 verbally acknowledged the signature of this document on 9/3/24. This consent was physically signed by one staff member, staff member G. This consent was not signed by a second witness, as shown as a requirement of the facility policy, Informed Consent.</p> <p>Review of a facility provided document titled Informed Consent, not dated, showed:</p> <p>Procedure/Responsibility:</p> <p>II. Nurse or Respective Department Personnel .</p> <p>B. Witnesses the patient's or the next of kin/legal representative's signature. The witnessing of consent is solely to verify the consenter's signature .</p> <p>2. In the event the patient is unable to give consent and the legal representative/next of kin is not immediately available, consent may be received by phone with a second witness verifying their agreement .</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During an interview on 10/8/24 at 3:28 p.m., NF3 stated resident #110 was creative in his attempts to elope from any facility. NF3 stated, If they had that guard on why did he get out .No one could answer me that one. NF3 stated if he did not have the wanderguard on, He'll (resident #110) be gone in a flash. NF3 stated resident #110 had dementia, and NF3 would be very concerned for his safety if he were to be outside without supervision. NF3 stated they did not recall signing a wanderguard consent for resident #110's wanderguard.</p> <p>Review of a resident #110's wanderguard consent showed: NF3 verbally signed this document on 9/3/24. This consent was physically signed by one staff member, but was not signed by a second witness as shown as a requirement of the facility policy, Informed Consent.</p> <p>3. During an interview on 10/8/24 at 12:10 p.m., staff member G stated, It's an issue, when asked about resident #110's elopement. Staff member G stated resident #110 had dementia and paranoia about wearing the wanderguard as he felt the wanderguard tracked his location. They stated nursing staff had convinced resident #110 that the wanderguard was a heart monitor and to keep it close to his heart. Staff member G stated the wanderguard was consistently in resident #110's shirt pocket. Staff member G stated if the wanderguard was on him anywhere it would work, and the doors would lock appropriately to prevent him from eloping. Staff member G stated the facility had not completed a wanderguard assessment and they did not have a schedule for checking that the wanderguards were working. Staff member G stated the residents were in and out of the memory care unit often enough for appointments and activities (located in the main part of the facility) that they felt this was sufficient for checking the status of the wanderguards for all the residents wearing them.</p> <p>During an interview and observation on 10/8/24 at 4:26 p.m., resident #110 laughed and showed the surveyor his wanderguard was located in his sock drawer. Resident #110 stated he had taken it off with a nail file.</p> <p>4. During an interview on 10/8/24 at 11:15 a.m., staff member A stated resident #400 eloped from the facility after following another staff member out of the activity room. The activity room was not located in the memory care unit.</p> <p>During an interview on 10/8/24 at 12:10 p.m., staff member G stated resident #400's wanderguard was placed on her wheelchair. Staff member G stated resident #400 was not an elopement risk because the resident did not exhibit signs of eloping. Staff member G stated she believed resident #400 had gotten confused and staff should have been monitoring her closer which led to the Facility Reported Incident on 9/2/24.</p> <p>Review of a resident #400's wanderguard consent showed a verbal signature by NF4 on 9/3/24. This consent was physically signed by one staff member, staff member G. This consent was not signed by a second witness as shown as a requirement of the facility policy, Informed Consent.</p> <p>5. During an interview on 10/8/24 at 11:15 a.m., staff member A stated all residents who were deemed mobile in the memory care unit had a wanderguard placed to prevent elopements from the facility. Staff member A stated wander assessments were not completed prior to the placement of the 15 wanderguards on 9/3/24. Staff member B stated the facility did complete wander frequency assessments, but had not started wanderguard assessments yet due to an update in their computer system in March.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/8/24 at 11:56 a.m., staff member F stated staff would not check the wanderguards daily and would not chart the placement of the wanderguard. Staff member F stated not really when they had been asked if education was given about dementia residents and wanderguards.</p> <p>During an interview on 10/9/24 at 9:37 a.m., staff member E stated a resident was deemed mobile when they were able to ambulate independently, ambulate with an assisted device, wheelchair or a motorized chair.</p> <p>During an interview on 10/9/24 at 10:17 a.m., staff member B stated the facility should have double verified the 15 wanderguard consents that were all verbally signed on 9/3/24 and should start implementing daily documentation for the wanderguards to ensure efficacy and safety to the residents wearing them.</p>		