STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275012	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Eastview	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48261 Based on observation, interviews, and record review, the facility failed to ensure ADL cares were provided timely for 3 (#s 3, 4, and 5) of 7 sampled residents. This deficient practice had the potential to increase resident's risk for infections, skin breakdown, pain, and overall decline. Findings include: 1. During an observation and interview on 12/30/24 at 9:42 a.m., resident #5 was in bed waiting to get up and stated her back was hurting from lying in bed too long. Resident #5 stated the facility did not have enough help. Resident #5 stated she regularly had to wait in bed for a long time to have someone help her up. Resident #5 stated the CNAs came in the room earlier, turned her call light off, and stated they would be back as soon as they could. A staff member entered the room to assist resident #5 out of bed and getting her dressed at 10:37 a.m. Review of resident #5's Care Plan, dated 12/30/24, reflected: - . [Resident #5] transfer with a Hoyer lift. [Resident #5] ambulates at w/c level. [Resident #5] needs assistance with ADLs as needed . [sic] - . [Resident #5] is incontinent of bladder . 2. During an observation and interview on 12/30/24 at 9:51 a.m., resident #3 was in bed and stated he was waiting for staff to get him up for the day. Resident #3 stated his preferred, . get up time is 6:30 a.m., and lately they (CNAs) were really late getting me up, even as late as 11:00 a.m. During an observation and interview on 12/31/24 at 9:44 a.m., resident #3 was in bed and stated he was waiting for staff to get him up. Review of resident #3's Care Plan, dated 12/30/24, reflected: - . [Resident #3] transfers with the [NAME] 3000 lift. He occasionally uses PWC for mobility. He needs extensive to total assist with ADLs . Review of a facility provided document, [NAME] Active Wounds, dated 12/30/24, reflected resident #3 had moisture associated skin breakdown on his right buttock. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/31/24 at 8:45 a.m., staff member F stated resident #3 had a chronic pressure ulcer and moisture skin breakdown. Staff member F stated, . Not getting him up can effect the healing process (of the ulcer). 3. During an interview on 12/30/24 at 9:55 a.m., resident #4 stated, They (facility) are short-staffed, so they try to get to me. Friday night I waited an hour to toilet. I wet my brief waiting. I just got my first shower yesterday since I first went to the hospital. It felt really good. I had not been offered one until Saturday, but I had family visiting, so I didn't take it, but then they gave me one on Sunday. Review of resident #4's EHR reflected resident #4 admitted on [DATE]. The EHR reflected resident #4 had showers on 12/12/24, 12/17/24, and 12/24/24. No charting was present for the shower refused on 12/28/24, due to family visit, and no charting was present for the shower the resident stated she received on 12/29/24. Resident #4 was scheduled to have showers on Sunday and Wednesday. During an interview on 12/30/24 at 10:17 a.m., staff member L stated the facility was commonly short-handed. Staff member L stated the staffing issues caused showers to not get done, trouble getting people up in the mornings, and getting people up before they have an incontinence episode was common. During an interview on 12/30/24 at 10:25 a.m., staff member I stated there were two CNAs with sixteen patients each. Staff member I stated the math (staffing ratio) didn't allow for CNAs to complete the ADL cares timely. Staff member I stated, They only give us 1.5 hours to get everyone up and ready for breakfast. So, things don't always get done. They're not getting to incontinent care in time, or making sure clean-up (after incontinence occurs) is properly done. We just don't have the staff to care for these people. Staff member I stated showers were not offered a second time when a resident refused one. Staff member I stated, We can't get what we have done now, so we cannot be going back and offering (the care)again, if they can't shower when we are ready for them, there's just no time. During an interview on 12/30/24 at 4:51 p.m., with staff member A and B, staff member B stated, We will definitely be working to address the call lights. It is a focus, and they are better, but we have to keep working on them (response times). During an interview on 12/31/24 at 7:51 a.m., staff member J stated care was neglected due to the low staffing levels. Staff member J stated some cares were being skipped and others done very late because the CNAs did not have the time to complete the required tasks, including during the night shift. Staff member J stated she came in Sunday morning and had to complete six bed changes, due to residents not being checked and changed (incontinence care), during rounding. Staff member J stated it took her until 11:00 a.m. to get everyone on her hall up, yesterday. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/31/24 at 8:17 a.m., staff member M stated, Two CNAs is rough. By the time you get half up, it's lunch. Many are not getting up when they want to because we don't have enough help to do it. Staff member M stated, The CNAs have 15-16 residents each, and with each resident taking 15-20 minutes to get them up and dressed for the day, the math (staffing ratio) just does not add up. That's not including the residents who need help with feeding at meals, call lights going off, and the showers we have to get done every day. Some (residents) aren't getting turned, skin breakdown on some . Staff member M stated one resident had a rash under her [NAME] due to staff not cleaning her her properly and another resident had a red, swollen penis from poor catheter care. Staff member M stated people are in such a hurry because they did not have time to do ADL tasks properly. During an interview on 12/31/24 at 12:20 p.m., with staff member A and B, staff member B stated the data for showers appeared to be errors, with some showers likely not charted and some charted on the wrong person or in error. Staff member A stated the managers watch showers pretty closely, so she felt the charting of cares were an area the facility needed to work on. Staff member A stated the staff should be offering a shower at a later time, if the resident is unable to take the shower, due to family, activities, etc. Review of a facility policy, BSS-Activities of Daily Living/Needs and Choices, last reviewed 7/2024, reflected: - III. Nursing ensures assistance with ADL is provided as directed in the care plan or as needed .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48261 Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to ensure residents call lights were answered in a timely manner and to address their safety and care needs timely for 4 (#s 1, 3, 4, 5) of 7 sampled residents. This deficient practice had the potential to result in residents not having their needs met. Findings include: 1. During an observation and interview on 12/30/24 at 9:42 a.m., resident #5 was in bed waiting to get up and stated her back was hurting from lying in bed too long. Resident #5 stated the facility did not have enough help. Resident #5 stated she regularly had to wait in bed for a long time to have someone help her up. Resident #5 stated the CNAs came in the room earlier and turned her call light off and stated they would be back as soon as they could. A staff member entered the room to assist resident #5 out of bed and getting her dressed at 10:37 a.m. 2. During an observation and interview on 12/30/24 at 9:51 a.m., resident #3 was in bed and stated he was waiting for staff to get him up for the day. Resident #3 stated the facility did not have enough staff. Resident #3 stated his preferred, .get up time is 6:30 a.m., and lately they (CNAs) were really late getting him up, even as late as 11:00 a.m. During an observation and interview on 12/31/24 at 9:44 a.m., resident #3 was in bed and stated he was waiting for staff to get him up. 3. During an interview on 12/30/24 at 9:55 a.m., resident #4 stated, They (facility) are short-staffed, so they try to get to me. Friday night I waited an hour to toilet. I wet my brief waiting. Review of the facility's, Call History, dated 12/11/24 - 12/30/24, for resident #4's room, reflected: - 26 call lights that were on for 20 minutes or more, - Of the 26 call lights, two were over 50 minutes, four were over 40 minutes, and six were over 30 minutes. 4. During an interview on 12/31/24 at 10:04 a.m., staff member J stated she was still trying to get her residents up for the day. Staff member J stated she still had resident #1 to get up, but she was cognitively impaired, required a Hoyer lift, and she yelled during cares. Staff member J stated she would have to find another CNA to assist her when they were available and done with their residents. During an interview on 12/30/24 at 10:17 a.m., staff member L stated the facility was commonly short-handed. Staff member L stated the staffing issues caused showers to not get done, trouble getting people up in the mornings, and getting people up before they have an incontinence episode was common. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/30/24 at 10:25 a.m., staff member I stated she only had two CNAs with sixteen patients each. Staff member I stated the math didn't allow for CNAs to complete the ADL cares timely. Staff member I stated, They only give us an hour and a half to get everyone up and ready for breakfast. So, things don't always get done, they're not getting to incontinent care in time, or making sure clean-up (after incontinence occurs) is properly done, we just don't have the staff to care for these people. During an interview on 12/30/24 at 2:09 p.m., staff member A stated the policy for call light times was 15 minutes or less. Staff member A stated the facility was working on call light times and determining the five longest call lights and the five residents with the most call lights to determine a root cause for the call light times. Staff member A stated staff member C was responsible for looking at the call light reports and determining the root causes and reporting to him weekly. Staff member A stated some long call light times were staff not turning the light off until they were finished with cares, and some call light times were just longer than he would like. During an interview on 12/30/24 at 2:40 p.m., with staff member A and staff member C stated the longer call light times were due to the higher acuity on the units and low staffing. Staff member C stated she tried to keep an eye on the call light board, when she was working, to assist if needed. Staff member C provided a copy of the root cause analysis she had completed and stated she had not done the root cause analysis during past couple of weeks. Staff member A stated staff member C was new, and the management team were working with the new managers on pulling the data. Staff member A stated the managers were just starting to learn what to do with the data. During an interview on 12/31/24 at 8:17 a.m., staff member M stated, The CNAs have 15-16 residents each, and with each resident taking 15-20 minutes to get them up and dressed for the day, the math (staffing ratio) just does not add up . Some aren't getting turned, skin breakdown on some . During an interview on 12/31/24 at 10:14 a.m., staff member D stated the life enrichment staff were regularly pulled to assist on the floor and were having to attend all outside appointments with residents. Staff member D stated staffing was a continued issue and was preventing life enrichment staff providing the activities scheduled. Staff member D stated, appointments were often 2-3 hours each, and the life enrichment staff were all required to be CNAs, so they get pulled to the units to work as CNAs, frequently. Review of the facility's, Call History, dated 12/27/24 - 12/29/24, reflected: - 23 call lights that were on for 20 minutes or more, - Of the 23 call lights, three were over 50 minutes, and six were over 30 minutes. During an interview on 12/31/24 at 12:03 p.m., staff member E stated the staffing shortage was related to the following challenges: - Finding people who want to work, - . have not seen so much lack of wanting to work in her career, - people quitting without notice, (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- people with attendance issues, - the facility did not want travelers, - there was a revolving door their (facility), as fast as we hire, they lose the same or more (staff) . During an interview on 12/31/24 at 12:20 p.m., with staff member A and B, staff member A stated the scheduler who worked at the facility for [AGE] years, left. Staff member A stated, The schedules were ok for a while, and then we found there were discrepancies in the schedules the staff received, and the schedule posted in the building. Staff were upset due to the lack of a dependable schedule, and the schedule was not evenly assigned between the units. Staff member A stated, We tried self-scheduling and that turned out to be a nightmare, and getting management that could manage, and a scheduler. So, 1/6/24 will be the day schedules will be back on track from the self-scheduling mess, we hope. Then we can focus on what to tackle next. Fixing the staffing will take time, it won't happen overnight. My best guess is six months to a year to get staffing where it should be. Review of the facility's policy, BSS Patient Call System, last revised 8/2024, reflected: - . IV. The assigned Facility employee responds to a patient call within a reasonable time (15 - minute average time for the facility).