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	10/23/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to identify and investigate a major injury of unknown origin in a timely manner for a cognitively impaired resident, which was found to be a femur fracture, even though a staff member thought the resident's leg looked awkward for a while but neglected to address the concern. The surgeon treating the resident found the fracture was already healing and difficult to repair due to the delay in treatment for the injury of unknown origin, for 1 (#1) of 4 sampled residents. This deficient practice increased the risk of further injury, pain, and or decline in status for the resident and increased the risk of a negative outcome for other residents due to the injury not being identified and or investigated as potential abuse/neglect. Findings include: A record review of a Facility Reported Event showed resident #1 sustained a major injury of unknown origin, which was reported to the State Survey Agency on 10/6/25. It was found the resident had a femur fracture, allegedly caused by a heater. During an observation on 10/21/25 at 11:35 a.m., resident #1 was lying in bed, flat on her back, with her left lower extremity elevated on multiple pillows. Resident #1's bed was in the lowest position. During an interview on 10/21/25 at 11:45 a.m., staff member B stated he assessed resident #1. Staff member B stated resident #1's left leg showed signs of external rotation, swelling, and deformity. Staff member B stated he called the physician and received physician orders to send resident #1 to the emergency room for further evaluation. Staff member B stated he had doubts about the fracture being caused by her foot being caught under the heater in her room. Staff member B stated he did not recall resident #1 being able to move her legs off the side of the bed independently. Staff member B stated there was no bruising or swelling to resident #1's left toes or foot, and the swelling/bruising would have been present if the heater caused the fracture. Staff member B stated he had not been spoken to about resident #1's injury of unknown origin, or what he had observed and assessed with resident #1, on the day of the incident.During an interview on 10/21/25 at 2:40 p. m., NF3 stated he had received a phone call from a physician at [Hospital Name], letting him know resident #1 had sustained a fracture and had asked permission to perform surgery on resident #1. NF3 stated he had given permission to the physician to perform the surgery. NF3 stated this was how he found out about #1's fracture. NF3 stated, [Facility Name] did call me and tell me they thought the fracture occurred from her foot catching on the heater. I am having a hard time understanding how [Resident #1's Name] gets a fracture from a heater. I just don't buy it. I don't feel this was a malicious act, but I do feel there was negligence. During an interview on 10/22/25 at 9:08 a.m., NF4 stated resident #1 had dementia and was non-verbal and non-ambulatory. NF4 stated, [Resident #1] was found lying in her bed by staff, and they had noted her left leg was rotated, and staff thought there was something wrong. I had assessed [Resident #1] with [Physician Name]. The fracture was found to be partially healed and was, at a minimum, two to three weeks old. It was not an acute injury. The bone showed callous formation, and there was no bruising noted on the left leg. The fracture was hard to reduce during the operation.During an interview on 10/22/25 at 11:15 a.m., NF5 stated he had evaluated resident #1 at the hospital. NF5 stated resident #1 presented with swelling and signs of pain in her left leg. NF5 stated, I called [Resident #1's] daughter, and she was claiming physical and sexual abuse, so I completed a trauma assessment and a genital urinary assessment. I had ordered X-rays, a pan scan (a full body CT scan) to quickly identify any areas of trauma. The left leg was swollen but did not show any bruising and when it was discovered there was a fracture, orthopedics was called, and they would come down and assess the resident. Once orthopedics takes over, my part is complete.During an interview on 10/22/25 at 1:24 p.m., staff member D stated she had walked into resident #1's room about 7:00 a.m., on 10/6/25 to perform morning cares. Staff member D stated that resident #1 was dependent on staff for care, including mobility, and both of resident #1's legs were on the bed. Staff member D stated that resident #1's left leg did not look right, so she had called in staff member J to look at resident #1. Staff member D stated she had attempted to roll resident #1, but resident #1 had cried out. Staff member D stated, That is when we called the nurse to come over and evaluate [Resident #1's Name]. Staff member D stated that resident #1's leg had . been looking awkward for a while; we just thought that was normal for her (resident #1). I never said anything to anybody about it. Staff member D stated resident #1 had a history of putting her legs over the side of the bed in the past, but had not seen resident #1 do that in quite a while.During an interview on 10/22/25 at 1:48 p.m., NF7 stated the Orthopedic team received an Orthopedic consult for resident #1 from the emergency department regarding a femur fracture. NF7 stated he had performed the open reduction internal fixation of the fracture (surgical procedure). NF7 stated there was rotation to the left leg with some

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and policy review, the facility failed to ensure a thorough investigation of alleged abuse and neglect was completed for a resident with a documented fracture for 1 (# 1) of 4 sampled residents; and failed to ensure other residents were protected from potential abuse during the investigation. This deficient practice had the potential to place all cognitively impaired residents at risk for abuse and neglect. Findings include: A review of a Facility Reported Incident submitted to the State Survey Agency on 10/6/25, showed: the incident was classified as an injury of unknown origin. Statements were collected from staff member I on 10/15/25 and staff member D on 10/13/25. No other staff, residents, or resident representatives provided statements or interviews. The investigation included notation, On 10/13/2025, [Facility Name] (re)initiated an internal investigation surrounding the allegations of suspected abuse as indicated in the hospital progress notes. [sic]. The investigation file did not contain evidence the time frame investigated was expanded to include the time frame indicated by the hospital providers. No staff were removed from the floor during the investigation. The investigation failed to show evidence that other residents were identified as being possibly affected for abuse or neglect.Review of a hospital Operative Note, dated 10/7/25, showed: . Procedure: Details. This fracture would not move with a femoral distractor placed. this fracture was mostly healed in a malunited position. [sic]. This indicated the fracture occurred prior to the date of the incident due to the amount of healing that occurred.During an interview on 10/21/25 at 11:45 a.m. , staff member B stated he assessed resident #1 and found swelling and left leg rotation. Staff member B stated resident #1 was sent to the Emergency Room. Staff member B stated he did not think the radiator/heater caused the injury to resident #1's left leg. Staff member B stated resident #1's left foot showed no signs of trauma from being caught under the radiator/heater. Staff member B stated he was unaware if resident #1 could independently put her foot for the side of the bed. Staff member B stated resident #1 was dependent on staff for all care. Staff member B stated all resident beds were moved away from the radiators/heaters after the incident.During an interview on 10/21/25 at 2:40 p.m., NF3 stated, [Facility Name] did call me and tell me they thought the fracture occurred from her foot catching on the heater. I am having a hard time understanding how [Resident #1's Name] gets a fracture from a heater. I just don't buy it. NF3 stated he had not seen resident #1 in several years but from what he understood resident #1 was no longer ambulatory and was non-verbal. NF3 stated resident #1 depended on staff for all of her care.During an interview on 10/22/25 at 1:24 p.m., staff member D stated staff members G and H were looking into resident #1's fracture. Staff member D stated staff member G talked to her about the incident. Staff member D stated she tried to explain how she found resident #1 and the events of that morning. Staff member D stated she felt staff member G was not comprehending her recollection of the incident and kept trying to tell her the fracture happened on the heater. Staff member D stated both of resident #1's legs were on the bed, and the left toes and foot were not red, swollen, or bruised. Staff member D stated she had not seen resident #1 put her leg over the bed recently, but she used to.During an interview on 10/22/25 at 1:48 p. m., NF7 stated, There was no bruising noted to the left leg. The fracture was not an acute fracture. The fracture was partially healed. I would estimate the fracture happened at minimum two to three weeks but could have occurred as long as eight weeks ago. I had a hard time getting the fracture reduced because of the healing. There was no torsion or twisting noted to the bone. It was just odd that it was not caught sooner. NF7 stated he thought the fracture was suspicious.During an interview on 10/22/25 at 3:01 p.m., staff member G stated an investigation was started right way. Staff members G and H stated they had done a re-enactment of what they thought to be the cause of the fracture. Staff member G stated he had laid down on the bed, in a supine position, put his left foot down next to the heater (about a 3-inch deep by 4 inches high recessed area), and staff member H started to raise the bed up. Staff member G stated he felt some pain and twisting in the knee area of his left leg. Staff member H stated they had talked to staff member D and staff member I about the incident, but had not talked to any other staff, including staff member B who had assessed resident #1 prior to being sent to the Emergency Room. Staff member H stated, He wrote a nursing note, and I felt that was complete and there was no need to interview him. Staff member H stated she had not looked at the operation report. Staff member H stated, If I would have seen the operation report I would have done more, I would have extended and looked further back and talked to more staff. I definitely would have done more. I was going off of what staff told me, it seemed like it was an acute event. I felt it was a recent fracture. Staff member G stated more interviews were completed, but there was no documentation

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and policy review, the facility failed to provide necessary care and services consistent with the resident's assessed needs and care plan for repositioning, toileting, and pressure ulcer prevention, at least every two hours as directed by the plan of care for 1 (#1) of 4 sampled residents. Findings include:During an observation on 10/21/25 at 11:35 a.m., resident #1 was lying in bed, flat on her back, with her left lower extremity elevated on multiple pillows. Resident #1's bed was in the lowest position.During an interview on 10/21/25 at 11:45 a.m. staff member B stated, The facility's policy on turning and repositioning is supposed to be done every two hours, and toileting or checking and changing dependent incontinent residents, was also supposed to be done every two hours. Staff member B stated he could not be sure residents were being turned, repositioned, or checked and changed every two hours. During an observation on 10/21/25 at 3:04 p.m., resident #1 was lying in her bed, flat on her back. Her left lower extremity was elevated on multiple pillows.During an observation on 10/22/25 at 10:08 a.m., resident #1 was lying in her bed, flat on her back. Her left lower extremity was elevated on multiple pillows.During an interview on 10/22/25 at 1:24 p.m., staff member D stated, We are supposed to turn and reposition and check and change the residents who are dependent for care every two hours.During an observation on 10/22/25 at 2:14 p.m., resident #1 was lying in her bed, flat on her back. Her left lower extremity was elevated on multiple pillows.During an interview on 10/23/25 at 6:05 a.m., staff member I stated his shift starts at 10:00 p.m. Staff member I stated he started rounds at 1:00 a.m., and 4:00 a.m., and that was when turning and repositioning was done and also when check and changes were done for dependent residents. Staff member I could not verbalize how often the facility required turning and repositioning, or the check-and-changes to be completed. Staff member I stated resident #1 was not positioned from side to side; she was always on her back. Staff member I stated he did have access to resident care plans, and he did know how to access them. Staff member I could not verbalize if there were any specific turning and repositioning or check and change requirements in resident #1's care plan.During an observation on 10/23/25 at 8:10 a.m., resident #1 was lying in her bed, flat on her back. Her left lower extremity was elevated on multiple pillows.During an interview on 10/23/25 at 8:13 a.m., staff member J stated, We are supposed to turn, reposition, and check and change (the residents) every two hours, but the reality is that does not always happen.During an interview on 10/23/25 at 8:43 a.m., staff member A stated it was his expectation for cares to be completed on residents every two hours. Staff member A stated there was no policy for turning and repositioning or a bowel and bladder incontinence policy.During an interview on 10/23/25 at 10:04 a.m., staff member P stated the facility's expectation was residents were to be turned and repositioned every two hours and as needed, depending on the situation for that particular resident. Staff member P stated residents were to be checked and changed at a minimum of every two hours; that was the general rule. Staff member P stated rounds were to be started on night shift after report was given by the off-going shift, and every two hours throughout the night.Review of a facility document titled Care Plan Revisions and Complete Comprehensive Care Plan, dated 6/2025-10/6/2025, showed: . Intervention: Assist resident with ADLs/mobility as neededDescription:.Turn and Reposition q 2 hoursCheck and Change q 2 hoursTotal assist with ADLs . [sic]Review of a facility document titled, Documentation of turn and reposition, dated 10/1/25-10/6/25, showed:-On 10/1/25, documentation showed resident #1 was repositioned one time in a 24-hour period at 9:30 p.m.-On 10/2/25, resident #1 was repositioned one time in a 24-hour period at 1:29 a.m.-On 10/3/25, documentation showed resident #1 was repositioned two times in a 24-hour period, at 4:56 p.m. and 9:00 p.m.-On 10/4/25, there was no documentation that resident #1 was repositioned in a 24-hour time period, and-On 10/5/25, documentation showed resident #1 was repositioned one time in 24 hours at 6:00 p.m.Review of a facility document titled, Documentation of Toileting and Check and Change, dated 10/1/25-10/6/25, showed:- . 10/1/25- 0200 (2:00 a.m.) Activity did not occur. 1100 (11:00 a.m.) Total assistance. 1930 (7:30 p.m.) Total assistance. Resident #1 was checked and changed two times in a 24-hour period.- . 10/2/25-1415 (2:15 p.m.) Total assistance. 1930 (7:30 p.m.) Total assistance. Resident #1 was checked and changed two times in a 24-hr period.- .10/3/25-0545 (5:45 a.m.) Total assistance. 1115 (11:15 a.m.) Total assistance. Resident #1 was checked and changed two times in a 24-hour period.- . 10/4/25-0430 (4:30 a.m.) Activity did not occur. 1915 (7:15 p.m.) Total assistance. 2215 (10:15 p.m.) Activity did not occur. Resident #1 was checked and changed one time in a 24-hour period.- . 10/5/25-1400 (2:00 p.m.) Total assistance. 1915 (7:15 p.m.) Total assistance. Resident #1 was checked and changed two times in

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, record review, the facility failed to identify and respond to increased behaviors indicative of pain or distress in a cognitively impaired resident for 1 (#1) of 4 sampled residents. Findings include: During an interview on 10/22/25 at 12:15 p.m., staff member C stated when a dementia resident exhibits an increase in behaviors, she would assess possible causes such as pain, positioning, incontinence, and perform a general head-to-toe assessment for other physical causesDuring an interview on 10/22/25 at 1:24 p.m., staff member D stated resident #1 exhibited scratching and pinching. Staff member D stated resident #1 had had done that since she was admitted , and it was usually only in the morning during cares. Staff member D stated there had been an increase in behaviors lately for resident #1 but could not say exactly when the behaviors started to increase.During an interview on 10/22/25 at 2:35 p.m., staff members E and F stated that behavior monitoring was done every shift. Staff member F stated if a resident was unable to verbalize the problem and was demonstrating behaviors such as yelling out, pinching, hitting, etc., she would look at basic needs first. Staff member F stated she would start by looking at the last time the resident ate, or the last time the resident was toileted. Staff member E stated, Sometimes the behaviors are just that the resident wants attention. A review of resident #1's behavior monitoring showed, between 9/1/25 and 10/6/25, resident #1 exhibited behaviors including pinching, scratching, and yelling/screaming 15 times. Review of resident #1's pain assessments, dated 9/1/25-10/6/25, showed: three pain assessments were completed, and only one of the pain assessments was completed on a day resident #1 had exhibited behaviors.A review of resident #1s care plan, with a with a start date 10/18/24 and end date 10/9/25, showed, Intervention: Identify stressors that lead to inappropriate behavior. Assess pain. [sic] Resident #1's electronic medical record did not contain evidence that pain was assessed as a possible cause of her increased behaviors.A review of resident #1's Quarterly MDS, with an assessment reference date of 6/29/25, showed: . E0200. Behavioral Symptoms.Physical behavioral symptoms directed towards others.1-behavior of this type occurred 1 to 3 days Section J: Health ConditionsPain management. Received PRN pain medications or was offered or declined? The response marked was 0-no A review of resident #1's Quarterly MDS, with an assessment reference date of 9/27/25, showed: . E0200. Behavioral Symptoms.Physical behavioral symptoms directed towards others, and this occurred 4 to 6 days. Section J: Health Conditions, for pain management, showed the question for if the resident received PRN pain medications or was offered or declined them. The response marked was 0-no.