

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  12/16/2025
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to promote a dependent resident's preferences, to ensure he received a shower when preferred, and on a shower day, he did not receive the shower as he requested, for 1 (#2) of 6 sampled residents. This deficient practice caused resident #2 to have feelings of frustration, feel trapped, and miss breakfast. Findings include: A review of a Facility Reported Event, dated 10/20/25, showed that staff member I failed to provide shower services to a dependent resident, who was resident #2, and this was upsetting to the resident. A neglect allegation was initiated by the facility. During an interview on 12/15/25 at 1:31 p.m., resident #2 stated, I got my shower today. I haven't had an issue since that incident (on 10/20/25). It was frustrating. I always get up before 8:00 a.m. and have my shower before breakfast. I felt trapped because I couldn't do anything. I am dependent on the staff for assistance. The staff have talked to me about it, and I am happy with the outcome. The staff member doesn't work with me anymore and was supposed to be getting more training. During an interview on 12/16/25 at 9:10 a.m., staff member B stated that, Those documents are the bathing preferences, and the care plans you requested. I can tell you the bathing preferences aren't on all of them. During an interview on 12/16/25 at 10:55 a.m., staff member I stated, I would get to know the residents to learn their preferences. I would look at their care plans if I had time, but you really don't have time to look at them. Resident #2 would usually have his shower before breakfast. I worked Mondays and Tuesdays, and I think his showers were on Mondays. I don't recall an issue like that happening with him before. I have showered him a couple of times. He refused to eat breakfast that day, demanding that he get his shower first. I didn't do his shower because I knew staff member H was coming in at 10:00 a.m., and they were assigned to do the bath, not me. I would say a call light should be answered within 10 minutes. During an interview on 12/16/25 at 11:25 a.m., staff member K stated, There are times when staff don't get to all their tasks. Showers are usually done around 6:00 a.m. to 10:00 a.m., sometimes later. We [staff] try to accommodate resident preferences, but sometimes it is hard. He [resident #2] likes to have his shower first thing in the morning. I think the staff member that day didn't do his shower first thing because they knew someone else was coming in, and they were scheduled to do it. I scheduled the person coming in at 10:00 a.m. to do [Resident #2's] shower because I didn't think it would get done if I scheduled one of the other staff members to do it. During an interview on 12/16/25 at 12:01 p.m., staff member H stated, I was late that day, and I wasn't told I had to do his [resident #2's] shower until around 11:00 a.m. I was frustrated that the staff didn't inform me that I had to give him his shower, and he was still in bed. I think the staff that was on that day just pushed it off, knowing I was coming in at 10:00 a.m. and didn't want to do his [resident #2's] shower. I'm pretty sure it's in his care plan to be up earlier than 10:00 a.m. During an interview on 12/18/25 at 10:10 a.m., NF3 stated, He [resident #2] had let me know what was going on, and that he hadn't had his bath yet and was left in bed. I called and left a message with two different staff members. I didn't hear back from them on what was going on. He was frustrated and feeling hopeless because he was dependent on the staff to do things for him. Review of a facility document titled Call History dated 10/20/25, showed resident #2's call light went off twice, once was on 10/20/25 at 6:43 a.m., and it took 47 minutes for staff to respond. The second time was on 10/20/25 at 9:28 a.m., and it took 43 minutes for the resident's call light to be responded to. This showed resident #2's call light was not answered for an extensive time on the day his shower was delayed. Review of resident #2's comprehensive care plan dated, 3/18/25, showed: Goal: Mobility/activity is maintained at optimum level for me, -[Resident name] will be assisted with ADLs as needed while allowing him to be as independent as he can be.;-Intervention: Assist resident with ADLs/mobility as needed;-Assist [resident name] with ADLs/mobility as needed.;-[Resident name] would like his showers on Monday and Friday mornings unless others requests differently;-[Resident name] wants to be up out of bed no later than 0800 each day unless he indicates otherwise. [sic] Review of a facility document titled Activities of Daily Living/Needs and Choices, with a revision date of 6/2025, showed: . Procedure/Responsibilities: I. Resident needs for assistance with Activities of Daily Living (ADL) are identified upon admission and periodically thereafter and recorded in their medical record. A. ADLs include the following: .9. Bathing .III. Nursing ensures assistance with ADL is provided as directed in the care plan or as needed.E. Resident will be given a choice of bath schedule and frequency. [sic]</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 (#1) of 6 sampled residents. This deficient practice caused the resident to have feelings of sadness and withdrawal, and the facility identified the concerns, and addressed them prior to the survey. Findings include:Review of a facility-reported event dated 11/13/25 showed, Life Enrichment Manager was informed that a volunteer had verbally abused a resident during bingo. CNO and CDON were notified. Investigation started.During an interview on 12/16/25 at 9:44 a.m., resident #1 stated a volunteer had been mean to her at one point. Resident #1 said the volunteer talked badly to her and made her feel uncomfortable. Resident #1 said the volunteer always told her to go to the bathroom even when she didn't need to. Resident #1 said the facility did follow up with her after the incident, and she was happy with the outcome. Resident #1 said she hasn't had any further issues with volunteers and feels safe at the facility. Review of a written statement dated 11/12/25, by staff member N, showed that [resident's name] was being treated inappropriately at and before bingo. [Resident's name] is made to sit next to staff member C. Staff member C, in front of two family members and a volunteer, has told [resident name] to use the potty, so she don't poop her pants. She has also used the words poopie pants and [resident's name] carries a white hand towel to place on the chair where she sits. She does this in an act of shame. [sic]Review of a written statement on 11/13/25, by NF4, showed, One gal who calls bingo is demanding and rude to the residents. That lady, her name is [resident's name], she yelled out, and the volunteer who makes her sit next to her said, We don't do that here! .Review of a written statement dated 11/13/25, by staff member M showed, Staff member C verbally accosted a resident about bringing a towel to sit on. Staff member C stated, I am not going to clean up after you. [Resident name] becomes withdrawn when staff member C is present the past few weeks. [sic]Review of resident #5's written interview with a date of 11/13/25 showed, During bingo, is there any staff member or volunteer that has talked rude. Not to me but to others yes. She [staff member C] makes residents mad and embarrassed. [sic]During an interview on 12/16/25 at 2:30 p.m., staff member B said the volunteer was immediately put on administrative leave pending an investigation. The investigation showed the incident did happen, and the volunteer was asked not to come back. I will have to check the computer for notes, but I'm pretty sure there was a follow-up with the resident for any negative effects. Education was provided to life enrichment staff on the facilities policy on abuse, neglect, and the reporting requirements. Staff member B stated all volunteers go through HR and HR does a background check on them.Corrective Action:Review of the facilities investigation findings submitted on 11/19/25 showed staff member C was immediately put on administrative leave upon notification of the allegation of abuse. Resident #1 was interviewed and was able to verify the allegations. All life enrichment staff were provided education on abuse, neglect, and reporting requirements.A review of the facility's Follow up with residents regarding abuse claims, dated 11/13/25, showed residents were interviewed individually regarding the abuse allegations, and no other residents reported any mistreatment to them, but did mention the way resident #1 was treated. Staff interviews were conducted, and statements gathered. Staff member C was permanently suspended, education was provided, and the facility had the concerns related to the abuse and volunteers on the monthly agenda for QAPI meeting, which was to occur on 12/30/25, to ensure all corrective actions were in place as identified and no further action was needed.</p>		