

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/16/2026
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)		
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review, the facility failed to ensure there was an adequate number of staff available to provide resident care needs promptly when residents requested assistance using their call lights or when they needed help with ADL care, for 4 (#s 3, 20, 34, and 59) of 23 sampled and supplemental residents. The failure resulted in the residents being frustrated and going without care for extended periods of time. Findings include: During an interview on 7/13/26 at 2:42 p.m., resident #59 stated, It depends on how busy they (the staff) are, and what time of day it is, regarding how long he waits for help with his activities of daily living. Certain times of the day were not as good as others for availability of staff. During an interview and observation on 7/14/26 at 8:26 a.m., resident #3 stated, I was still waiting to get up for breakfast and called for help just before 7:00 a.m. Resident #3 pushed his call light again at 8:50 a.m. Per resident #3, he received no assistance from 7:00 a.m. to 8:50 a.m. During an observation and interview on 7/14/26 at 8:54 a.m., staff member J entered resident #3's room and stated, I was in the resident's room earlier this morning but had forgotten the Sara lift, and when I returned to [Resident #3's] room, the resident had fallen asleep. Staff member J stated he did not want to wake the resident and left the resident sleeping to shower another resident. During an observation and interview on 7/14/26 at 10:10 a.m., resident #3 received his breakfast meal three hours after his initial request to get up for breakfast. Resident #3 ate in the dining room by himself. Resident #3 stated he was frustrated by their lack of response. Review of the facility's document titled, Call History, received on 7/16/26, showed the following call light response times for resident #3 on 7/14/26, which started at 7:01 a.m. when resident #3 called for assistance to get up for the day. - Call time 7:01 a.m., cancel time 7:02 a.m., wait time 24 seconds. Per the previous resident interview, resident #3 did not receive care while staff were in the room and shut the call light off. - Call time 8:03 a.m., cancel time 8:25 a.m., wait time 22 minutes. Per the previous resident interview, resident #3 did not receive care during the delayed time period. - Call time 8:50 a.m., cancel time 9:19 a.m., wait time 28 minutes. During an interview on 7/14/26 at 11:12 a.m., resident #34 stated the staff was usually helping others with showers, and she could not get the help she needed. Resident #34 stated it took two to three hours in the morning, on day shift, to receive any help. Resident #34 stated she had the night staff wake her at 5:30 a.m. to get her dressed. Resident #34 stated the night staff got her up early, dressed her, and got her in her wheelchair where she would sleep until 7:00 a.m. Resident #34 stated they (the day shift) are so short-staffed. She would like to sleep in her recliner until 7:00 a.m. but did not trust them (the day staff) to come assist her for her ADL care. During an interview on 7/15/26 at 11:17 a.m., staff member L stated every unit should have three CNAs to provide morning cares; however, the morning shower schedule was heavy on some days. Staff member L stated in the morning, one to two CNAs were pulled from the floor to serve meals and give showers. Staff member L stated, It has delayed patient care and can be challenging (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(getting residents up and out to breakfast).During an interview on 7/15/26 at 1:24 p.m., staff member M stated, Sometimes we are short-staffed; mornings are hit and miss. On the missed days, morning cares (getting residents up and out for breakfast) are delayed, especially for the early risers (6:00 a.m. to 7:00 a.m.). Staff member M stated they would answer the call light, tell the resident there was a wait time, and turn off the call light before exiting the resident's room.During an interview on 7/16/26 at 9:37 a.m., staff member B stated that the facility liked to have one CNA to eight residents; staff call-offs can affect the ratio. Staff member B stated, We do have a lot of call-offs. Staff member B stated that when call-offs happened, staff member B would try to get overflow from the hospital to fill in; staff member B would provide resident care at times as well if needed.		

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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 observation, interview, and record review, the facility failed to follow training during resident care and use proper hand hygiene, to include when gloves were used, between dirty and clean procedures for 2 (#3 and #4) out of 2 residents observed for peri-care and wound care; and failed to ensure staff used proper hand hygiene during the medication pass for 4 (#s 2, 4, 56, and 73) out of 6 residents sampled for medication administration. This deficient practice increased the risk of the spread of infection. Findings include:1. Peri-care resident #3During an observation and interview on 7/14/26 at 8:54 a.m., Staff member J entered resident #3's room and did not perform hand hygiene before they donned gloves and a gown. Staff member J grabbed a clean brief and two wet washcloths. Staff member J reached under his gown with his gloved hand to answer a status check using the facility's internal communication system. Staff member J failed to uphold proper infection control for hand hygiene and when reaching under his gown.-Staff member J approached the resident and placed both wet washcloths on the footboard of the resident's bed. Staff member J opened the resident's brief, tucked the front half of the brief between the resident's legs, and used the soapy washcloth to wipe the resident's penis and scrotal area with the washcloths that were on the footboard.-At 9:16 a.m., staff member K entered resident #3's room and stated to staff member J that the call light was still on. Staff member J placed the soiled washcloth on the resident's footboard and, with soiled gloves, pushed the call button on the wall to turn the light off. -Staff member K returned with a gown and gloves on. Staff member J, without removing their soiled gloves, used the bed remote to adjust the bed height. Staff member K removed the resident's soiled brief and retrieved one package of disposable wipes and two blue chuck pads. Staff member K used the disposable wipes to clean the stool from the resident's buttock area. Staff member K, without removing their soiled gloves, grabbed the two clean blue chuck pads, the clean brief, and placed them part-way under the resident's buttocks and lower back.-Staff member J entered the resident's bathroom wearing the same soiled gloves; returned to the bedside and handed staff member K a tube of barrier cream. Staff member K applied the barrier cream to the resident's buttocks area.-Staff member J used the disposable wipes to clean stool from the resident's buttock area. Staff member J, without removing their soiled gloves, pulled the clean chuck pads and clean brief into place. Both staff members J and K adjusted the resident's position in bed with their soiled gloves on.-Staff member K used the disposable wipes to wipe the resident's penis and scrotal area. While still wearing the soiled gloves, staff member J picked up resident #3's bedside water cup and offered the resident a drink. Staff member K stated to staff member J, Not while lying down. Staff member J returned the water cup to the bedside table.-Both staff members J and K closed the resident's brief while still wearing the same soiled gloves. Staff member K used their removed gown to cover and scoop the soiled brief and chuck pads off the resident's bed before they discarded them in the trash.-Staff member J, wearing the same soiled gloves, pulled the resident's clean pants up to the resident's mid-buttocks, used the bed remote to raise the head of the resident's bed, picked up the resident's hearing aid from the bed, picked up the bedside water cup, and offered the resident a drink. Staff member J held the water cup for the resident to drink. Staff member J placed the water cup back on the bedside table and placed the hearing aid in the resident's left ear and then touched the resident's right ear and hearing aid, all with the same soiled gloves. Staff member J then placed the resident's clean shirt on the resident and reached under his gown a 2nd time and touched the facility's internal communication device to speak to another staff member.Once the resident was dressed, staff member J performed the following tasks with soiled gloves: -Placed the Sara lift sling on the resident and used the Sara lift (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	controls to raise the resident.-Removed a pillow from the resident's wheelchair and placed it on the floor; then placed a pair of sandals (which were under the pillow) on top of the pillow previously placed on the floor. -Staff member J took the catheter drainage bag from the resident's lap and placed the drainage bag directly on the floor, and took their phone out of their pocket and set it on the resident's floor. Staff member J removed the soiled gloves for the first time since the care session started, without performing hand hygiene. The staff member then donned new gloves.-After the drainage bag was drained, staff member J entered the resident's bathroom, placed the UDMC on the counter next to the sink, and then discarded the urine in the toilet. Without cleaning the UDMC, staff member J set it on the back of the resident's toilet.-While wearing soiled gloves, staff member J knelt in front of resident #3 and placed the resident's sandals on the resident's feet. Staff member J attempted to finish buttoning the resident's shirt while using their soiled gloves, but stated they were having difficulty and removed gloves without performing hand hygiene, then buttoned the remaining buttons on the resident's shirt. Staff member J then picked up the pillow from the floor and placed it on the right side of the resident (between the resident and the wheelchair).-Staff member J picked the O2 tubing and nasal cannula off the floor and placed the now soiled nasal cannula in the resident's nose. Staff member J picked up a pillow from the floor (that had previously fallen off the resident's bed) and placed it on the resident's bed. -Staff member J used the Sara lift and sling, without cleaning it, and pulled the resident's pants up. Staff member J reached under his gown and again touched the facility's internal communication device to speak to another staff member, without sanitizing his hands. During an interview on 7/14/26 at 10:12 a.m., staff member J stated, when asked about hand hygiene during care sessions, Gel in, and gel out while entering a room, before and after peri care brief changes. I suppose I didn't do that. I should have changed gloves after his bottom was done.2. Peri-care and wound care resident #4During an observation on 7/15/26 at 1:01 p.m., staff members L and M, while wearing gowns and gloves, removed the resident's soiled brief and cleaned the stool from the resident's buttocks and peri area. After the resident was cleaned, staff member L discarded the soiled brief, performed hand hygiene, and left the room.-Staff member I entered resident #4's room in a gown and gloves to assess the wound located on the tip of the resident's penis. Staff member I assessed and cleaned the resident's wound. While wearing soiled gloves, staff member I reached under their gown and removed the Rover device from their pocket. Staff member I used their Rover device to take pictures of the wound and then set the Rover device on the resident's bedside table. Staff member I then entered the resident's bathroom, exited with a medicated ointment, and applied it to the wound while wearing the soiled gloves. -Both staff members I and M, using soiled gloves, placed a clean brief on the resident. Staff member M adjusted the resident's pillows, and then both placed a blanket on resident #4 without removing their soiled gloves. -Staff member I took off their protective gown and gloves, and without performing hand hygiene, picked up their Rover device from the resident's bedside table and placed it in their pocket. Staff member M removed the gown and gloves, and without performing hand hygiene, picked up the Hoyer sling and shorts from the foot of the bed, then hung the Hoyer sling in the resident's bathroom. During an interview on 7/16/26 at 9:37 a.m., staff member B stated the following should happen regarding hand hygiene during cares: Gel into the room, glove up, brief change, remove gown and gloves, gel again, new gowns and gloves., then continue patient (resident) cares.3. Medication PassDuring an observation on 7/14/26 at 12:43 p.m., staff member H carried out the following steps for a medication administration task:- The staff member logged on to the computer/EMAR (electronic medication administration record), then grabbed the bar code scanner, located keys from their pocket, unlocked the half door, and exited the kitchen serving area. Staff member H approached resident #4 in the dining area and scanned the barcode (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attached to the resident's chair. Staff member H then walked back to the kitchen serving area, used the keys from their pocket, unlocked the half door, unlocked the medication cart, and pulled the resident's information up on the computer/EMAR.-Staff member H, without performing hand hygiene, pulled a bottle from the medication cart and used the bar-code scanner to scan the medication. Staff member H placed the medication in a plastic medication cup, poured the medication in a crush bag, crushed the medication, and poured the crushed medication back into the medication cup. Staff member H used a clean plastic spoon and scooped pudding into the medication cup. Staff member H left the spoon in the medication cup. Once the medication was prepped, staff member H put away the medication bottle, closed and locked the medication cart, locked the computer screen, picked up the medication cup with the medication pudding mixture and spoon, unlocked the half door with the keys from their pocket, and approached resident #4. During an observation on 7/14/26 at 12:49 p.m., staff member H performed hand hygiene using an alcohol-based sanitizer. Staff member H then picked up their Rover device, retrieved the keys from their pocket, unlocked the half door, and approached resident #56 in the dining area. Staff member H used their Rover device to scan the barcode attached to the resident's chair.-Staff member H then walked back to the kitchen serving area, and using the keys, unlocked the half door and medication cart, then started to pull the medication cards for resident #56. Staff member H pushed the medication card bubble with one hand, allowing the medications to fall onto their other hand above the medication cup. Staff member H spread their two fingers, allowing the medications to drop into the medication cup. Staff member H put away all medication cards, closed and locked the medication cart, picked up the medication cup, unlocked the half door with the keys from their pocket, and approached resident #56. Staff member H administered the medications to the resident. Staff member H failed to maintain proper medication transfer procedures and failed to properly perform hand hygiene before and after medication preparation.During an observation on 7/15/26 at 7:51 a.m., staff member I was standing at the medication cart in the dining area. Staff member I locked the medication cart, picked up their Rover device, and approached resident #2 in the dining area. Staff member I used their Rover device to scan the barcode on the back of the resident's chair. Staff member I returned to the medication cart, used keys from their pocket to unlock the medication cart, and started to pull and scan (with their Rover device) all medication cards for resident #2. Staff member I placed all medication(s) into a medication cup, put all medication cards back into the medication cart, locked the medication cart, and grabbed a clean plastic spoon. Staff member I approached resident #2 and administered the medications. The staff member did not sanitize their hands.During an observation and interview on 7/15/26 at 8:01 a.m., staff member I performed hand hygiene with an alcohol-based hand sanitizer before picking up their Rover device. Staff member I approached resident #56 in the dining area and used their Rover device to scan the barcode on the back of the resident's chair. Staff member I walked back to the medication cart and unlocked it, then started to pull and scan all medication cards for resident #56. Staff member I placed all medications into a medication cup and put all medication cards back into the medication cart. Staff member I stated they liked to wait until the resident has food in front of them before giving them their medications. Staff member I used a marker from their pocket to write resident #56's name on the medication cup and then placed the medication cup in the top drawer of the medication cart.During an observation on 7/15/26 at 8:09 a.m., staff member I locked the medication cart and approached resident #73. Staff member I scanned the barcode on the back of the resident's chair before returning to the medication cart. Staff member I unlocked the medication cart and pulled all the medication cards and scanned all medication cards needed for resident #73. Staff member I used a marker from their pocket and wrote the resident's name on the plastic medication cup. Staff member I placed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications in the labeled plastic medication cup. Staff member I touched their internal communication device to speak to another staff member and used their phone to call the pharmacy. Staff member I returned all medication cards to the medication cart, placed the filled medication cup in the top drawer, and locked the medication cart. Staff member I unlocked the medication cart with keys from their pocket and picked up the previously filled medication cup for resident #56. Staff member I failed to properly perform hand hygiene before and after medication preparation. During an interview on 7/16/26 at 9:37 a.m., staff member B stated hand hygiene (either using an alcohol-based sanitizer or washing with soap and water) should be done before and after prepping medications and in-between residents. Staff member B stated it was never acceptable to .pop pills from the med card to hands., they should always be popped from the card to the cup.-Review of the facility's policy, Hand Hygiene, revised June of 2025, showed: . Use an alcohol-based waterless antiseptic agent for routinely decontaminating hands if hands are not visibly soiled in all other clinical situation described below. (D 1 - 7.). D., 1. Before having direct contact with patients.2. After contact with a patient's intact skin (as in taking a pulse or blood pressure or lifting a patient).3. After removing gloves.4. After contact with body fluids or excretions, mucous membranes, nonintact skin, or wound dressings, as long as hands are not visibly soiled.5. When moving from a contaminated body site to a clean body site during patient care.6. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.		

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F 0600 Level of Harm - Minimal harm or potential for 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. Based on interview and record review, the facility failed to protect the resident's right to be free from neglect of care by a staff member for 1 (#65) of 6 residents sampled for neglect of care. The neglect of care placed the resident at an increased the likelihood of adverse events related to incontinence and immobility. Findings include: Review of a Facility-Reported Incident, dated 12/15/25, and submitted to the State Survey Agency on 12/22/25, showed staff member E was alleged to have neglected resident #65 on 12/15/25. The investigative findings showed staff member E had not provided repositioning and incontinence care for resident #65. The investigative file showed staff member E did not accept assistance offered by other staff members and other staff members assigned to the unit did not take the initiative to assist staff member E when they clearly saw resident #65 had not been turned. The resident was receiving end-of-life care and was totally dependent for assistance. Review of the written statement by staff member F, dated 12/15/25, showed staff member F witnessed neglect of care by staff member E. Staff member F wrote, . it was clear that he (resident #65) had no cares completed in 7 hours. (Cath was not emptied, Full bed strip needed, Q2 turns were not complete, . There was a washcloth found stuffed in his peri area (when rounds were completed that morning, there was no washcloth there). No turns or cares had been documented.A review of documents showed the investigation was thorough, but the facility did not identify the event as neglect of care. The resident's care plans and assessments reflected the resident's needs accurately. During an interview on 7/16/26 at 7:53 a.m., staff member B stated she investigated the allegation of neglect and believed the cause was a teamwork failure and staff member E needed education to accept assistance from other staff when it was offered. Staff member B stated staff member E was educated on accepting assistance from her co-workers. Staff member B stated she did not perform any ongoing monitoring of the care provided by staff member E. The staff member had training prior to the event on abuse/neglect during the new employee training. Review of the facility's policy titled, [Facility Name] Resident Abuse/Neglect Allegations [Facility Name], last revision date was November of 2025, showed the definition of neglect was, . is the failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy also showed employees who suspect neglect must report their suspicions to their supervisor so an investigation could be initiated.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report allegations of resident abuse to the State Survey Agency within 24 hours of the incident for 2 (#s 4 and 74) of 23 sampled and supplemental residents. Findings include: Review of the Facility-Reported Incident, dated 4/1/26 at 3:50 p.m., showed staff member F reported an allegation of abuse to staff member B on 4/1/26. Staff member F stated the incident occurred the week prior. Resident #4 was inappropriately touched by another resident. The allegation of resident-to-resident abuse was not reported to the State Survey Agency within 24 hours of the incident. During an interview on 7/16/26 at 9:40 a.m., staff member F stated she reported, on 6/24/26, to the nurse she found resident #74 in resident #4's room. Staff member F stated resident #74 was rubbing the leg of resident #4. Staff member F stated she failed to effectively communicate the incident to the nurse on duty the evening the incident occurred. During an interview on 7/16/26 at 10:40 a.m., staff member B stated the incident involving resident #4 and #74 which occurred on 6/24/26 was not reported to the State Survey Agency within 24 hours because staff member F reported the incident to the nurse in charge and a miscommunication occurred. Staff member B stated the nurse had thought resident #74 was consoling resident #4. Staff member B stated the facility reported the incident on 4/1/26 to the State Survey Agency after receiving an email on 4/1/26 from staff member F who reported the incident to the nurse on 6/24/26. Review of the facility's policy titled, [Facility Name] Resident Abuse/Neglect Allegations [Facility Name], last revision dated November of 2025, showed: Allegations of Abuse, Neglect, and/or Misappropriation of Funds. All employees who suspect abuse, must report their suspicions to their supervisor, so an investigation can be initiated. All employees adhere to the mandatory reporting law (53-5-511MCA) when suspecting abuse. II. The COO/CDON/ DON or designee initiates an investigation immediately when there is any report of suspected resident abuse. Protocol: . c. Report to the Unit Manger (or their Designee) and follow the direction provided - which may include completion of an initial report to the State Certification Abuse Reporting Hotline. d. Reports of alleged abuse or incidents resulting in serious bodily injury are reported to the Executive Director (or delegate [usually the manager on-call]), the State, and the Ombudsman, no later than 2 hours after the allegation is made. e. Investigation must be started 'immediately' - which is defined by CMS as: 'as soon as possible, but not to exceed 24 hours after the discovery of the incident.' [sic]		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to notify the resident, the resident's representative, and the local Ombudsman of the reason, in writing, for the transfer or discharge and the Bed Hold information, if applicable, for 1 (#10) of 2 residents sampled for discharge or transfer. Findings include: During an interview on 7/16/26 at 9:20 a.m., staff member G stated that when a resident was transferred to the hospital the nurse initiates a Bed Hold in the resident's electronic medical record. Staff member G stated the residents do not get a copy of the Bed Hold or Notice of Transfer, and a resident or power of attorney does not sign the form. Review of resident #10's electronic medical record failed to include a Bed Hold and Notice of Transfer for resident #10's facility-initiated transfer on 6/21/26. On 7/15/26, a request was made for a copy of resident #10's Bed Hold and Notice of Transfer form for the 6/21/26 facility-initiated transfer. No documentation or records were received from the facility by the end of the survey During an interview on 7/16/26 at 10:40 a.m., staff member B stated the nurse was responsible for completing a resident Bed Hold and Notice of Transfer form. Staff member B stated it appeared the letter for the bed hold and transfer was not completed because it was not documented in resident #10's electronic medical record.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to provide safe, competent care while performing direct resident care and utilizing a mechanical lift during a transfer. The failures involved staff not performing appropriate hand hygiene (refer to F880 - Infection Control), failing to report a resident's pain, failing to safely supervise a resident while using a mechanical lift, and failing to keep a urinary drainage bag below the bladder to prevent urine backflow, for 1 (#3) of 16 sampled residents. Findings include: During an observation and interview on 7/14/26 at 8:54 a.m., staff member J entered resident #3's room with the Sara lift and the following steps were observed:-Staff member J told resident #3 he could not find pants or socks in the resident's closet. Staff member J exited resident #3's room and returned with hospital scrub pants and a package of hospital grippy socks. Staff member J did not perform hand hygiene before they donned gloves and a gown. -Staff member J placed the half-full catheter drainage bag on the foot of the bed, and the catheter tubing showed backflow as it was approximately three-fourths full of dark yellow to light orange urine with sediment present. A strong urine scent was present. Staff member J threaded the drainage bag through the left pant leg and then left the drainage bag on the foot of the bed, while they pulled the resident's pants on to approximately mid-thigh. Staff member J failed to keep the drainage bag below the bladder to prevent urine backflow.-Staff member J lowered the bed to the lowest position and asked resident #3 to roll to his right side. Resident #3 could not roll unassisted. Staff member J stated they knew the resident had pain in his right shoulder, which limited the use of his right arm. Staff member J pushed the resident's left shoulder to assist the resident to roll away from staff member J. While on his right side, resident #3 grimaced and let out a quiet moan. Staff member J stated to the resident, I know that side hurts (right side). -Staff member J returned the resident to his back and removed the hospital gown. Staff member J entered the resident's bathroom and returned with two dripping wet wash-clothes (one with soap), and a new brief. Staff member J reached under the resident's gown with his gloved hand and answered a status check using the facility's internal communication system. Staff member J stated into the device that help was not needed. Staff member J did not request assistance with resident care.-Staff member J placed the wet washcloth(s) on the footboard of the resident's bed where they dripped on the floor. Staff member J opened resident #3's soiled brief and tucked the front of the brief between the resident's legs. Staff member J used the wet soapy washcloth from the footboard of the bed to wipe the resident's penis and scrotal area. Staff member K entered resident #3's room and stated to staff member J that the call light was still on and that they were there to help. Staff member J placed the soiled soapy washcloth back on the resident's footboard. Staff member J turned off the call light without removing the soiled gloves. Staff member J did not follow infection control procedure moving from clean to dirty tasks.-Staff member K asked staff member J to raise the level of the bed to more easily provide care. Staff member K entered the resident's bathroom and grabbed one package of disposable wipes and two blue chuck pads. Both staff members J and K rolled the resident to his left side. Resident #3's face showed a grimace. Staff member J stated to the resident, I know this hurts, buddy. Staff member J used disposable wipes to remove stool from the resident's buttock area. While wearing the same gloves, staff member J pulled the clean chuck pads and the clean brief into place. Resident #3 grimaced when staff members J and K rolled him to his back.-While wearing soiled gloves, staff member J picked up resident #3's bedside water cup and offered the resident a drink. Staff member K (continued on next page)		

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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.			
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated to staff member J, Not while lying down. Staff member J returned the water cup to the bedside table.-Staff member K exited the resident's room. While staff member J pulled the resident's pants up to mid-buttocks, he used the bed remote to raise the head of the resident's bed. The resident's hearing aid was seen on the resident's bed. Staff member J picked up the resident's hearing aid while wearing the soiled gloves. After raising the head of the resident's bed, staff member J picked up the bedside water cup with the same soiled gloves on and offered the resident a drink; staff member J held the water cup while the resident drank.-Staff member J pulled resident #3's legs to the left side of the bed, then pulled the resident's left arm and left shoulder until the resident was in a halfway seated position. Resident #3 grimaced during this position change. Staff member J left the resident unsupported sitting on the edge of the bed to check resident #3's closet for an undershirt. Resident #3 was unable to maintain the position and lay back down on the bed with his legs hanging off the left side of the bed. Staff member J failed to ask for assistance with the transfer to ensure resident safety, and left the resident in the lift and walked away from it.-Staff member J returned to the bed and again pulled the resident's left arm and left shoulder until the resident was back in a halfway seated position. Resident #3 grimaced during this position change. While still wearing the same soiled gloves, staff member J placed a clean shirt on the resident and started to button the shirt closed. Resident #3 slowly laid back on the bed while his shirt was being buttoned. Staff member J pulled the resident's left arm and left shoulder until the resident was once again back in a halfway seated position.-Staff member J placed the drainage bag in the resident's lap. Staff member J, while still wearing the same soiled gloves, reached under his gown to answer a page from the facility's internal communication system. The resident lay back on the bed while the page was answered. Staff member J again pulled the resident's left arm and left shoulder till the resident was back in a halfway seated position. Resident #3 once again grimaced and moaned in pain during this position change. -Staff member J wrapped the [NAME] sling around the resident's trunk and hooked the sling to the lift. Staff member J placed the right leg in the left leg support of the lift and then pushed the lift closer to the resident, pinching the right leg between the lift and the resident's bed. Resident #3 stated, Ouch! Staff member J stated, Oh, sorry, while they pulled the lift away from the resident's bed. Staff member J placed both legs in the leg support of the lift and fastened the leg belt. -Staff member J, while wearing the same soiled gloves, raised the resident into a standing position and then left the resident in a half-standing position while they removed a pillow from the resident's wheelchair. Staff member J placed the wheelchair behind the resident and stood in front of the Sara lift to lower the resident. Staff member J then noticed there were sandals on the seat of the wheelchair. Staff member J, while wearing the same soiled gloves, returned to the wheelchair and removed the sandals from the wheelchair seat.-Staff member J returned to the front of the Sara lift and lowered the resident into the wheelchair. Resident #3's wheelchair had an oxygen tank and tubing attached to the back of the wheelchair. The oxygen tubing, which included the nasal cannula, was resting directly on the floor behind the wheelchair. Staff member J took the drainage bag from the resident's lap and placed it directly on the floor. Staff member J stated they were going to empty the urine bag now, so I can get you out of the way (rather than providing the care after breakfast). -Staff member J then removed the soiled gloves without performing hand hygiene and donned new gloves. After the drainage bag was emptied, staff member J removed their soiled gloves and buttoned the remaining buttons on the resident's shirt. Staff member J picked up the oxygen tubing from the floor and placed the nasal cannula in the resident's nose.-Staff member J noticed the resident's pants were not pulled up completely. Staff member J placed the [NAME] sling around the resident's trunk, hooked the sling to the lift, and raised resident #3 into a half-standing position in order to completely pull up the (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's pants. Resident #3 remained in the half-standing position while staff member J reached under their gown to answer a status check from the facility's internal communication system. After staff member J responded to the status check, staff member J adjusted resident #3's pants and returned the resident to a seated position. During an interview on 7/14/26 at 10:12 a.m., staff member J stated this was their second day working on their own; they had finished their training and facility orientation. Staff member J stated they knew to keep the drainage bag on the same side of the body that the catheter was inserted on. Staff member J could not say what level of the body the drainage bag should remain during cares. Staff member J asked if he could go ask another staff member and left resident #3's room. Staff member J returned to resident #3's room at 10:21 a.m. and stated he could look on the intra-web later for the answer. Staff member J stated they thought it should be below where the catheter is inserted, and I should have done that. Staff member J stated the pain assessment was not in their scope of practice. But they knew to move as fast as possible when giving care to limit the amount of pain the resident experienced. Staff member J stated the Sara lift was the lift they were told to use with resident #3 because the resident could still use his left arm. Staff member J stated as long as the resident was comfortable and not in pain, they could leave the resident in the Sara lift (standing position) while they removed items from the wheelchair or went and grabbed supplies. During an interview on 7/15/26 at 1:24 p.m., staff member M stated they had been employed at the facility for almost a year and received training on many things like catheter care, resident care, hand hygiene, and more, but could not remember exactly. Staff member M stated all CNAs needed to shadow another CNA for six weeks and had a skills checklist completed before being allowed on the floor to work by themselves. During an interview on 7/15/26 at 2:24 p.m., staff member I stated CNAs were to report to the nurse on duty any signs or reports of pain by a resident. Staff member I stated they were not aware of any training the CNAs received regarding non-verbal pain cues, but it's common sense. Staff member I stated (regarding lift training) all staff members, get all the training in the world, with a refresher training every year provided by the manager. During an interview on 7/15/26 at 3:05 p.m., staff member K stated CNAs had a two-day workshop once they were hired which covered the following training: policies, resident care, dementia education, how to document, hand hygiene, lifts and how to use them, bathing, laundry, isolation, food handling, and how to feed the residents. Staff member K stated there was more training covered but could not remember all of it off the top of their head. Staff member K stated all CNAs shadow a CNA preceptor for at least four weeks. Staff member K stated some staff members may get longer if they asked for it. Staff member K stated a skills checklist should be done before a new staff member was allowed to work on the floor by themselves. Staff member K stated the checklist was to be completed by the CNA being shadowed by the new staff member. Staff member K stated they believed catheter care training covered the position of a urine drainage bag. During an interview on 7/16/26 at 9:37 a.m., staff member B stated CNAs received six weeks of on-the-floor training with annual refreshers. Staff member B stated the training included using the mechanical lifts and making sure the CNA knew the correct way they were to be used, and for using the lift pads/sling placement, and the leg and safety strap placement for the sit-to-stand (Sara lift). Staff member B stated CNAs could not assess pain as in-depth as a nurse could, but they should have awareness of signs of resident pain. When pain occurred, the CNAs were trained when to report it to the nurse during the initial CNA training. Review of staff member J's competency checklist titled, Initial Competency Assessment-Certified Nursing Assistant, Dept: East View, dated 7/9/26, showed staff member N signed off that staff member J was competent on the following skills: . Overall Care and Safety: Demonstrates ability to observe patient's mental and physical conditions and seek out assistance when necessary. Dated 6/30/26., (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verbalizes knowledge of the delivery of patient care in an environment that optimizes patient safety and reduces the likelihood of medical/health care errors. Dated 6/30/26,. Demonstrates compliance with infection control policies and procedures. Dated 6/30,. Demonstrates ability to find and speak to the patient safety guide as it pertains to meeting regulatory requirements (located on [Facility Name] Intranet). Dated 6/30,. Demonstrates ability to adapt to unexpected events and critical situations and escalates patient care concerns appropriately and reports to the nurse. Dated 6/30, . Safety:. Appropriately assists patients at-risk for falls and assists with implementing safety precautions following health system policy and procedure. Dated 6/30.Review of the facility's policy titled, .Lift and Transfer Guideline, revised on January of 2021, showed: . VII. Types of Lifts . A. Sara lift . d. Brings the Sara lift up to the patient, placing the patient's feet on the footrest and continuing forward until the kneepad is in contact with the patient's knee or upper shin. j. NOTE: Those patients who have suffered a stroke or who can only hold on with one hand or not at all can still be lifted by the Sara lift but require a second nurse to stand by to strive to provide safety . k. Caution: The Sara lift is not designed for long periods of suspension or transportation.		