

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Benefis Senior Services - Grandview		STREET ADDRESS, CITY, STATE, ZIP CODE 3015 18th 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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>48261</p> <p>Based on interviews and record review, the facility failed to provide a safe and orderly discharge from the facility, to home, for 1 (#1) of 3 sampled residents, and the resident had not met his goals prior to the discharge, he had a wound/fistula, multiple medications, and needed ongoing rehabilitation services. The failure increased the risk of a poor outcome and safety concerns for the resident due to his inability to care for himself as needed. Findings include:</p> <p>During an interview on 10/2/24 at 10:18 a.m., NF1 stated resident #1 was discharged home alone, and the family had not seen any home health services since the discharge occurred, which was eight days prior. NF1 stated resident #1 lived alone, and the family lived in the same apartment complex but were not planning to provide fulltime care to resident #1 upon discharge. NF1 stated the facility relayed they would be sending physical therapy, occupational therapy, and nursing, to assist with resident #1's care needs and training once home. NF1 stated resident #1 was not able to provide himself peri care, he could barely walk out of the hospital with a walker, and was dropped off at the street of his apartment complex. He had to walk a long distance to his apartment, and go up eleven steps, to get to the apartment. NF1 stated resident #1 barely made the walk, with many stops along the way, and he had the assistance of NF2 holding him. NF1 stated the family was unsure of the resident's medications, with more than 30 pills to be taken at various times and were in fear of causing a medication error. NF1 stated resident #1 was falling at the facility and was again falling at home after discharge. NF1 stated she had attempted to get the primary care provider initial appointment moved up to a closer date, but was told there were no appointments sooner. NF1 stated she also contacted the home health agency and was told they could not assist resident #1 until the 10/8/24 appointment, because they needed orders to treat from the new primary provider. NF1 stated she contacted the facility, and spoke with staff member C, who told her the facility could no longer assist resident #1, because he was no longer a resident in the facility.</p> <p>During an interview on 10/2/24 at 11:41 a.m., NF2 stated resident #1 was barely able to walk out of the facility with a walker, and the nurse was concerned about resident #1 needing a wheelchair. NF2 stated resident #1 was now wheelchair bound at home and he was trying to assist resident #1 with his walker to get him some strength. NF2 stated resident #1 stated when he cannot see his legs, he cannot walk. NF2 stated he was assisting resident #1 with diabetic pressure wounds on his feet, that he had on discharge from the facility, by using iodine soaks. NF2 stated he had the idea to use iodine soaks from resident #1, who had used iodine soaks on his prior pressure ulcers. NF2 stated there were no wound care or fistula instructions provided in the discharge paperwork.</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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/2/24 at 11:49 a.m., NF3 stated she attended a care conference to discuss resident #1's discharge plans. NF3 stated staff member C began to become angry and was blaming resident #1 for not getting the care he needed prior to discharge. NF3 stated staff member C was mad because the family was asking too many questions about the discharge plan.</p> <p>During an interview on 10/2/24 at 1:20 p.m., with staff member A and C, staff member C stated the required elements for a discharge included the resident meet their prior level of ADL status or their new baseline, based on their diagnosis; the resident would need a safe place to discharge to; and we would try to get a home evaluation, if possible. Staff member C stated her role was to set-up the home health, physical therapy, and occupational therapy. Staff member C stated she did send a referral for services for resident #1 and was not aware the services were never started. Staff member C stated she did not follow-up with the residents or family following a discharge from the facility, and did not the contact referral agency to confirm services would be in place for discharge. Staff member C stated the family of resident #1 was not pleasant to work with, and the agency usually contacted the family or resident directly to start care.</p> <p>During an interview on 10/2/24 at 1:55 p.m., resident #1 stated he had current swelling at his fistula site and down his arm with a pain level of a 5-6 out of 10. Resident #1 stated he had reported pain and swelling when he was in the facility, and the facility said he would need to talk to his primary provider on the 10/8/24 appointment. Resident #1 stated the parking lot (at his residence) was under construction, and he nearly had a fall getting to his apartment, and NF2 had to catch him. Resident #1 stated he was still very weak, had no balance, and my brain is still messed up [confusion and foggy]. Resident #1 stated the facility tried to say he was refusing therapy, but he never did. Resident #1 stated the facility even made him get up at 6:00 a.m. and miss breakfast to do therapy. Resident #1 stated he was not a morning person, but he did the therapy so he could get better.</p> <p>During an interview on 10/2/24 at 4:21 p.m., NF4 stated the facility was aware of the regulations requiring the primary physician to write orders for services provided after the discharge. NF4 stated the agency could not start services until the 10/8/24 appointment with the new primary physician, so new orders could be written for services. NF4 stated she did not know why the facility discharged the resident prior to the appointment.</p> <p>Review of resident #1's After Visit Summary, dated 9/24/24, reflected the following:</p> <ul style="list-style-type: none"> - A follow-up appointment with the new primary physician was scheduled for 10/8/24, - Follow-up with Home Health for skilled nursing, physical therapy, and occupational therapy, - Medication orders with medications to be picked up at pharmacy. <p>The After Visit Summary did not contain wound care orders for the diabetic wound care to the left foot or treatment/care of the fistula.</p> <p>Review of resident #1's Occupational Therapy Discharge Report, dated 9/23/24, reflected resident #1 had not met the following goals:</p> <ul style="list-style-type: none"> - Safely completing grooming tasks progressing from seated tasks to standing; <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Safely perform toilet transfer and toileting tasks using standard commode and grab bars; - Safely perform bathing tasks; - Demonstrate improved ADL safety by increasing Modified Barthel score from 37 to 80 or better to safely return home with least restrictive assist. <p>The Occupational Therapy Discharge report showed the recommendation included home health occupational therapy.</p> <p>Review of resident #1's Physical Therapy Discharge Report, dated 9/23/24, reflected the assessing physical therapist recommended, . continued physical therapy intervention via home health services to ensure safe transition into prior level of living and continue to maximize functional gains.</p> <p>Review of resident #1's Physician Discharge Summary, dated 9/24/24, reflected the follow:</p> <ul style="list-style-type: none"> - Resident #1 was homebound, requiring skilled home health services; - The physical therapy content showed, . the patient does not believe he feels prepared to discharge home; - Wound care needs for diabetic wounds; - PT and OT were recommended. <p>The facility failed to ensure necessary services, including skilled nursing, physical therapy and occupational therapy were in place prior to discharging resident #1 home alone, putting resident #1 at risk for a negative outcome.</p>		

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245</p> <p>Based on interview and record review, the facility failed to ensure call lights were answered in an appropriate timeframe for 3 (#s 5, 6, and 10) of 4 sampled residents concerning call lights; and the facility failed to prevent falls for 1 resident (#5) requiring help after pushing the call light. This had the potential to result in more falls in the facility with those residents requiring help and pushing the call light button for assistance. Findings include:</p> <p>a. During an interview on 10/2/24 at 10:06 a.m., resident #10 stated she would wait the longest for her call light to be answered when it was shift change or after 6:00 p.m. Resident #10 stated she would often wait 20 minutes for her call light to be answered. Resident #10 stated staff would also turn off her call light and leave the room before all her needs were met. Resident #10 stated when she had spoken up in the past to staff, and she had been reprimanded by the staff about complaining. She stated, They say they'll be back in ten minutes and they don't. And sometimes the pagers (the pagers alert the staff call lights were going off) don't work at all. They're usually aware of it, but (it) still doesn't make you feel very good. Resident #10 stated, [Pagers are not working] It seems like it happens often.</p> <p>Review of a facility provided document, titled Call History, dated from 9/18/24 to 10/2/24, showed resident #10 had 15 call light uses, eight of those were over 15 minutes; two were 20 minutes, two were 27 minutes, one was 32 minutes, two were over 40 minutes, and one call light wait time was for an hour.</p> <p>b. During an interview on 10/2/24 at 11:25 a.m., resident #6 stated she pushed the call light, 15 minutes ago and she, often waits a long time.</p> <p>Review of a facility provided document titled Call History, dated from 9/18/24 to 10/2/24, showed resident #6 had 14 call light uses, 13 of those were over 15 minutes, including one for an hour wait, and one for a two-hour wait time.</p> <p>c. During an interview on 10/2/24 at 12:10 p.m., resident #5 stated he would wait over 45 minutes to get his call light answered. Resident #5 stated in one instance he was tired of waiting and had tried to get up without staff present.</p> <p>Review of a nursing note in resident #5's EHR, dated 9/5/24, showed resident #5 fell on [DATE] at 12:00 p. m.</p> <p>Review of a facility provided document titled Call History, dated 9/4/24 to 9/5/24, showed resident #5's call light had been on for 36 minutes, starting at 11:41 a.m., on the day of the fall.</p> <p>Review of a facility provided document titled Call History, dated from 9/18/24 to 10/2/24, showed the resident #5's had four call light uses; two were over 15 minutes, one was over 30 minutes, and one was a 59 minute call light wait time.</p> <p>During an interview on 10/2/24 at 3:21 p.m., staff member A stated the expectation for call lights to be answered was seven to nine minutes.</p>		