| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 275157 | A. Building<br>B. Wing | 05/20/2025 |

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| Benefis Senior Services - Grandview | 3015 18th Ave S<br>Great Falls, MT 59405 |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>48268<br><br>Based on interview and record review, the facility failed to provide the required SNF Beneficiary Notification, Form CMS-10055 to 1 (#111) of 3 sampled residents who received Medicare Part A skilled services. Findings include:<br><br>During an interview on 5/19/25 at 2:27 p.m., staff member A stated the facility had not completed the SNF Beneficiary Notification Form CMS-10055 when resident #111 was discharged from skilled care services. Staff member A was not able to explain why the notice was not completed.<br><br>Review of the facility-provided document titled, SNF Beneficiary Notification Review, showed the start date for Medicare Part A skilled services was 4/10/25, with the last covered day of 5/12/25. The facility was not able to provide evidence the SNF Beneficiary Notification Form CMS-10055 was completed. |

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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>41951<br><br>Based on interview and record review, the facility failed to ensure psychotropic medications, prescribed on an as needed basis, were limited to 14 days unless the resident's medical record included documented rationale for continued use for 2 (#3 and #6) of 17 sampled residents. Findings include:<br><br>1. Review of resident #3's current as needed medication records, as of 5/18/25, showed:<br><br>- alprazolam 0.25 mg, by mouth, nightly as needed.<br><br>The medication order for resident #3 did not include an end/stop date or was limited to 14 days.<br><br>During an interview on 5/19/25 at 7:44 a.m., staff member A stated antipsychotic or psychotropic medication orders were limited to 14 days. He stated there should be a stop date on the medication orders for these medications.<br><br>48268<br><br>2. During an interview on 5/19/25 at 11:28 a.m., staff member I stated PRN psychotropic medication orders were, usually for less than 14 days, but (resident #6) is on hospice, so I just don't know if it can be ordered for longer.<br><br>Review of resident #6's physician orders showed two separate and active orders for as needed (PRN) lorazepam concentrated solution with a one year end date. The orders read as follows:<br><br>- LORazepam (Intensol) concentrated solution . Route oral . Admin Dose 0.5-1 mg Frequency: Every 2 hours PRN . Start Date 4/18/25 . End Date 4/18/26 .<br><br>- LORazepam (Intensol) concentrated solution . Route oral . Admin Dose 1-2 mg Frequency: Every 1 hour PRN . Start Date 4/18/25 . End Date 4/18/26 . [sic] |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41951<br><br>Based on interview and record review, the facility failed to notify the resident and/or the resident's representative, in writing, of the facility's bed hold policy when transferring a resident to the hospital for 1 (#3) of 17 sampled residents. Findings include:<br><br>During an interview on 5/19/25 at 2:37 p.m., staff member B stated the facility did not have documentation of a bed hold policy notification for resident #3's hospitalization on [DATE].<br><br>Review of the facility's policy titled, [Facility] Room Hold Policy, last revised 6/2024, showed:<br><br>- . Policy:<br><br>- . Resident and/or resident's representative will be notified in writing of [Facility] Room Hold Policy. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>41951<br><br>Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan which included the minimum necessary instructions needed to provide effective and person-centered care of the resident for 3 (#s 3, 17, and 21) of 17 sampled residents. Findings include:<br><br>During an observation on 5/17/25 at 3:02 p.m., resident #17 was lying in bed, receiving oxygen via nasal cannula.<br><br>Review of resident #17's document titled, Baseline Care Plan, dated 4/7/25, did not include a problem, goals, or interventions for oxygen therapy.<br><br>During an observation on 5/18/25 at 8:35 a.m., resident #3 was lying in bed, receiving oxygen via nasal cannula.<br><br>Review of resident #3's document titled, Baseline Care Plan, dated 4/28/25, did not include a problem, goals, or interventions for oxygen therapy.<br><br>During an observation and interview on 5/18/25 at 8:20 a.m., resident #21 was receiving supplemental oxygen via nasal cannula. Resident #21 stated he had a catheter in place due to urinary retention and needed a lot of assistance with toileting or to even get out of bed due to his cancer diagnosis.<br><br>Review of resident #21's document titled, Baseline Care Plan, dated 4/14/25, did not include a problem, goals, or interventions for oxygen therapy, urinary catheter care, or any needed assistance for his extensive needs with activities of daily living.<br><br>During an interview on 5/19/25 at 7:56 a.m., staff member C stated nursing started the baseline care plans for the residents at admission. Staff member C stated the baseline care plan should include activities of daily living, pain, urinary issues, falls, psych meds, and oxygen, in addition to other areas needed to provide the initial care for residents.<br><br>During an interview on 5/20/25 starting at 8:56 a.m., staff member C stated when completing the initial care plan, they (facility staff) were not always including all the information for the continuity of care of the resident. Staff member G stated some of the system areas for the computer entry needed to be discussed so a thorough baseline care plan was completed. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41951<br><br>Based on observation, interview, and record review, the facility failed to initiate a person-centered comprehensive care plan to include the use of oxygen therapy for 2 (#s 3 and 17); and failed to include an increased risk of aspiration for a resident admitted to the hospital and returned after an event of food aspiration for 1 (#3) of 17 sampled residents. Findings include:<br><br>1. Resident #3<br><br>During an observation on 5/18/25 at 8:35 a.m., resident #3 was lying in bed, receiving oxygen via nasal cannula.<br><br>During an interview on 5/19/25 at 12:23 p.m., staff member D stated since resident #3 returned from the hospital after an aspiration event, they (staff) either asked the resident to eat in the dining room, or where she could be watched. Staff member D stated if resident #3 remained in her room for meals, staff sat with her during that time.<br><br>During an interview on 5/19/25 at 12:26 p.m., resident #3 stated staff never sat with her when she ate in her room, and it was her choice to stay in her room during meals.<br><br>Review of resident #3's Nursing Admission Note, dated 4/29/25, showed she was admitted to the facility for management of aspiration and respiratory failure.<br><br>Review of resident #3's Admission MDS, with an ARD of 5/4/25, Section K - Swallowing/Nutritional Status, showed:<br><br>- Under K0100. Swallowing Disorder,<br><br>- . C. Coughing or choking during meals or when swallowing medications,<br><br>- D. Complaints of difficulty or pain with swallowing.<br><br>Both areas were marked with an X, which designated they applied.<br><br>Review of resident #3's Admission MDS, with an ARD of 5/4/25, Section O - Special Treatment and Programs, showed:<br><br>- .C1. Oxygen therapy, while a resident.<br><br>Review of resident #3's Comprehensive Care Plan, printed 5/18/25, did not include a problem, goals, or interventions for oxygen therapy or an increased risk for aspiration or swallowing difficulties.<br><br>2. Resident #17<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 5/17/25 at 3:02 p.m., resident #17 was lying in bed, receiving oxygen via nasal cannula. Resident #17 stated she had been on oxygen since her admission into the facility on [DATE].<br><br>Review of resident #17's Admission MDS, with an ARD of 4/13/25, Section O - Special Treatment and Programs, showed:<br><br>- .C1. Oxygen therapy, while a resident.<br><br>Review of resident #17's Comprehensive Care Plan, printed 5/18/25, did not include a problem, goals, or interventions for oxygen therapy.<br><br>During an interview on 5/19/25 at 8:36 a.m., staff member C stated the care area of oxygen therapy should be included in the comprehensive care plan for residents #17 and #3. Staff member C stated the MDS assessment care areas should be included in the comprehensive care plan. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>48268<br><br>Based on observation, interview, and record review, the facility failed to update resident care plans to include actual falls and updated fall interventions for 2 (#s 4 and 180) of 17 sampled residents. The failures placed the residents at risk for recurrent falls and injuries. Findings include:<br><br>1. During an observation and interview on 5/17/25 at 3:45 p.m., resident #4 was seated in a wheelchair, leaning to the right side, holding both arm rests. Resident #4 stated he had some falls in the past, stating, I think it's this chair. I don't know, I think I just slide out.<br><br>During an interview on 5/18/25 at 9:15 a.m., staff member I stated, He (resident #4) has had some falls, I think. I am not sure what interventions were placed to keep him from falling. I have not been here a long time, so might not be the best person to talk to . I would look in the (medical) record, or the care plan if I wasn't sure how to care for him.<br><br>Review of resident #4's progress notes showed he experienced an unwitnessed fall from bed on 10/5/24.<br><br>Review of the facility document titled, Risk Management Worksheet, dated 10/5/24, showed resident #4 experienced a fall from his bed on 10/5/24 at 9:10 a.m. The report showed, BP normally low at times on BP meds . wife noted [resident name] is very impulsive . Care plan updated . [sic]<br><br>Review of resident #4's care plan, dated 9/26/24, showed, Potential for Falls. The care plan did not reflect the fall on 10/5/24, did not reflect resident #4's impulsivity, and did not show new interventions post-fall.<br><br>32998<br><br>2. During an interview on 5/20/25 starting at 8:32 a.m., staff members B, C, and G stated an event report was triggered by nursing following every fall. Staff members B, C, and G stated the Risk Management team was also the fall committee. They stated the Risk Management team met weekly, and care plans were updated on Mondays, Wednesdays, and Fridays. Staff members B, C, and G stated the care planned interventions were reviewed, and evaluated for effectiveness to determine if any new interventions were to be added. Staff members B, C, and G stated the Post Fall Assessment had information on root cause analysis. Staff members B, C, and G stated a sample of chart audits were done weekly to determine if the steps for falls were completed. Staff member B, C, and G stated the 24 hour report was reviewed by the manager to determine if anything needed follow up. Staff member G stated the care plans did not update automatically.<br><br>Review of resident #180's Significant Event report, dated 4/23/25, showed the resident was found on the floor, kneeling next to his bed. The resident was confused and stated he just rolled out of bed. There were no injuries documented.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of resident #180's Significant Event report, dated 5/3/25, showed the resident was found with his upper body on the bed and his lower extremities on the floor. The resident sustained lacerations to both knees. No other injuries were documented.<br><br>Review of resident #180's Significant Event report, dated 5/14/25, showed the resident was found lying on the floor, and partially on his wheelchair. The report showed the resident appeared to have slid out of his wheelchair to the floor. The resident was assessed and no injuries were documented.<br><br>Review of resident #180's care plan showed interventions implemented on 4/20/25, two days following admission. There were no updated interventions following the falls on 4/23/25, 5/3/25, and 5/14/25, to attempt to reduce or pevent future falls, related to the root causes from the three falls. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41951<br><br>Based on observation, interview, and record review, the facility failed to ensure the oxygen rate of delivery was included in the provider's oxygen orders for 4 (#s 3, 17, 78, and 129); failed to ensure a form of documentation was in place for when oxygen tubing was last changed for 5 (#s 3, 17, 21, 78, and 129); and failed to ensure proper infection control practices were adhered to for a respiratory nebulizer mask/mouthpiece for 1 (#17) of 17 sampled residents. These deficient practices had the potential to affect the correct rate of oxygen delivery and increase the risk for infections in residents with prescribed oxygen. Findings include:<br><br>1. Oxygen Orders<br><br>During an observation on 5/17/25 at 3:02 p.m., resident #17 was lying in bed, receiving oxygen via nasal cannula. The oxygen concentrator was set at three liters per minute.<br><br>Review of resident #17's Oxygen Therapy orders, dated 4/7/25 at 5:02 p.m., showed oxygen to be delivered continuous, via nasal cannula; and, Keep O2 Sat Above 90%. The provider's order for oxygen did not include a rate of delivery.<br><br>During an observation on 5/17/25 at 3:19 p.m., resident #78 was seated in his recliner, receiving oxygen via nasal cannula. The oxygen concentrator was set at four liters per minute.<br><br>Review of resident #78's Other Nursing orders, dated 4/30/25 at 1:38 p.m., showed, RT/RN to determine oxygen supplementation to maintain oxygen saturation > 92%. Review of resident #78's Oxygen Therapy orders, dated 4/30/25 at 1:38 p.m., showed oxygen to be delivered continuous, via nasal cannula; and, Keep O2 Sat Above 90%. The two provider's orders were contradictory and neither order defined the oxygen rate of delivery.<br><br>During an observation on 5/17/25 at 3:49 p.m., resident #129 was lying in bed, receiving oxygen via nasal cannula. The oxygen concentrator was set at two liters per minute.<br><br>Review of resident #129's Oxygen Therapy orders, dated 5/9/25 at 1:37 p.m., showed, oxygen to be delivered, (home O2 @ noc) [sic] continuous, via nasal cannula, Keep O2 Sat Above 88%. The provider's order for oxygen did not include a rate of delivery.<br><br>During an observation on 5/18/25 at 8:35 a.m., resident #3 was lying in bed, receiving oxygen via nasal cannula.<br><br>Review of resident #3's Oxygen Therapy orders, dated 4/28/25 at 4:54 p.m., showed oxygen to be delivered continuous, via nasal cannula; and, Keep O2 Sat Above 92%. The provider's order for oxygen did not include a rate of delivery.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/18/25 at 1:30 p.m., staff member D stated vital signs were recorded two times a day and oxygen saturation was monitored at that time. Staff member D stated oxygen orders were written all the time with only the titration of oxygen to a certain saturation level. He stated he felt comfortable with the titration orders for oxygen, but he had [AGE] years of experience in nursing.<br><br>During an interview on 5/19/25 at 7:41 a.m., staff member B stated some oxygen orders for residents did not include a rate of delivery. Staff member B stated those oxygen orders were likely the orders when the resident was discharged from the hospital, before admission to the facility. Staff member B stated it had to do with the computer system used by both the hospital and the nursing facility.<br><br>2. Oxygen Tubing<br><br>During an observation and interview on 5/17/25 at 3:02 p.m., resident #17 was receiving oxygen via nasal cannula. No visible date or labeling was on the oxygen tubing to show the last time the tubing was changed. Resident #17 stated they changed the tubing, the other day.<br><br>During an observation on 5/17/25 at 3:19 p.m., resident #78 was receiving oxygen via nasal cannula. No visible date or labeling was on the oxygen tubing which showed the last time the tubing was changed.<br><br>During an observation on 5/17/25 at 3:49 p.m., resident #129 was receiving oxygen via nasal cannula. No visible date or labeling was on the oxygen tubing which showed the last time the tubing was changed.<br><br>During an observation on 5/18/25 at 8:22 a.m., resident #21 was receiving oxygen via nasal cannula. No visible date or labeling was on the oxygen tubing which showed the last time the tubing was changed.<br><br>During an observation on 5/18/25 at 8:47 a.m., resident #3 was receiving oxygen via nasal cannula. No visible date or labeling was on the oxygen tubing which showed the last time the tubing was changed.<br><br>During an observation and interview on 5/18/25 at 1:32 p.m., staff member D stated oxygen tubing was changed on Saturday nights but was unsure if there was any documentation in the computer system where it would be recorded. Staff member D stated each resident's oxygen tubing change date should be written on the oxygen tubing. Located in the nurse's lounge/room was a whiteboard with instructions for the changing of oxygen tubing. The whiteboard showed, Replace weekly on NOCS Saturdays, Nebulizer tubing/mask, O2 tubing, Date when changed. [sic]<br><br>During an interview on 5/19/25 at 7:38 a.m., staff member B stated on Saturday nights, CNAs changed the oxygen tubing and marked/dated the tubing of the change. She stated there may have been a mix up this last Saturday due to the assigned CNAs filling in from a different campus location. Staff member B stated she had suggested the staff would place tape over the writing so it did not wear off the tubing and could be easily read. She was unsure if the oxygen tubing changes were documented in the resident's medical record.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's policy titled, [Facility]-Respiratory Therapy, last revised 1/2001, showed:<br><br>- . B. Equipment is cleaned or replaced in the following manner:<br><br>- . 2. Cannulas are changed weekly or if soiled, completed by the night shift.<br><br>3. Nebulizer machine/mask/mouthpiece<br><br>During an observation and interview on 5/17/25 at 3:02 p.m., resident #17's nebulizer machine was sitting on the carpeted floor, next to the trash receptacle. There were four used tissues/paper towels on top of the nebulizer mouthpiece, with the mouthpiece touching the floor. Resident #17 stated the staff had changed the nebulizer mouthpiece on 5/16/25.<br><br>Review of resident #17's current scheduled medication orders, printed 5/18/25 at 12:19 p.m., showed:<br><br>- albuterol 2.5 mg/3ml, 0.083% nebulizer solution, to be administered via nebulization, four times daily.<br><br>During an observation on 5/18/25 at 8:33 a.m., resident #17's nebulizer machine was lying on the carpeted floor, next to the trash receptacle, with the mouthpiece touching the floor.<br><br>During an interview on 5/18/25 at 1:38 p.m., staff member D stated resident #17's nebulizer machine and mouthpiece should not be lying on the floor. He stated it would not adhere to proper infection control practices. Staff member D stated resident #17 did move items around sometimes, but since she was unable to get out of bed independently, he doubted she would have placed the nebulizer on the floor. Staff member D stated he would replace the mouthpiece with a clean one.<br><br>During an interview on 5/19/25 at 7:47 a.m., staff member B stated it would be poor infection control practice to place a nebulizer and mouthpiece on the floor. |

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| Benefis Senior Services - Grandview | 3015 18th Ave S<br>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) |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>41951<br><br>Based on observation, interview, and record review, the facility failed to ensure staff member H adhered to sanitary hygiene practices, by wearing a beard net/covering while preparing residents' food trays in the kitchen area. This failure increased the risk of hair getting in food for any resident the employee was preparing food for, or from the area the employee was working in, when not wearing protective hair coverings. Findings include:<br><br>During an observation on 5/19/25 at 8:50 a.m., staff member H was preparing four individual residents' breakfast trays on the countertop located in the 500-hall kitchen area. Staff member H was wearing a hairnet but did not have a beard net covering his facial hair.<br><br>During an interview on 5/19/25 at 9:04 a.m., staff member H stated he should have worn a beard net while he prepared trays in the kitchen area. Staff members E and F stated a hat or hairnet, and beard net, if indicated, must be worn to prepare food in the kitchen area.<br><br>Review of the facility's document titled, Food & Nutrition Services Dress Code, last revised 8/26/24, showed:<br><br>- . Hair/Nails<br><br>- Generally, hair must be restrained in foodservice area's.<br><br>. If your hair is over 1/4 in length, you must wear one or a combination of the following:<br><br>- . Facial hair restraint for facial hair longer than 1/4 inch. [sic] |