STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, assess, measure, document, monitor, and obtain physician orders promptly for the treatment and care of an avoidable pressure ulcer, including failing to develop and implement a baseline care plan for pressure ulcer prevention. The pressure ulcer developed within ten days of the resident's admission to the facility and worsened to a Stage IV, causing the resident pain. She did not want to be repositioned and voiced not wanting to live. The resident was placed in Hospice for end-of-life care and services for 1 (#27) of 5 residents sampled for pressure injuries. This deficient practice increased the risk of negative outcomes of the admission identification process of pressure injuries and residents at risk of developing pressure injuries.On [DATE] at 10:04 a.m., Immediate Jeopardy was announced to the Administrator, Chief Nursing Officer, and Director of Quality and Patient Safety for F686-Pressure Ulcers Care and Prevention. The Severity and Scope identified for the Immediate Jeopardy were identified to be at the level of J, and upon verification for the removal of the immediacy, be lowered to a G. An acceptable plan for the Removal of Immediacy was approved on [DATE] at 6:05 p.m.Findings include:During an interview on [DATE] at 8:03 a.m., NF3 stated resident #27 was admitted to the hospital due to a fall at home, which resulted in a hip fracture that required surgical repair. Resident #27 was then admitted from the hospital to the facility for rehab services on [DATE], before planning to return home. NF3 stated the resident did not have any pressure injuries while in the hospital, and her skin was intact when she was admitted to the facility on [DATE]. NF3 stated that the only skin concern resident #27 had when she was admitted to the facility was a surgical wound on her right hip, which was healing. NF3 stated she was made aware of the wound on resident #27's sacrum on [DATE]. She stated she was not aware of how long the resident had had the sacral wound since the facility had never informed her of the wound. NF3 stated she had a meeting with the facility in [DATE], and they had told her the wound was present upon the resident's admission to the facility. She stated she did not believe this to be true since the resident did not have a pressure injury while in the hospital, and the facility had never mentioned a sacral wound when the resident was admitted . NF3 stated the facility had not completed a skin assessment when resident #27 was admitted and had not implemented any wound prevention interventions for the resident until after the wound was identified. She stated that staff member G was the only staff member who had informed her of the pressure injury on resident #27's sacrum. She stated staff member G had told her they were going to order an air mattress and have the wound nurse assess the resident's wound. NF3 stated she was surprised and upset to find out these interventions were not in place sooner. NF3 stated that when the facility informed her of the sacral wound, she was told it was Unstageable (Full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. Until enough slough and/or eschar is removed to determine true depth, the ulcer cannot be staged (severity classified) - as defined in the cited facility's policy). She stated that after resident #27's wound was debrided at the Wound Clinic, she was informed the sacral wound was a Stage IV (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Full thickness: Involves epidermis, dermis, and subcutaneous tissues, muscle, or bone - as defined in the cited facility's (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	policy). She stated the resident was in a lot of pain from her sacral wound and no longer wanted to get out of bed or be repositioned. NF3 stated they decided to discharge the resident to an inpatient hospice on [DATE], and the resident died on [DATE]. NF3 stated she felt the facility's failure to identify and treat the sacral wound contributed to the resident's death.Review of resident #27's Hospital Discharge Care Plan, dated [DATE], showed a closed surgical wound, last assessed [DATE], as clean, dry, and intact. The Hospital Discharge Care Plan did not address a sacral pressure injury.Review of resident #27's Hospital Case Management Note, dated [DATE], showed the resident was transferred from the hospital to the facility on [DATE], for physical and occupational therapy following the surgical repair of her right hip fracture. The active problem list did not include a sacral pressure injury.Review of resident #27's Hospital Provider Discharge Note, dated [DATE], did not include a sacral pressure injury that was present upon the resident's discharge from the hospital to the facility.A. admission Assessment and Baseline Care PlanReview of resident #27's Facility Nursing admission Note, dated [DATE], showed skin was within normal limits and no pressure-related injury was present on admission. The Nursing admission Note did not include a skin assessment or identification of a sacral pressure injury.Review of resident #27's Provider admission Note and Orders, dated [DATE], did not show that a pressure-related injury was assessed or present on admission to the facility on [DATE].Review of resident #27's Care Plan Meeting, effective from [DATE] to [DATE], showed:- admission Team Discussion, dated [DATE], showed, Medical Problems: Wounds: No was documented.- admission Nursing Assessment, dated [DATE], showed, Skin [within normal limits]. No pressure related injury present on admission.- Dietitian Assessment, dated [DATE], showed, Nutritional Assessment Note. Braden Scale Score: 15 (At Risk). Wounds: surgical at right hip. A pressure injury was not noted.- Provider Assessment and Plan, dated [DATE], did not show that a pressure-related injury was assessed or present on admission.- Current Problems, showed, Pressure Injury of sacral region, unstageable, noted on [DATE]. The sacral pressure injury was not noted until [DATE]. Review of resident #27's Baseline Care Plan, with an effective date of [DATE] through [DATE], showed a Braden Skin Score, with no date, which was scored at 17 (Mild Risk). A skin assessment, with no date, showed, Integumentary [within defined limits], Skin Color: Pale, Skin Integrity: bruising, Bruising: [left upper extremity, right lower extremity, right groin]. Skin and Ulcer treatments: Pressure reducing device for chair, Pressure reducing device for bed, Turning/repositioning program, Pressure ulcer care. The baseline care plan did not include identification of a sacral pressure injury, location, Stage, wound characteristics, wound treatment, or provider orders, goals, or effective prevention interventions. Review of resident #27's Skin Assessment Flowsheets, dated [DATE] to [DATE], showed the following skin assessments:- [DATE]: Integumentary [within defined limits]. Skin Integrity: Bruising. Is resident at risk for pressure ulcer/injury: yes was documented.- [DATE]: Integumentary [within defined limits]. Is resident at risk for pressure ulcer/injury: yes was documented. - [DATE]: Integumentary [within defined limits]. Skin color: Pale. Is resident at risk for pressure ulcer/injury: yes. Skin and ulcer treatments: pressure reduction was documented.Resident #27's Skin Assessments completed on [DATE] and [DATE] did not identify a sacral pressure injury. No additional skin assessments were completed or documented for resident #27 from [DATE] to [DATE], 11 days.Review of resident #27's Braden Scale Flowsheets, dated [DATE] to [DATE], showed Braden Scale Assessments (a standardized assessment tool to predict the risk of developing pressure injuries) were completed on the following dates:- [DATE]: Score of 15 (At Risk)- [DATE]: Score of 15 (At Risk)- [DATE]: Score of 16 (At Risk)- [DATE]: Score of 16 (At Risk)- [DATE]: Score of 17 (Mild Risk)- [DATE]: Score of 17 (Mild Risk)Review of resident #27's Nursing Note, dated [DATE], showed, Situation: sacral [decubitus] Background: [Resident] was originally admitted for right femur [fracture]. During my assessment with the patient, she reported having ?butt pain'. [Resident] was encouraged to turn to her side with assistance [every two hours] and [as needed]. I was assisting [Resident] in repositioning, and she said do you want to look at my butt? I said yes absolutely. She was assisted in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	standing and walking to the bathroom. When she was finished using the bathroom I removed the dressing that was in place and assessed the wound. Action: I assessed the wound and redressed the wound. When she returned to the bed I assessed what level the (air mattress) pump is on and it was placed on a firmer setting. The bed setting was changed. Discussed my thoughts with the patient (resident) and her spouse. I told them I feel she needs to be sent to wound care and also placed on a specialty mattress. Reaction: [Resident] was given a [pressure relieving cushion] and 2 Percocet (5-325) for pain. Notified [staff members EE, FF, GG, and B] about my discovery today. [sic].Review of resident #27's Nursing Note, dated [DATE], showed, 5-Day Charting and Daily Notes: [Resident] has a new discovery of sacral wound. I messaged [Staff member EE] that I feel [resident] needs a wound care consult and a Hilrom [sic] air mattress. A Hillrom air mattress is a pressureˆreducing support surface designed to help prevent and treat pressure injuries. The interventions documented and provided in resident #27's baseline care plan included a pressure-reducing device for the bed and chair, which were not timely or effectively implemented to prevent the resident's pressure ulcer from initially developing or worsening.B. Timely Wound Identification, Assessments, Measurements, Documentation, and Physician OrdersReview of resident #27's Physician admission Orders, from [DATE] to [DATE], did not show physician orders for a sacral pressure injury.Review of resident #27's Nursing Note, dated [DATE], showed, . Skin: visualized skin intact, no unusual markings. 5-Day Charting and Daily Notes: .Dressing to sacrum changed and documented in flowsheet. Review of resident #27's Flowsheet documentation for [DATE] showed, Integumentary [within defined limits]. Is resident at risk for pressure ulcer/injury: yes was documented. Review of resident #27's Nursing Note, dated [DATE], showed, Skin: incision intact, healing appropriately. No evidence of infection. The nursing note did not address the resident's sacral wound.Review of resident #27's Nursing Note, dated [DATE], showed, Skin: Dressing to sacrum soiled, changed.Review of resident #27's Nursing Note, dated [DATE], showed, Skin: visualized skin intact, no unusual markings. 5-Day Charting and Daily Notes: She stayed calm throughout the shift, took her meds and had her sacral ulcer dressed. [sic]Review of resident #27's Nursing Note, dated [DATE], showed, Skin: Sacral dressing intact. 5-Day Charting and Daily Notes: on alert charting for new admit [DATE]. The nursing notes from [DATE] to [DATE] failed to include the necessary identification, measurements, documentation, or information for the facility attempting to obtain physician orders to treat resident #27's sacral injury. Review of resident #27's Nursing Note, dated [DATE], showed, . Skin: .dressing to buttocks changed tonight. Pain: ongoing significant pain in hips and buttocks which is stable and controlled by [as needed] meds. pressure injury on buttocks and was added to the avatar. Dressing dated 2/22 was removed tonight, measurements taken, and redressed. Secure chat sent to [staff member H] nurse to assess [sic]. The nursing notes from [DATE] to [DATE] showed the sacral wound was not assessed, measured, and documented, as needed to prevent further deterioration of the wound. Review of resident #27's Physician Orders from [DATE] to [DATE] showed wound orders for the sacral wound were not implemented and in use until [DATE].Review of resident #27's Wound Assessment Flowsheets from [DATE] to [DATE] showed, Wound [DATE] Pressure Injury Mid Sacrum: Wound Properties Date First Assessed: [DATE]. Present on Original admission: [No]. Primary Wound Type: Pressure injury. (Comments): stage 4. Wound bed: 83% Slough. Margins: Poorly defined. Treatments: Cleansed site with normal saline, barrier cream, barrier film, impregnated gauze foam changed. [sic]Review of resident #27's Wound Assessment Flowsheets, dated [DATE], showed the sacral pressure wound description as: Old drainage, black, non-blanchable, erythema, yellow, purple, drainage, eschar, painful. Wound measurements showed: wound length: 4.2 cm, width: 3 cm, wound surface 9.9 cm [squared], wound depth: 0.2 cm.Review of resident #27's Wound Care Nurse Note, dated [DATE], showed, Significant Event. Wound [DATE]: Pressure Injury Mid Sacrum. Date First Assessed: [DATE]. Present on Original admission: No. The Wound Assessment showed, Site Assessment: Black, blanchable erythema, yellow, purple, drainage. Peri-Wound Assessment: Non-Blanchable erythema, painful. Wound Length: 4.2 cm, Wound Width: 3 cm, Wound Surface Area: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9.9 cm [squared], Wound Bed Slough: 83%, Margins: Poorly defined, Drainage: small, Drainage Description: Serosanguineous, Pressure Injury Stage: [Unstageable]. Staff to [turn and rotate] patient [every 2 hours] to offload sacrum, pump (for air mattress) on bed. [sic] Review of resident #27's Nursing Note, dated [DATE], showed, .Action: Issues/Changes this shift: Resident rests in bed the entire shift and reports being uncomfortable and in pain. Resident refuses to be repositioned or move to recliner. Resident given pain medication [as needed] that appears to be effective.Review of resident #27's Wound Care Nurse Note, dated [DATE], showed, Wound healing is not progressing as expected. Nutrition: status poor. [Patient] on Hilrom airbed, staff to [turn and reposition every 2 hours] to offload buttock. Referred [Resident] to [Wound Care Clinic], first visit [DATE]. [sic]Review of resident #27's Nursing Note, dated [DATE], showed, .Pain: ongoing significant pain in buttocks which is stable and controlled by PRN meds. 5-Day Charting and Daily Notes: .Pressure injury on buttocks. She was turned and repositioned every [two hours] and she wasn't happy with staff for this. Education was given about relieving pressure off the wound. She reluctantly stated understanding. She is pleasant and a little grumpy with staff tonight.Review of resident #27's Physician Wound Clinic Note, dated [DATE], showed, Diagnosis: Unstageable sacral pressure ulcer. This is a first-time evaluation. who apparently fell about 2-1/2 weeks ago and fractured her right femur. She underwent surgery with [Surgeon Name] to fix this fracture. In the interim she has developed a pressure ulcer on her sacral area. She recently received an air mattress and is working on protein intake because she has poor appetite and they are working on getting her [Pressure Relieving] cushion. She is a resident at the [Facility Name]. She has a wound on her sacral area which has been treated with Xeroform's and sacral Optifoam. [sic] The Debridement Notes showed: - Debridement type: surgical, Level of debridement: subcutaneous tissue. Pre-debridement measurements: Length (cm): 4.5, Width (cm): 3, Depth (cm): 0.2, Surface Area (cm) [squared]: 10.6.- Post-debridement measurements: Length (cm): 4.5, Width (cm): 3, Depth (cm): 0.5, Percent debrided: 95%, Surface Area (cm2): 10.6, Area Debrided (cm2): 10.07, Volume (cm3): 3.53.- Tissue and other material debrided: dermis, epidermis and subcutaneous tissue. Devitalized tissue debrided: fibrin, necrotic debris and slough. This was an excisional debridement. Plan: This is a first-time evaluation. There was necrotic tissue which I debrided. down to the subcutaneous tissue level. We will continue with Xeroform as well as sacral Optifoam which will be changed every other day. [sic]Review of resident #27's Wound Nurse Progress Note, dated, [DATE], showed, . Wound to sacrum is worsening. [Patient] ?I wish they would just let me go, I'm 94 and I just want to die, my butt hurts'.Review of resident #27's Provider Wound Clinic Note, dated [DATE], showed, . HPI: The patient returns today for evaluation of a stage IV mid sacrum pressure ulcer. She states she no longer wants to live. She reports being in extreme pain secondary to the sacral pressure ulcer. The medical record reflects a hospice consultation pending.Impression Plan:- 1. Sacral pressure ulcer dimensions have increased most likely reflecting evolution of the initial [Deep Tissue Injury]. The primary dressing will be changed to Vashe moistened gauze in an effort to facilitate debridement of devitalized debris through twice daily dressing changes.- 3. As stated in the HPI, a hospice consult is pending for this patient who states she no longer wants to live. [sic]Review of resident #27's Provider Discharge Summary, for facility admission dates [DATE] to [DATE], showed: . She also developed a stage IV sacral wound with associated pain, requiring escalation of pain management and wound care interventions. In the final days of admission, she expressed a desire for hospice care due to continued decline, persistent pain, and lack of perceived quality of life, with family and care team in agreement. [sic]During an interview on [DATE] at 4:28 p.m., staff member G stated the facility currently had designated nurses who completed the new admissions. She stated the admission nurses would complete the initial skin assessments to identify any new or existing wounds. The staff would document those findings in the resident's record. Skin assessments were to be completed at least weekly and or on the resident's shower days. Staff member G stated that if a resident had an existing wound, the wound would be assessed and measured. The dressing would be changed per the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physician's orders and documented in the resident's medical record. Staff member G stated that if a new pressure injury was noted, she would notify the provider, the family, and, depending on how complex the wound was, staff member H, and or the resident would be referred to the wound clinic. She stated she would update the resident's medical record to show the new wound care orders and other physician-ordered treatments. Staff member G stated that staff member H and the staff nurses could also take a picture of the wound and document the wound in the resident's medical record. Staff member G stated that pressure-relieving interventions were usually started upon a resident's admission. Depending on a resident's risk of developing pressure ulcers, those interventions would be modified to the resident's needs.During an interview on [DATE] at 5:01 p.m., staff member B stated that designated nurses completed resident admissions. Staff member B stated the expectation was that they would complete a head-to-toe skin assessment upon the resident's admission. If there were wounds present on admission, a picture was taken of the wound, the wound would be measured, and the details would be documented in the resident's record. Staff member B stated nurses should complete skin assessments weekly and complete a Braden assessment at the same time. Staff member B stated that a baseline care plan was usually developed by the nurse admitting the resident. The wound prevention interventions would be addressed in the care plan, including any wound characteristics, measurements, and provider orders. She stated that if there was a pressure wound, staff member H would also be involved in the resident's care and monitor, assess, measure, take pictures, dress, and document the findings in the resident's record. It was the expectation that for any newly identified pressure injuries, the nursing staff were to notify the family, the provider, obtain physician orders, send a message to staff member H, and document the wound in the resident's record. Staff member B stated she was made aware of resident #27's wound at the time it was discovered, but did not follow up on it at the time. Staff member B stated the facility had not identified pressure ulcers as an area of concern to be addressed or considered for process improvement using the facility's Quality Assurance Program. During an interview on [DATE] at 5:13 p.m., staff member H stated that when there was a new admission to the facility, she would review the resident's record to see if they had any wounds. She stated she had not completed a full head-to-toe skin assessment on a resident in a long time. She stated she managed mostly pressure wounds for three facilities, including this facility. Staff member H said that when she sees a resident for the first time for a pressure injury, she would review the resident's record first and then assess the wound. If the wound was not staged (severity classification) or if it did not have measurements, she would obtain those measurements, take pictures of the wound, document it, and get wound orders from the physician. She stated she would also refer residents to the Wound Clinic if the wound was complex. Staff member H stated she first assessed resident #27 after the resident had already been admitted . She stated she had assessed resident #27's sacral wound and determined the resident needed to be seen by the Wound Clinic because the resident's wound was not progressing (improving/healing). She stated they had tried positioning and turning the resident every two hours, but the resident did not wish to be moved. She stated that after the wound was identified, the resident was ordered [NAME] Boots (pressure-relieving), an air mattress, and a pressure-relieving cushion for her chair. Staff member H stated she would be able to assess a wound to determine if it was a Kennedy ulcer (Kennedy terminal ulcer (KTU) is a type of skin wound that develops rapidly in individuals who are nearing the end of life. It is a form of skin failure, where the body's skin breaks down as part of a multi-organ decline and a natural part of the dying process). Staff member H stated she did not feel resident #27's pressure injury was the result of a KTU. She stated the physicians at the Wound Clinic, where the resident was seen, also did not classify resident #27's pressure injury as a KTU. Staff member H stated that for the age of resident #27, although considered high-risk, resident #27's pressure ulcer would still be considered avoidable.During an interview and record review on [DATE] at 9:00 a.m., staff members B and D stated they had both reviewed resident #27's medical record, and although there was documentation of nurses' notes from [DATE] through [DATE], both (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff members stated there was no documentation in the resident's record of skin assessments, wound assessments, or physician orders to treat the resident's sacral wound until [DATE]. Both staff members B and D stated the resident's baseline care plan addressed some bruising and did not address anything regarding a sacral wound with a comprehensive assessment of the wound before [DATE].During an interview on [DATE] at 10:05 a.m., staff member K stated he started completing admissions for the facility on [DATE]. He stated he would review a resident's record for any skin concerns and then complete a full head-to-toe skin assessment of the resident at the time of admission. Staff member K stated that for a new wound noted on admission, he would assess the wound, take measurements, obtain images of the wound, obtain provider orders, and document everything in the resident's record. He stated a baseline care plan should also be generated, which addressed the pressure injury, including the treatment orders for the wound and interventions to prevent the wound from worsening or new wounds from developing.A review of the facility's Policy and Procedure titled, Pressure Injury, with a revision date of 5/2026, showed: I. Pressure injury prevention is part of the standard of care for admitted Residents.II. A Braden Scale is completed on admit and weekly with skin assessments. Implement interventions to prevent skin breakdown for any patient scoring 16 or less.Score 15-16 = At Risk. IV. RN/LPN implements following measures to maintain skin integrity as indicated.- A. Reduce/relieve pressure against bony prominences.1. Reposition at least [every] 2 hours utilizing pillows or foam to keep bony prominences from direct contact with one another.2. Reposition [every] 1 hour when in chair. Teach to shift weight [every] 15 minutes when in chair.3. Position patient in 30-degree side lying position. Do not turn patient onto the trochanter.4. Relieve all pressure on heels. Use pressure redistribution boots or heel protectors.5. Apply lotion to dry, flaky skin.6. Utilize pressure redistribution mattresses as indicated .9. Use pressure redistribution wheelchair cushions for at risk patients when in chair.10. Use weight shifts, or pelvic tilts when necessary to relieve sacral pressure.A review of the facility's policy and procedure, titled Wound Assessment, with a last revised date of 7/2025, showed: .I. Document:B. Dimensions - in centimeters - length x width x depth/length - head to toe, width - side to side depth - deepest part of wound (utilize sterile swab).C. Type of wound.4. Pressure ulcer: a localized injury to the skin and/or underlying tissue usually over bony prominence, as a result of pressure, or pressure in combination with shear.8. Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. Area may be painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. May be difficult to detect in individuals with darker skin tones.D. Description of Wound- Stage IV: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed.- Unstageable: Full thickness tissue loss in which the base of the or ulcer is covered by slough (yellow, tan, gray, Necrotic green or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and /or eschar is removed to determine true depth, the ulcer cannot be staged.- Full-thickness: Involves epidermis, dermis, and subcutaneous tissues, muscle, or bone.F. Wound base condition and color.G. Drainage - Note color, consistency, odor, and amount.H. Condition of Surrounding Skin - (example: intact, erythema, induration, dry, scaly, macerated, denuded).I. Signs and Symptoms of Infection - Edema, erythema in surrounding skin, purulent drainage, leukocytosis, odor, fever, increasing pain, confusion.J. Wound assessments are to be completed on admissions.b. Senior Services -Wound assessments and measurements are completed weekly.K. Skin assessments are completed quarterly for long-term residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain informed consent to include an explanation of the risks, benefits, and alternatives before the administration of psychotropic medications for 1 (#36) of 18 sampled residents. Findings include: During an observation and interview on 6/1/26 at 2:22 p.m., resident #36 was lying in bed. Resident #36 stated she was admitted to the facility on [DATE], after she had fallen at home and fractured her hip. Resident #36 stated she had increased sleepiness and all she wanted to do right now was sleep. Resident #36 stated she had a history of depression, but was not sure if that was what was causing her sleepiness.Review of resident #36's pharmacy medication regimen review, dated 5/29/26, showed: . Please obtain consent for duloxetine .Review of resident #36's physician orders, dated 5/29/26, showed duloxetine (antidepressant) 60 milligram capsule daily, which was ordered on 5/30/26.Review of resident #36's psychotropic informed consent form showed the form was signed by resident #36 on 6/1/26.Review of resident #36's medication administration record, dated 5/29/26 - 6/8/26, showed two doses of duloxetine were administered before the psychotropic informed consent form was signed.Review of resident #36's physician's orders, dated 6/3/26, showed mirtazapine (antidepressant) 7.5 milligrams nightly.Review of Resident #36's medication administration record, dated 5/29/26 - 6/8/26, showed five doses of mirtazapine were administered between 6/3/26 and 6/7/26.Review of resident #36's electronic medical record showed no signed informed consent form in the medical record before the administration of the first dose of mirtazapine on 6/3/26 at 9:16 p.m.During an interview on 6/2/26, at 8:14 a.m., staff member J stated that psychotropic medications required a consent form to be completed by the resident or the resident's representative.During an interview on 6/3/26 at 3:22 p.m., staff member C stated the expectation for psychotropic consents was for the consent forms to be completed per the facility's policy.During an interview on 6/3/26 at 3:44 p.m., resident #36 stated the facility staff did not discuss the risks, benefits, or alternatives of any of her medications, which included duloxetine and mirtazapine, before receiving the medications.Review of a facility policy titled, Appropriate Use of Psychotropic Drugs, dated 8/2025, showed: . II. Nursinga. Obtains a signed consent form for the psychotropic medication from the resident - if the resident is unable to sign, the POA must sign - and place in the resident's chart. [sic]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
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 investigative findings to the State Survey Agency within the required timeframe of 5-working days for 1 (#6) of 18 sampled residents. Findings include:Review of the facility's reported incident, dated 12/18/25, showed, CNA went into resident (#6's) room during rounding and reports resident was walking back to bed from the bathroom in her socks with her cane. Resident reported to the CNA she had fallen. The resident was favoring her left leg and complaining of pain.Review of the facility's investigative findings for the incident involving resident #6, reported on 12/18/25, showed the investigation findings were submitted to the State Survey Agency on 1/29/26, 42 days after the incident occurred; therefore, the report was untimely. The investigative findings showed resident #6 sustained an acute left-sided pubic rami fracture.During an interview on 6/1/26 at 1:55 p.m., staff member B stated that at the time of the incident involving resident #6's fall, she was unaware that the findings of the investigation for the event had not been submitted within the required reporting timeframe. Staff member B stated she submitted the findings as soon as she identified it was not done.Review of a facility policy titled, Elder Justice Act & Reporting, dated 7/2025, showed no procedure or timeframe information for the submission of investigative findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for a resident that included the minimum necessary information needed to provide person-centered care for 1 (#39) of 18 sampled residents. This deficient practice increased the risk of the resident not receiving necessary care and services. Findings include: During an observation and interview on 6/2/26 at 9:10 a.m., resident #39 was sitting in a wheelchair watching television in her room. Resident #39 stated she was recently admitted to the facility on [DATE]. The resident planned on returning to an assisted living facility after her inpatient physical and occupational therapy. Resident #39 stated she needed staff assistance with her activities of daily living due to weakness and pain she experienced. Resident #39 stated she needed assistance with transferring, and the staff was using a mechanical lift for her transfers. During an interview on 6/2/26 at 9:20 a.m., staff member F stated resident #39 required staff assistance with dressing, toileting, personal hygiene, and transfers.During an interview on 6/3/26 at 12:17 p.m., staff member B stated that no baseline care plan was created for resident #39.During an interview on 6/3/26 at 4:00 p.m., staff member K stated that for new admissions, baseline care plans were to be initiated at the time of admission or no later than 48 hours after admission. Staff member K stated he wasn't sure how the baseline care plan was missed for resident #39.During an interview on 6/3/26 at 4:20 p.m., staff member M stated she had access to resident care plans. Staff member M stated she did not recall seeing a care plan in the medical record when resident #39 was admitted . Staff member M stated she was verbally told by other staff members that the resident needed assistance with transfers and activities of daily living.Review of resident #39's electronic medical record, on 6/3/26, showed that resident #39 was admitted on [DATE], and no baseline care plan was created within the first 48 hours. Review of a facility policy titled, Initial Nursing Assessment and Development of Interdisciplinary Resident Care Plans, dated 4/2025, showed: . Procedure:Admitting licensed staff completes the nursing assessment and baseline care plan upon admission. [sic]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility staff failed to adhere to accepted infection control standards, including proper hand hygiene and glove use, during a medication pass for 2 (#s 33 and 39) of 18 sampled residents. This deficient practice increased the likelihood of the transmission of infections. Findings include:During an observation on 6/2/26 at 9:20 a.m., staff member F entered resident #39's room. No hand hygiene was performed by the staff member before entering the room. Staff member F walked over to the medication cabinet, which was located on the wall in the room. Staff member F used his badge to unlock and open the cabinet. Staff member F placed the handheld charting device called a Rover onto a flat surface. He picked up a medication card and scanned it with the Rover. He then placed the medication card over the plastic medication cup and pushed the medication from the card into the medication cup. Staff member F repeated this process four times. Staff member F walked over to the resident and handed her the medication in the cup. No hand hygiene was performed by staff member F after touching the medication cards or Rover device before handing the medication cup to resident #39. Staff member F walked back to the medication cabinet, picked up an inhaler, and handed it to resident #39. Resident #39 self-administered two puffs of the inhaler. Staff member F informed resident #39 he had to go to the medication room to get her B-12 vitamin injection. Staff member F exited the room. Staff member F returned to resident #39's room with a medication syringe. No hand hygiene was completed upon entering resident #39's room. Staff member F donned gloves and administered the injection to resident #39. No hand hygiene was performed before donning gloves to prevent the spread of infectious agents. During an interview on 6/2/26 at 9:28 a.m., staff member F stated he was previously educated on proper hand hygiene.During an observation on 6/3/26 at 8:32 a.m., staff member J went to resident #33's room for a medication pass. Staff member J walked over to the medication cabinet on the wall and used his badge to unlock and open it. Staff member J picked up a medication card, scanned the card with the Rover, placed the medication card over the plastic medication cup, pushed the medication out of the medication card, and into the medication cup. Staff member J repeated this process five times. Staff member J picked up the Rover and the medication cup and set them down on resident #33's bedside table next to her meal tray. Staff member J donned a pair of gloves, picked up the medication cup and handed it to resident #33. No hand hygiene was performed prior to donning gloves. Staff member J picked up the Rover and walked back to the medication cabinet. Staff member J placed the Rover onto a flat surface. Staff member J walked back to resident #33 and removed a nicotine patch. He then walked back to the medication cabinet, placed the nicotine patch in his left hand, and removed the glove. Staff member J donned a glove on the left hand. No hand hygiene was performed between doffing and donning a new glove. Staff member J picked up the Rover and scanned a new nicotine patch. Staff member J opened the nicotine patch and placed it on resident #33's chest area. Staff member J picked up the Rover and scanned the lidocaine patches. Staff member J removed scissors from his shirt pocket and opened three lidocaine patch packages. He walked over to resident #33 and placed the three lidocaine patches along her left side, low back, and hip area. Gloves were not doffed by staff member J after touching the dirty equipment or prior to placing the new medication patches onto clean areas for the resident. Staff member J doffed his gloves and donned a new pair. No hand hygiene was performed before donning new gloves. Staff member J picked up a tube of diclofenac cream and walked over to patient #33. Resident #33 refused the diclofenac cream. Staff member J doffed his gloves and left the room. No hand hygiene was performed after doffing his gloves.During an interview on 6/3/26 at 8:49 a.m., staff member J stated he had been educated on proper hand hygiene and when hand hygiene should be performed.During an interview on 6/4/26 at 12:27 p.m., staff member S stated that hand hygiene education was recently provided to staff. Staff member S stated the expectation for hand hygiene was to follow the policy and CDC (Centers for Disease Control) guidelines. Review of a facility policy (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275157	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Grandview	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Hand Hygiene, dated 6/2025, showed: . Hand hygiene is expected of all employees before and after all patient/resident contacts, after glove use, . [sic]