

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/10/2025
NAME OF PROVIDER OR SUPPLIER  Benefis Senior Services - Westview		STREET ADDRESS, CITY, STATE, ZIP CODE  500 15th Ave S Great Falls, MT 59405	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a referral for an orthopedic consult was followed up on, and there was a delay of three months, where the facility did not follow up on it, for 1 (#2) of 4 residents sampled. Findings include:</p> <p>During an observation and interview on 2/10/25 at 1:20 p.m., resident #2 showed the deformities on her right hand to her index and ring fingers. She stated it was from an old bone break and it still caused her discomfort.</p> <p>Review of resident #2's physician progress notes, dated 11/18/24, showed, . She is requesting to see orthopedic doctor about deformities in her right hand that are causing discomfort. Right index finger and right ring finger have significant deformities present . referral to hand surgeon.</p> <p>Review of resident #2's EMR failed to show a result of this referral.</p> <p>During an interview on 2/10/25 at 4:05 p.m., staff member B stated they could see where the order was sent, and it had appeared ortho had called the resident's personal cell phone instead of the unit's line. Staff member B stated the referral follow up was ultimately up to nursing to complete. Staff member B stated resident #2 was now set up to be seen later in the week.</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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