STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275158	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Westview	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)
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 submit two reportable events in the designated required timeline for 2 (#s 20 and 23) out of 19 sampled residents. Resident #20 had an injury of unknown origin identified on 5/24/26, and it wasn't initially reported to the State Survey Agency until 5/26/26. Resident #23 was a victim of physical abuse that occurred on 7/22/25, and it was not initially reported until 9/19/25. Findings include:1. Review of the Facility-Reported Incident submitted 5/26/26, showed the Chief Director of Nursing was completing chart reviews and found a resident with an injury of unknown origin. The report showed resident #20 was found sitting on the floor. Due to increased pain, resident #20 was sent to the emergency room for an evaluation. The emergency room diagnosed resident #20 with a periprosthetic fracture around the internal prosthetic hip joint.Review of resident #20's nursing note showed she fell on 5/24/26, and the abuse allegation report was not submitted until two days after the fall for the injury of unknown origin. 2. Review of the Facility-Reported Incident, dated 7/22/25 at 6:00 p.m., showed resident #23 backed her wheelchair into a male resident. The male resident, with a closed fist, hit resident #23 on the back between her shoulder blades. The information about the physical alteration was submitted to the State Survey Agency via the online reporting portal on 9/19/25, which was 56 days after the incident occurred, and this was reported late. During an interview on 6/18/26 at 11:00 a.m., with staff members A and B, staff member B said she was completing a chart review and identified that resident #23 sustained physical abuse. Staff member B said she submitted the abuse event to the State Survey Agency the day the allegation was found. Staff members A and B said the facility had a process for the staff to report abuse allegations. The nurse on duty was to call the manager who was on call for that shift. If the manager did not immediately respond, the nurse would call the Chief Director of Nursing. In the absence of the Chief Director of Nursing, the staff knew to call the Administrator. The Chief Director of Nursing or Administrator would come to the facility, report the abuse allegation, and start the investigation. Staff members A and B were not sure where the breakdown occurred for the reporting of the allegations.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm 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. Based on interview and record review, the facility failed to revise a care plan for a resident who had documented safety concerns related to leaving the facility without supervision for 1 (#40) of 21 sampled and supplemental residents. This failure resulted in the resident exiting the facility unsupervised, placing the resident at risk of harm. Findings include:During an interview on 6/17/26 at 8:52 a.m., staff member F stated the nursing manager was responsible for updating a resident's care plan. Staff member F stated nursing staff did not add additional interventions or change the care plan. During an interview on 6/18/26 at 10:00 a.m., staff member B stated resident #40's care plan should have reflected that the resident was not allowed to leave the facility without supervision. Staff member B stated it was the responsibility of the nursing manager to update resident #40's care plan. Staff member B stated the nurse manager responsible for updating the resident's care plan was no longer employed with the facility. Staff member B stated she did not know why resident #40's care plan had not been updated to reflect that the resident was not allowed to leave the facility without supervision.Review of resident #40's nurse progress note dated 8/7/25 at 12:18 p.m. showed the resident was told she could not leave the facility without supervision. Resident #40 became upset and wanted to leave the facility. The resident was encouraged several times not to leave the facility. Staff educated the resident about safety concerns and leaving the facility against medical advice. Resident #40 agreed to stay at the facility.Review of resident #40's physician note, dated 8/11/25, showed that resident #40 was not allowed to leave the facility without supervision. Review of resident #40's care plan failed to show that the resident's care plan was updated, identifying that the resident was not allowed to leave the facility without supervision.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure social services was provided to one resident needing assistance with transitioning to a long-term care facility and managing the resident's finances for 1 (#1); and ensuring psychosocial well-being was assessed for a resident following a physical altercation for 1 (#23) of 19 sampled residents. The failure could result in undue stress for the residents related to the lack of social service assistance. Findings include:1. During an interview on 6/17/26 at 8:10 a.m., resident #1 was observed sitting in a wheelchair at the breakfast table. Resident #1 asked if the surveyor could find an advocate for him. Resident #1 said that when he was first admitted to the facility on [DATE], there were many staff members to help him with his needs. Resident #1 said, since a day or two after admission, no one has been in to help now. Resident #1 said he had no family or friends to help him. Resident #1 said he needed to get to his home or have someone go to his home and get his mail. Resident #1 said he had money and he needed to pay his insurance and household expenses. Resident #1 said he needed some other help as well. Resident #1 said he had gone to a dental appointment, and he had some paperwork and information at home from the dentist. Resident #1 said the plan was for the dentist to pull one tooth and make him a partial plate. Resident #1 said he would like to have the partial denture so he could eat and chew more easily. Resident #1 said he would like the Veterans Administration to help if they could. Resident #1 said he was very frustrated and needed an advocate.During an interview on 6/17/26 at 11:49 a.m., staff member D said he thought he saw resident #1 once shortly after the resident was admitted for social services. Staff member D was unaware that resident #1 had concerns with his teeth and needed to see a dentist. Staff member D said he was unaware that resident #1 needed assistance with picking up items from his home so he could pay his bills. Due to the lack of awareness of staff member D, resident #1's social service needs were not being met. 2. Review of resident #23's nursing note dated 7/22/25 showed that resident #23 backed her wheelchair up and bumped another resident. The other resident used his closed fist and hit resident #23 in the back between her shoulder blades.During an interview on 6/17/25 at 11:25 a.m. and 11:49 a.m., staff member D said he would talk to residents after there was a resident-to-resident altercation/event, but only sometimes. Staff member D said he was unaware that resident #23 had a physical altercation with another resident. Staff member D said he did not follow up with resident #23 in order for the resident's social service needs to be met. On 6/17/26 at 4:34 p.m., a request was made to the facility for a copy of resident #23's nursing or social services notes addressing the altercation and resident #23's reaction and/or concerns following the 7/22/25 altercation. No notes addressing resident #23's psychosocial well-being were provided by 6/18/26 at 12:01 p.m., at the end of the survey.