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	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Westview	500 15th Ave S Great Falls, MT 59405

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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 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform each resident of his or her visitation rights and ensure that all visitors enjoy equal visitation privileges. 35356 Based on observation, interview, and record review, the facility failed to develop, implement, and inform residents, to include 1 (#78) of 13 sampled residents, of their policy and procedure for resident visitations. This deficient practice had the potential to affect all residents and their visitors. Findings include: During an observation and interview on 5/17/25 at 2:00 p.m., resident #78 was sitting in the common area with another resident and her two family members. Resident #78 stated she had to visit with her friends in the common area because staff would not allow her to have visitors in her room. During an interview on 5/18/25 at 9:42 a.m., resident #78 stated she was not allowed visitors in her room. She stated she only agreed to have visitors in the common area because she wanted to keep the peace with staff. During an interview on 5/19/25 at 11:06 a.m., NF1 stated staff member A had explained the facility had a specific visitation policy for residents. She stated staff member A had told her there was a condition of that policy which allowed the facility to limit certain visitors. During an interview on 5/19/25 at 12:09 p.m., staff member E stated residents could have visitors. She stated if a resident wanted to have a visitor stay overnight it would need to be approved by staff first. During an interview on 5/19/25 at 3:10 p.m., staff member A stated staff were to follow the facility policy and procedure for visitation. On 5/19/25 at 1:20 p.m., a request for the facility's policy and procedure on visitation was submitted. A policy and procedure titled, Visitation Policy, for the Hospital System, was provided. A review of the provided document did not have developed policy and procedures specific to Senior Services or long term care. During an interview on 5/20/25 at 8:33 a.m., staff member K stated they did not have a policy and procedure for visitation related to Senior Services. She stated the provided policy and procedure was specific to the hospital.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 35356 Based on observation, interview, and record review, the facility failed to ensure resident privacy during visits for 1 (#78); and failed to provide privacy curtain or a door for a resident's bathroom for 1 (#2) of 13 sampled residents. Findings include: 1. During an interview on 5/18/25 at 9:42 a.m., resident #78 stated she was not allowed to have visitors in her room and was told by staff that she would have to meet with her visitors in the common area. She stated she felt that the staff were not allowing her to meet privately with other residents or her friends. During an interview on 5/19/25 at 10:22 a.m., staff member I stated she was informed by staff member E that resident #78 was not allowed to have visitors and, If you see any visitation in her room ask for it (visitors) to come out into a common area. The vistitation in the common area did not allow for private conversations. During an interview on 5/19/25 at 12:37 p.m., staff member F stated staff member E decided that if resident #78 was going to have visitors they would have to meet in a common area and not her room. The common area was not private. Review of the facility's policy and procedure titled, Patient Rights and Responsibilities, with a review date of 8/2022, showed, .IV. Senior Care Registration: .11. To have private visits and to have visitors at any time . Review of the facility's Resident Rights and Responsibilities provided to residents at admission, showed, Resident Rights: .11. To have private visits and to have visitors at any time . 14005 2. During an observation and interview on 5/18/25 at 10:56 a.m., resident #2 was sitting on her bed in her room. There was no door or curtain providing privacy for resident #2 when she was used the bathroom. The bathroom was open to resident #2's main living space. Resident #2 said it really bothered her to not have a door on the bathroom. Resident #2 said not having a door on the bathroom did not allow for privacy. Resident #2 said she felt exposed, especially when she was taking a shower. During an interview on 5/19/25 at 10:50 a.m., staff member E said she was unaware resident #2 had a problem with not having a door on her bathroom. Staff member E said she checked with every new admission within 24 hours of the resident being admitted to the facility. Review of the facility's policy and procedure titled, Patient Rights and Responsibilities, with a review date of 8/2022, showed, .IV. Senior Care Registration: .10. To get proper privacy, property and living arrangements .

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35356 Based on observation, interview, and record review, the facility failed to ensure a resident was free from mental abuse by depriving a resident their rights to private visitations (see F563 & F583) and isolating the resident from social interactions for staff convenience, causing the resident to experience ongoing feelings of being dull, bored, and frustrated which resulted in the resident expressing feelings of being a prisoner, for 1 (#78) of 13 sampled residents. Findings include. During an observation and interview on 5/17/25 at 2:00 p.m., resident #78 was sitting in the common area with another resident and NF3 and NF4. Resident #78 stated she had to visit with her friends in the common area because she was not allowed visitors in her room. (See F563 & F583) During an interview on 5/18/25 at 9:42 a.m., resident #78 stated she was not allowed to have visitors in her room. She stated the facility had been limiting her visitations for several months. She stated on several different occasions, while having visitors in her room, staff told her that she would need to move the visit out of her room to the common area. She stated she knew this was not right but had agreed to not having visitors in her room to keep the peace with the staff. She stated this restriction of not being allowed visitors in her room has caused her to feel dull, bored, and frustrated, and she stated she feels like a prisoner always being watched by staff. She stated the restriction on having visitors has been difficult because socialization was very important to her. Review of resident #78's Nursing Note, created by staff member E, dated 3/21/25, showed, Writer walked by and was rounding and saw resident and another resident family member [NF4] hugging on resident and tickling her. Advised resident that it was not ok. Resident family member then sat on bed and visited for remainder of evening. Review of resident #78 Electronic Health Record Summary Care Plan, with a care plan meeting dated 11/12/24, showed, Resident Preferences: entertainment activities, reading and socializing/chatting [coffee with [Name]/Trivia Facts] . Psychosocial/Mood: Able to express needs, feelings, thoughts, understands others and person/family visitation . : Activities: Goal: I will maintain my current level of socialization as evidenced by no complaints of isolation at monthly care plan meetings or quarterly. During an interview on 5/19/25 at 10:13 a.m., staff member H stated she was told by staff member E that resident #78 was not to have NF4 visit her in her room any longer, and they were to only visit in the common area. Staff member H stated she did not know everything that had happened to limit the resident's visits, but she knew resident #78 was very upset about it. During an interview on 5/19/25 at 10:22 a.m., staff member I stated she was informed by staff member E that resident #78 was not allowed to have visitors and, If you see any visitation in her room ask for it (visitors) to come out into a common area. Staff member I stated resident #78 Takes it upon herself that she runs the facility and encourages residents to come to her if they have any problems. Staff member I stated resident #78 can have visitors as long as it was not other resident family members or other residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/19/25 at 10:45 a.m., staff member J stated staff member E had directed her to only allow resident #78 to have visitors in the common room. During an interview on 5/19/25 at 10:55 a.m., staff member G stated resident #78 was no longer allowed to have certain visitors in her room. During an interview on 5/19/25 at 11:06 a.m., NF1 stated she was asked to attend a meeting with resident #78, staff member E, and staff member F, regarding resident #78's visitation rights. She stated she was told by staff member E that the resident was having visitors in her room, and she was getting those visitors riled up about the care at the facility. NF1 stated when meeting with staff members E and F, and resident #78, it was discussed that resident #78 was not allowed to have certain visitors in her room, and she would have to meet those visitors in the common area. NF1 stated resident #78 verbally agreed during that meeting to not have certain visitors in her room, and she agreed to meet those visitors in the common area. During an interview on 5/19/25 at 11:21 a.m., NF3 stated they have been friends with resident #78 for many years. She stated they were told by facility staff that NF4 could no longer visit resident #78 in her room. She stated the facility had never spoken to her, or NF4, about the incident which resulted in NF4 not being able to visit resident #78 in her room. NF3 stated that one day NF4 came to her and told her that staff had told him he was no longer allowed to visit resident #78 in her room, and they could only visit in the common area. She stated that NF4 was visibly upset and sad that he was no longer allowed to visit resident #78. She stated resident #78 had also expressed to her that she was upset that NF4 could no longer visit her in her room. During an interview on 5/19/25 at 12:09 p.m., staff member E stated they have had problems with resident #78 in the past telling them that she would shut them down and speak negatively about the facility. She stated they have had problems with other family members speaking with resident #78 in her room and the resident gets riled up. She stated that resident #78 was told that she was not allowed to have visitors in her room other than her family, because if resident concerns came up about the facility, they needed to know about it so they could fix it. Staff member E stated she was not aware of any concerns which were brought up during resident #78's private visits in her room that the facility was not aware. Staff member E stated there were no safety concerns between resident #78 and NF4 visiting each other. She stated they would just sit in her room all day and were being negative about the facility. She stated resident #78 agreed during a visit with NF1, staff member F, and herself that she would limit her visits with certain individuals to the common area so staff could observe. During an interview on 5/19/25 at 12:37 p.m., staff member F stated for resident #78 there had been concerns about her having a lot of complaints and telling other residents and/or their visitors about those complaints. So, staff member E decided that if she was going to have visitors they would have to meet in a common area and not her room. He stated it seemed like resident #78 was creating more issues with family members bringing them into her negativity. He stated most of her complaints had to do with food but was not aware of any concerns which were not shared with the facility. Staff member F stated he recalled a meeting between himself, resident #78, staff member E, and NF1, regarding the resident not having visitors in her room. He stated she had agreed that she would no longer have visitors in her room. He stated this meeting was not documented at the time and they did not provide resident #78 with anything in writing about limiting her visits to the common areas or their rationale to why her visits should be limited to the common area. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of resident #78's Patient Relations Worksheet, with a received date of 5/19/25 at 3:20 p.m., showed: - Comments/Abstract: [Resident #78] said she is not allowed visitors in her room. - Referral Data: [Resident #78] is asked that if she has any visitors that are not her immediate family, they need to visit in the common areas. There was a meeting with [Resident #78, staff member E, NF1, and staff member F] that this message was relayed. - Interview Data: [Staff member E] reports that [Resident #78] had another resident's grandson visiting and was touching [Resident #78]. [Resident #78] reported that she is fine with the grandson touching her. [Resident #78] has had the grandson in her room on several previous occasions along with family members of other residents. [Resident #78] often seeks out other residents and/or family members to air her grievances while also discussing issues in resident council. Review of the facility's policy and procedure titled, Resident Abuse/Neglect Allegations, Senior Services, with a last reviewed date of 6/2024, showed: .Definitions: Mental Abuse - any act which results or has the potential to result, in mental impairment of the resident's intellectual or psychological functions including but not limited to, humiliation, harassment, threats, punishment, or deprivation . Willful means the individual must have acted deliberately, not that he/she must have intended to inflict injury or harm . II. All employees are trained upon hire and annually regarding abuse, neglect and how to deal with work-related stresses, i.e., catastrophic reactions involving residents . Review of the facility's policy and procedure titled, Patient Rights and Responsibilities, with a review date of 8/2022, showed: .IV. Senior Care Registration: . 2. To be free from abuse and neglect (verbal, sexual, physical [and] mental abuse . 4. To voice concerns without fear of being punished [and] to express any complaints you have about your care or treatment . 11. To have private visits and to have visitors at any time, as long as you wish to see them [and] as long as the visit doesn't interfere with the provision of care and privacy rights of others .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 14005 Based on observation, interview, and record review, the facility failed to ensure residents were free from restraints, unless there had been a documented medical symptom, for 1 (#68) of 13 sampled residents. Findings include: During an observation on 5/18/25 at 1:30 p.m., resident #68 was observed sitting in his wheelchair near the nurse's station. Resident #68 had a loose-fitting seat belt on his wheelchair. Resident #68 was not able to remove the seat belt when asked to do so by the surveyor. Review of resident #68's Evaluation For Use Of Restraints and/or Alarms showed resident #68's last assessment was completed 6/15/22. The evaluation did not show what medical condition or symptoms were being treated with the use of the seat belt. Review of resident #68's electronic health record did not show any ongoing re-evaluation of the need for a physical restraint. Review of resident #68's care plan, most currently updated on 2/10/25, failed to show a seat belt was to be used. During an interview on 5/19/25 at 10:50 a.m., staff member E said resident #68 used the seat belt to prevent falls. Staff member E said the care plan gets updated right after an event like a fall, and interventions were put into place to attempt prevention of more falls. Staff member E was not aware there was no care plan for the seat belt. Review of resident #68's physician order, dated 5/19/25, showed no order for the wheelchair seat belt use. Review of the facility's policy and procedure titled, Physical Restraint or Alarm Assessment, Use, and Reduction Plan, with a review date of 2/2025, showed: . I . Physician writes an order for a restraint and documents rational for use . II . Nursing . Ensures a Physician order is received for any device. Ensures the restraint is the appropriate device to meet the needs and medical symptoms. Initiates a care plan addressing the use of the device . IV. Restraint reduction program. Residents are assessed at least quarterly for restraint reduction .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan that reflected the care needs, and to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, for 2 (#s 14 and 68) of 13 sampled residents, which included failing to ensure interventions were in place and documented for dialysis and dialysis related emergencies and monitoring of the resident for #14; failed to ensure interventions were in place to prevent identified elopement risks and/or review and revise interventions in place following elopements for #68. Findings include: 1. Review of resident 14's care plan revealed resident #14 admitted to the facility on [DATE] with the diagnoses of congestive heart failure, osteomyelitis of the thoracic vertebrae, Diabetes Mellitus Type II, Depression with anxiety, and pulmonary fibrosis. The comprehensive care plan identified resident #14 would go to dialysis on Tuesday, Thursday, and Saturday. There was no evidence that would demonstrate a person-centered care plan was developed. The care plan failed to include: - the name, location and phone number for the dialysis center. - the identification of when and who would monitor pre-weight and vitals post dialysis. - the type and location of dialysis, transportation arrangements, and the intervention and goals based upon the type of dialysis. - which arm of the resident was to use for blood pressure monitoring. - who to contact for dialysis related emergencies or concerns. - monitoring risk factors and complications, such as the dialysis access site for signs or symptoms of infection or hypotension. 2. Review of resident #68's nursing note, dated 3/11/25 at 5:32 p.m., showed resident #68 was attempting to get on the elevator. The button got pressed and resident #68 was still on the elevator. The note showed, Resident was reminded of safety again but may not be able to understand. Review of a nursing note dated 3/12/25 at 5:18 p.m., showed resident #68's family member was informed of the resident getting on the elevator. The nurse and the family member discussed the potential to move the resident to another unit/building with a secure unit. The information presented to the family member was shared with the social worker. Review of nursing note, dated 5/8/25 at 2:39 a.m., showed resident #68 got onto the elevator and was found on the third floor. Resident #68 continued to search for an exit for the next two and a half hours. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nursing note, dated 5/8/25 at 10:50 p.m., showed resident #68 was found on the first floor and was brought back to the unit. Resident #68 continued to hang out near the elevator for two hours. The attempts to redirect resident #68 away from the elevators were unsuccessful. Review of nursing note, dated 5/9/25 at 8:47 a.m., showed the elopement of 5/8/25 at 2:39 a.m., was discussed with the social worker. The nursing note showed the Social Worker will contact the power of attorney regarding moving resident #68 to a secured unit in another facility. Review of the nursing notes, from 3/12/25 through 5/9/25, showed there was no follow up efforts to move resident #68 to a secure unit, even after it was suggested by nursing staff to keep resident #68 safe, from elopements. Review of resident #68's care plan, last updated 2/26/25, showed: - Diagnoses which included ataxia with falls, cognitive impairment, history of traumatic brain injury and a cerebral vascular accident. The care plan failed to identify the risk of elopement and interventions the staff should take to prevent further elopements. - The comprehensive care plan identified behavioral symptoms as a problem for aggression, resisting care, and being verbally abusive. Resident #68 eloped on 3/11/25, 5/8/25, and 5/9/25. The care plan failed to identify how resident #68 eloped or what measures were put in place to prevent a similar future elopement. - The care plan failed to demonstrate a person-centered care plan with activities or diversions which would be offered based on resident #68's work history, interests, or appropriate interests for the resident's progression in the dementia disease process. Furthermore, there was no evidence of interventions put in place to prevent elopements. During an interview on 5/19/25 at 10:50 a.m., staff member E stated care plans were completed by the MDS nurses. Staff member E said the MDS nurse comes to the facility to assess the residents. Staff member E said the MDS nurses updated the care plan with any changes or additions to the care. The care plan was not updated to the potential transfer to a secure dementia unit.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50245 Based on observation, interview, and record review, the facility failed to ensure pre-poured medications were given timely for 3 (#s 7, 79, and 80) of 13 sampled residents. This deficient practice had the potential to result in late medication administration, and time sensitive medications given too closely together, possibly resulting in a high half-life concentration of medication in the body. Findings include: During an interview and observation on 5/18/25 at 8:06 a.m., staff member N had pre-poured medications for seven residents and had these cups of medications locked in the top drawer of the medication cart. Staff member N stated the medications were scanned, and therefore documented in the MAR as given at that time for each resident. Staff member N stated they would sometimes change the administration time to the time after the medication was administered. Staff member N stated they had not changed the administration time that day for any of the residents because they were running behind. Staff member N stated they were late to work that day and this contributed to not updating the administration times in the individual resident records. Staff member N also stated they would not change the administration times if the facility was short staffed. The specific example staff member N gave was if there was only one nurse for the entire facility, which occurred quite a bit. Staff member N stated they knew this method (prepouring and not documenting correct administration time) was wrong. 1. During an observation of resident #7's medication administration, the medications: gabapentin, Tums, Senna, oxybutynin, and Propranolol, were given at 8:14 a.m. Staff member N reviewed the medications in the medication cup with the medication cards while reviewing the MAR. Review of resident #7's MAR showed the medications were administered at 7:32 a.m. Therefore the MAR documentation was inaccurate. 2. During an observation of resident #80's medication administration, the medications: Vitamin C, Atenolol, Keflex, digoxin, multivitamin, cranberry pill, Zoloft, and docusate sodium, were given at 8:19 a.m. Review of resident #80's MAR showed the medications were administered at 7:38 a.m. Therefore the resident's MAR had inaccurate documentation. During an observation on 5/18/25 at 8:24 a.m., staff member N's Brain (a tool used in Epic) showed all tasks and medications were completed until 9:00 a.m., on 5/18/25. Staff member N still had three medication cups left in the medication drawer to be administered to residents. 3. During an observation on 5/18/25 at 8:28 a.m., resident #79's medication administration was completed for the medications Vitamin C, baclofen, Flexeril, DSS, Lexapro, metformin, multivitamin, a nonformulary pill. Review of resident #79's MAR showed the medications were administered at 8:03 a.m. The medical record included inaccurate administration times. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 10:25 a.m., staff member E stated it was unacceptable to improperly document a medication that had been given at a later time.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 50245 Based on observation and interview, the facility failed to ensure basic ADLs were being completed for 2 (#s 5 and 83) of 13 sampled residents. This deficient practice had the potential to result in residents feeling unclean and unkept. Findings include: 1. During an interview on 5/17/25 at 3:12 p.m., resident #83 stated her face was sometimes washed in the morning by staff. Resident #83 stated her hair was only half brushed as she was only able to reach the left side of her head. During an interview on 5/18/25 at 2:05 p.m., NF5 stated resident #83's hair was not brushed, and her teeth were not brushed yet for the day. During an interview on 5/19/25 at 8:35 a.m., resident #83 stated she combed her hair the best she could. She stated she was able to brush the left side of her hair but was unable to brush the right side of her hair due to a stroke, which she had in the past. During an observation and interview on 5/19/25 at 10:03 a.m., NF5 was helping resident #83 brush her hair and teeth. NF5 stated they noticed resident #83 needed these cares done and would just do them for her family member. NF5 stated they had wondered what would happen if she did not come every day to help resident #83 with her cares. 2. During an interview on 5/17/25 at 2:15 p.m., NF6 stated her family member (#5) was often left in her room in the dark when the other residents were at breakfast. NF6 stated this made them very mad as their family member was not getting out of bed, not being encouraged to eat more, and not socializing with the other residents. During an observation on 5/19/25 at 8:37 a.m., resident #5's hair was in two braids that were observed to be frizzy and looked as if the braids had been slept in. During an observation on 5/19/25 at 10:02 a.m., resident #5's hair was still in the two frizzy braids. During an interview on 5/19/25 at 1:01 p.m., staff member F stated they thought staff should not rely on family to do basic ADLs. Staff member F stated they could see staff rely on family members for the cares to get completed, out of habit. Staff member F stated they did not think relying on family for the provision of the ADL care should happen.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 35356 Based on observation, interview, and record review, the facility failed to consistently assess, measure, and monitor a resident's pressure ulcer; and failed to ensure wound dressings were provided as ordered by the physician, and failed to ensure sufficient wound documentation was completed, to prevent the progression of a worsening Stage III pressure ulcer for 1 (#75). This deficient practice had the potential to cause worsening wounds and infection for the resident; and the facility failed to ensure 1 (#7) of 13 sampled residents properly received perineal care to prevent the occurrence of a wound related to the use of an indwelling catheter. Findings include: 1. During an interview on 5/17/25 at 3:57 p.m., resident #75 stated she had recently returned to the facility after being admitted to the hospital with sepsis. She stated she was very susceptible to developing infections. Resident #75 stated she developed a pressure ulcer on the back of her right upper thigh from not being cleaned, and the area was getting moist. She stated the pressure ulcer developed after she was readmitted to the facility. She stated she had Addison's disease which caused her skin to be very sensitive and prone to skin breakdown. She stated staff would not listen to her regarding how to apply the wound dressing, and then the dressing would roll up and frequently come off. She stated she was worried the wound had become bigger and staff were not consistent with changing the dressing. She stated she was to be seen at the Wound Clinic once a month, and she was supposed to have the dressing changed every other day. During an observation on 5/18/25 at 4:17 p.m., staff member C provided wound care and a dressing change for resident #75. Resident #75 had an oval shaped wound located on the back of her right upper thigh. The wound was approximately 3 cm x 2 cm in size and was red and beefy in appearance. A. Assess, Measure and Monitor Pressure Ulcer During an interview on 5/18/25 at 4:17 p.m., staff member C stated staff member D provided weekly wound care at their facility on Thursdays. She stated if a wound dressing needed to be changed sooner, or more frequently during the week, staff would perform the dressing changes. Staff member C stated she did not measure or assess the wound when she performed dressing changes for resident #75 because staff member D assessed and measured the resident's wounds when she did her weekly rounds. Staff member C stated she could usually tell if resident #75's wound had worsened when she provided the dressing change. During an interview on 5/19/25 at 4:52 p.m., staff member B stated the facility had a wound care nurse that came to the facility at least once a week, on Thursdays, to provide wound care for the residents with wounds. She stated the wound care nurse would assess, measure, and provide dressing changes during that visit. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/20/25 at 8:35 a.m., staff member D stated she provided wound care for residents at the facility every week on Thursdays. She stated she started at this facility early in the morning each Thursday. She stated she also rounded, everyday, Monday through Friday. Staff member D stated she did not take measurements of a resident's wound every time she provided wound care, but would take a picture of the wound, which was uploaded into the resident's record. She stated she did try to obtain measurements of the wound at least once a week. Staff member D stated resident #75 was usually in bed or asleep when she was there to do her wound care, and the resident would tell her to come back later. She stated she sometimes did not return later, so she would notify the nurse on duty, so the staff could provide the resident's wound care. Staff member D stated she had not had a recent opportunity to assess, measure, or monitor resident #75's right leg wound. She stated she believed resident #75 had a recent Wound Clinic visit which showed her wound was slightly worse. Staff member D stated after reviewing resident #75's medical record, she did not think resident #75's dressing changes were being completed, consistently. During an interview on 5/20/25 at 9:07 a.m., resident #75 stated she had not seen staff member D every week. She stated staff member D only came to her room in the early mornings to do wound care. She stated she was usually asleep or still in bed when staff member D wanted to do her wound care, and she did not want to get up that early. She stated she would ask staff member D to come back later, but she never returned later. Resident #75 stated staff member D only did wound care in the mornings. If you did not get up while she was there, so she could do the wound care, staff member D would say you refused, and would not return later in the day to try and do the wound care. Review of resident #75's Nurse Progress Note, dated 4/21/25, showed, Resident has pressure sore that continues to be open from chronically. [sic] Measurement 0.5 cm x 0.3 cm x 0.1 cm. Resident had prior dressing on from 4/16 from hospital. Wound bed was beefy red, surrounding skin purple in color. Resident had dressing redressed cleansed with [normal saline] and skin prep to surrounding and replaced with foam dressing. [sic] Review of resident #75's Physician Wound Clinic Progress Note, dated 4/22/25, showed, Wound Length: 0.5 cm, Width:0.4 cm, Depth: 0.1 cm, Pressure Stage: 3 . Note: This patient returns today. Her right posterior thigh pressure ulcer appears to be improved and there is no slough. Will continue with barrier cream as well as Xeroform, No Sting Sacral Opti foam gentle which will be changed every other day and will see her back in a month. Review of resident #75's Physician Wound Clinic Progress Note, dated 5/19/25, showed, Wound Length: 2.7 cm, Width: 2 cm, Depth: 0.2 cm, Stage: 3 . Right posterior thigh wound is slightly larger. I debrided it as noted above. Will continue to with the barrier cream, Xerofoam No Sting and sacral Opti foam gentle. I will see her back in one month and she will have this changed every other day . A review of resident #75's Medical Record, Wound Care Notes, Progress Notes, and Flowsheets, from 4/21/25 to 5/20/25, did not reflect the resident's wound was assessed, measured or monitored from 4/22/25 to 5/19/25. Wound Clinic Physician Progress Notes showed resident #75's Stage 3 pressure injury went from improving on 4/22/25 to a worsening Stage 3 Pressure Injury on 5/19/25. A review of the facility's policy and procedure titled, Wound Assessment, with an effective date of 11/2024, showed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Document: A. Location . B. Dimensions .C. Type of wound . D. Description of Wound . E. Presence of undermining or tunneling . F. Wound base condition and color . G. Drainage . H. Condition of surrounding skin . I. Signs and symptoms of infections . 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. A review of the facility's policy and procedure titled, Wound Management, with an effective date of 5/2024, showed, .IX. Monitor healing: A. Measure, Assess, and photograph the wound on admission. B. assess the wound with each dressing change. C. Measure wounds 2 times a week, Mondays and Thursdays. D. If ulcer does not exhibit healing, reassess treatment plan. B. Provide Wound Dressing Changes/Documentation During an interview on 5/18/25 at 4:17 p.m., staff member C stated resident #75's dressing was to be changed every three days or as needed. She stated the nursing staff were expected to change the dressing as ordered on the days the wound care nurse was not able to change the dressing. During an interview on 5/19/25 at 4:52 p.m., staff member B stated the facility had a wound care nurse that came to the facility at least once a week, on Thursdays, to provide wound care for the residents with wounds. She stated the wound care nurse provided dressing changes during that visit. She stated the nurses were also responsible for providing dressing changes as ordered by the physician and as needed. During an interview on 5/20/25 at 8:35 a.m., staff member D stated resident #75 was to have the dressing changed on her right leg pressure ulcer every other day. She stated she had not been able to provide dressing changes for resident #75 for a couple of weeks. She stated when she provided a dressing change it was documented in the resident's electronic record. Staff member D stated she did not see that resident #75's dressing changes were being documented, and it looked like the dressing changes were not being done consistently. During an interview on 5/20/25 at 8:45 a.m., staff member C stated the dressing changes for resident #75's wound were to be documented under the flowsheet. She stated she believed the dressing changes were being completed as ordered, but they were not being consistently documented. During an interview on 5/20/25 at 9:07 a.m., resident #75 stated she had not seen staff member D every week. She stated the nurses did not regularly change the dressing to her pressure ulcer. She stated the dressing often slipped or rolled up and would fall off when she transferred. She said they did not always put a new dressing on right away. A review of resident #75's Wound Clinic Physician Progress Notes, showed resident #75's Stage 3 pressure injury went from improving and measuring 0.5 cm x 0.4 cm, on 4/22/25, to a worsening Stage 3 Pressure Injury measuring 2.7 cm x 2 cm on 5/19/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of resident #75's Work Task History for Treatment Orders and Treatment Administration Record (TAR), dated 4/18/25 to 5/18/25, showed, Apply/change dressing every other day. A review of the TAR showed the resident dressing changes were completed on the following dates: 4/23/25, and not documented on the following dates: 4/27/25, 5/3/25, 5/7/25 and 5/11/25, and skipped on the following dates: 4/21/25, 4/25/25, 4/29/25, 5/1/25, and 5/9/25. The resident's wound care orders were changed on 5/19/25. A review of resident #75's Medical Record, Wound Care Notes, Progress Notes, and Flowsheets, from 4/21/25 to 5/19/25, showed the wound care and dressing changes were completed and documented for one day, on 4/23/25. Review of resident #75's Active Physician Orders, dated 5/19/25, showed, Apply/change dressing every third day. Comments: cleanse with [normal saline] pat dry, no-sting barrier to surrounding intact skin, apply Xeroform to wound bed, cover with foam dressing. Change every 3rd day and as needed if soiled or removed. 50245 2. During an interview on 5/17/25 at 4:30 p.m., resident #7 stated he had a catheter that had leaked for months on and off. Resident #7 stated staff would change the catheter, but it would often still leak. Resident #7 also stated he had sores on his privates. He stated he had told the staff about his sores, but he felt they did not listen, and he often felt they did not do perineal care correctly. He stated, You'd think they'd do this (clean) every night automatically. He stated some staff would clean twice a day but sometimes they would not at all. Resident #7 stated he asked a staff member in the past to change his brief, and the staff responded with You're okay to him. During an interview on 5/19/25 at 9:27 a.m., resident #7 stated he was uncircumcised, and when staff completed perineal care, they often forgot to pull the foreskin back to properly clean the area. He stated this was where the sore was. During an interview and observation on 5/19/25 at 1:52 p.m., staff member S stated it looked like resident #7 had been sitting in that chair [wheelchair] too long because resident #7's buttocks had looked red. Staff member S stated, Oh my goodness when they observed the wound underneath the uncircumcised skin on resident #7's foreskin. Staff member S did not have anything to measure the wound with but guessed on the measurements of 0.5 cm x 0.2 cm x 0.1 cm depth. Staff member S stated they thought resident #7's wound could have been from his catheter that was removed less than a month ago. Staff member S was unaware resident #7 had a wound at all. The wound bed was observed to be superficial and pink. The wound edges were light pink, and the overall wound size was less than an inch in length. The wound was the size and shape of the catheter tubing where the foreskin rested on the tubing. During an interview on 5/20/25 at 9:01 a.m., staff member D stated they had not known about resident #7's wound, and stated there was now an order for a dressing change to be done daily. Staff member D stated resident #7 had gotten his catheter removed 4/28/25. They stated there was a possibility he got a device related wound, but staff member D was unsure due to the peculiar spot. Staff member D stated, It looks like it was a little larger (in the past), and had been healing along the margins (sides of the wound). Staff member D stated it was concerning resident #7 had a wound, and was not notified. Staff member D stated it was hard to help if they did not know about it. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A request was made for #7's Wound cares/task check off, etc. related to [resident #7]'s private area wound prior to 5/19/25. During an interview on 5/20/25, staff member E stated not having information regarding resident #7's wound. Review of resident #7's EHR Skin Assessment, located in the Flowsheets, with a date of 5/17/25, showed: WDL (within defined limits).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50245 Based on observation, interview, and record review, the facility failed to ensure residents were getting turned to prevent skin breakdown throughout the day, for 3 (#s 7, 13, and 83) of 13 sampled residents. This deficient practice increased the risk of skin breakdown for any resident who did not get turned frequently enough. Findings include: 1. During an interview on 5/17/25 at 3:12 p.m., resident #83 stated staff only repositioned her in her Broda chair when she asked them to. She stated staff kept putting cream on her buttock area, and said something amongst themselves, but never said anything to resident #83 directly about her buttock area being red. Resident #83 stated staff would let her sit in her chair all day without turning or standing occasionally. She stated some staff would not clean her properly. She stated most staff were pretty good, but some will just change her brief and that was all they would do. She stated she gets recurrent UTIs and worried about skin breakdown. During an observation and interview on 5/19/25 at 7:45 a.m., staff members L and J stated resident #83's buttock was slightly pink, and the skin area was blanchable. Staff member J stated resident #83 told them her buttock area hurt when they pushed on the area. Review of resident #83's EHR showed her skin assessment was: WDL (within defined limits, no skin issues noted). During an observation and interview on 5/18/25 at 2:05 p.m., on 5/18/25 at 3:28 p.m., and on 5/19/25 at 3:47 p.m. During the observation periods, the resident was not repositioned by staff, and she did not have pillows for positioning in place. During an observation and interview on 5/19/25 at 3:48 p.m., resident #83 stated she got out of the Broda chair twice to use the restroom, but otherwise was in the Broda chair all day long. 2. During an interview on 5/17/25 at 3:13 p.m., resident #13 nodded yes when asked if his buttock hurt when he sat for a long time in the Broda chair. During an observation on 5/19/25 at 8:44 a.m., resident #13 was lying in bed on his back. During an observation and interview, on 5/19/25 at 3:46 p.m., resident #13 was lying on his back in the Broda chair. Resident #13 was not observed to have changed position. Resident #13 stated he got up once so far that day to use the restroom, but other than that, he was in the same position all day. Review of resident #13's EHR showed resident #13 was not turned at all on the following days: 4/20/25, 4/21/25, 4/24/25, or 4/25/25. 3. During an interview on 5/17/25 at 4:30 p.m., resident #7 stated his back would get sore from sitting a long time. He stated he would sometimes work with a restorative aide and get out of the chair, but stated, It's not a heck of a lot. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/19/25 at 9:27 a.m., resident #7 stated his buttock area would get really sore when he sits in his wheelchair too long. He stated it only takes about 30 minutes for it to start hurting. When asked, resident #7 stated staff had never repositioned him with a wedge or pillow in the wheelchair, and replied, They've never done that. During an observation on 5/19/25 at 3:45 p.m., resident #7 was sitting in his wheelchair. Resident #7 was not repositioned at this time. During an interview on 5/19/25 at 1:01 p.m., staff member F stated they were aware of one restorative staff member who went between all three buildings. Staff member F stated they felt this employee had a lot on their plate, and in total, that person took care of about 70 residents between all of the three buildings for restorative services. Staff member F stated the CNAs could help with turning, repositioning, and mobility in the facility, but stated the nurses were way too busy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 14005 Based on observation, interview, and record review, the facility failed to timely identify elopement risks and implement sufficient preventative interventions for a resident with repeated elopement(s), for 1 resident (#68) and the resident had severe cognitive impairments, of 13 sampled residents. There continued to be elopement hazards for this resident, and it was identified necessary staff were not aware of how to identify or classify an elopement. Findings include: During a facility tour, 5/17/25 at 2:00 p.m., the long-term care unit was on the fourth floor and was accessible by two sets of elevators. The elevators did not require special codes to access and were not monitored. The facility had numerous non-monitored doors and exits on the first floor. Review of resident #68's most current elopement/wander assessment dated , 1/23/23, showed the resident was not at risk for eloping. No current elopement assessment was provided by the end of the survey, but was requested. Review of resident #68's nursing note, dated 2/20/25, showed resident #68 had a BIMS of 7, reflecting severe cognitive impairment. Review of resident #68's nursing note, dated 3/11/25 at 5:32 p.m., showed resident #68 was attempting to get on the elevator. The button got pressed and resident #68 was still on the elevator. The note showed, Resident was reminded of safety again but may not be able to understand. Review of resident #68's nursing note, dated 3/12/25 at 5:18 p.m., showed resident #68's family member was informed of the resident getting on the elevator. The nurse and the family member discussed the potential to move him to another unit/building which has a secure unit. The information presented to the family member was shared with the social worker. Review of resident #68's nursing note, dated 5/8/25 at 2:39 a.m., showed resident #68 got onto the elevator and was found on the third floor. Resident #68 continued to search for an exit for the next two and a half hours. Review of resident #68's nursing note, dated 5/8/25 at 10:50 p.m., showed resident #68 was found on the first floor and was brought back to the unit. Resident #68 continued to hang out near the elevator for two hours. The attempts to redirect resident #68 away from the elevators were unsuccessful. Review of resident #68's nursing note, dated 5/9/25 at 8:47 a.m., showed the elopement of 5/8/25 at 2:39 a.m., was discussed with the social worker. The nursing note showed the Social Worker will contact the POA regarding moving resident #68 to a secured unit in another facility. Review of the resident #68's nursing notes, from 3/12/25 through 5/9/25, showed there was no follow up to move resident #68 to a secure unit, even after it was suggested by nursing staff to keep resident #68 safe, from another elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #68's plan of care, with the most current update of 2/10/25, failed to show the resident's risk for elopement and the resident's wandering and elopements were not addressed on the care plan. The care plan did not direct the staff on how to manage resident #68 when he was exit seeking and attempting to elope. During an interview on 5/18/25 at 12:50 p.m., staff member G said the events where resident #68 left the unit via the elevator were discussed with staff member A. The administrative team decided the event would be classified as an AWOL and it was not classified as an elopement. A review of the State Operations Manual, Appendix PP, F689 - Accidents and Hazards showed: A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Facility policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without the facility's awareness and/or appropriate supervision . A review of the facility policy and procedure titled, BSS Elopement or Leaving Against Medical Advise (AMA) from [Facility Name] Senior Services showed the following definitions: - Away (or absent) without leave: A resident who is cognitively intact and can appreciate safety risk . These absences do not meet the definition of elopement since the resident is cognitively aware of the consequences and safety issues and the absence is intentional. - Elopement is the ability of a cognitively impaired resident, who is not capable of protecting themselves, to successfully leave the facility unsupervised and unnoticed, potentially coming to harm. Elopers are differentiated from the wanderers by their overt, and often repeated attempts to leave the facility, and premises. During an observation and interview on 5/18/25 at 1:30 p.m., resident #68 was observed in the hallway near the elevators. Resident #68 was not able to answer any questions during the interview due to the resident's cognitive status and confusion. During an interview on 5/19/25 at 12:55 p.m., staff member F said resident #68 has been getting on the elevator for about two months now. Staff member F said he just rode the elevator up and down, however when questioned further, staff member F did admit resident #68 got off on other floors. Staff member F said the facility had a wander guard system, but said he was unsure how the wander guard system would work on this floor. Staff member F said resident #68 was not using a wander guard. Staff member F said the resident had not been moved to the secured facility because the family member was touring the facility, and there were no open rooms. During an interview on 5/19/25 at 1:20 p.m., staff member G said there were seven open beds in the facility with a secure unit.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 14005 Based on observation, interview and record review, the facility failed to ensure residents who received dialysis were provided services, consistent with professional standards of practice, to include physician orders for the dialysis and appropriate nutrition and per the resident's preferences, for 1 (#14) of 13 sampled residents. The deficient practice placed the resident at risk for pre-dialysis and post-dialysis complications. Findings include: During an interview on 4/22/25 at 8:29 a.m., resident #14 said he had been getting dialysis at a dialysis center across town. Resident #14 said he goes to dialysis on Tuesday, Thursday, and Saturday. Resident #14 said he left the facility at approximately 6:00 a.m., and returned to the facility at approximately 11:00 or 11:30 a.m., depending upon how long he had to wait for the facility van. Review of resident #14's admission physician orders, dated 8/22/24, showed the resident did not have a physician order for the dialysis treatment. Review of resident #14's physician order received on 5/19/25, showed the physician order for hemodialysis was created on 5/19/25. During an observation on 5/18/25 at 5:03 p.m., resident #14 received a meal tray at his bedside with the following items on the plate: green beans, a bun, chicken noodle soup, and a small piece of pumpkin pie. Resident #14 was not at his bedside to eat the meal. During an interview on 5/19/25 at 8:30 a.m., resident #14 said he did not receive protein with his supper meal the day prior (5/18). Resident #14 said he was tired of chicken, and he did not get any meat. During an interview on 5/19/25 at 9:25 a.m., staff member Q stated resident #14 should be getting double servings of protein and not getting any meat would not be according to his diet. Staff member P said there are other options available if he did not want chicken.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35356 Based on observation, interview, and record review, the facility failed to provide sufficient staffing contributing to a worsening pressure ulcer injury for 1 (#75), ADLs not being completed for 2 (#s 5 and 83), long call light times and low staffing concerns reported by residents for 3 (#s 13, 79 and 83), and repositioning not being completed for 3 (#s 7, 13 and 83) of 13 sampled residents. Findings include: During an interview on 5/17/25 at 3:57 p.m., resident #75 stated she had a pressure ulcer on her right upper leg. She stated she thought it was worse because staff did not always change the dressing. She stated she preferred to have her dressing changed during the day, not at night, but often the day staff did not have time to change it. She stated on several different occasions she had been told by staff that they don't have time to change it. During an observation on 5/18/25 at 4:17 p.m., staff member C provided wound care and a dressing change for resident #75. Resident #75 had an oval shaped wound located on the back of her right upper thigh. The wound was approximately 3 cm x 2 cm in size and was red and beefy in appearance. During an interview on 5/20/25 at 8:35 a.m., staff member D stated resident #75 was usually in bed or asleep when she was there to do her wound care, and the resident would tell her to come back later. She stated she sometimes would not return later so she would notify the nurse on duty so they could provide the resident's wound care. Staff member D stated she had not had a recent opportunity to assess, measure, or monitor resident #75's right leg wound. She stated she believed resident #75 had a recent Wound Clinic visit which showed her wound was slightly worse. Staff member D stated after reviewing resident #75's medical record, she did not think resident #75's dressing changes were being completed consistently. A review of resident #75's Medical Record, Wound Care Notes, Progress Notes, and Flowsheets, from 4/21/25 to 5/20/25, did not reflect the resident's wound was assessed, measured or monitored from 4/22/25 to 5/19/25. Wound Clinic Physician Progress Notes showed resident #75's Stage 3 pressure injury went from improving on 4/22/25, to a worsening Stage 3 Pressure Injury on 5/19/25. 50245 During an interview on 5/17/25 at 2:15 p.m., NF6 stated resident #5 was often left in her room in the dark when the other residents were at breakfast. NF6 stated this made them very mad as their family member was not getting out of bed, not being encouraged to eat more, and not socializing with the other residents. During an interview on 5/17/25 at 3:12 p.m., resident #83 stated the staff members were doing their best but stated she had waited an hour and a half to get changed this morning. Resident #83 stated, I pushed it again (call light). I thought I had forgotten. She stated, When you pay $2,500 . for care, it matters. Resident #83 stated she thought the facility should adjust the price for the quality of care that they received. Resident #83 stated her face being washed, teeth being brushed, and hair brushed occurred sometimes, in the morning with staff help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/17/25 at 3:13 p.m., resident #13 stated the call lights sometimes took a long time to be answered. He also stated his buttocks hurt when he sat for a long time. During an observation on 5/18/25 at 8:02 a.m., two nurses were observed working on the floor. No CNAs were observed on the floor at that time. During an interview on 5/18/25 at 8:06 a.m., staff member N stated he would pre-pour medications when the facility was short staffed. He stated the facility staffed the unit with only one nurse quite a bit. During an interview on 5/18/25 at 1:43 p.m., resident #79 stated the staffing did seem to run low sometimes. He stated he does not get upset with the low staffing as long as they let him know, and then he does not call as much. During an interview on 5/19/25 at 9:27 a.m., resident #7 stated his buttock area would get really sore when he sits in his wheelchair too long. He stated it only took about 30 minutes for it to start hurting. Resident #7 stated staff have never repositioned him with a wedge or pillow (for pressure relief) in the wheelchair. He stated, They've never done that. During an observation on 5/19/25 at 10:02 a.m., resident #5's hair was in two braids that were observed to be frizzy and looked as if the braids had been slept in. During an interview and observation on 5/20/25 at 8:16 a.m., NF5 stated resident #83 had told them she felt that she got the brunt of what was going on when the facility was short staffed and she pushed the call button for help. NF5 stated the staff members could be short-mannered with her. Resident #83 stated before she was in the facility she used to be able to shower every day, and now she feels bad pushing the call button, because she does not want to be a bother. Resident #83's face had flaky skin on it, and she stated she had not been offered a washcloth this morning after she had been dressed. She stated the little things in life like washing your face with a warm washcloth would be nice in the morning. During an interview on 5/20/25 at 8:34 a.m., staff member S stated they would sometimes get floated to the other buildings to work. They stated they did feel short staffed more than half of the time at this facility. The expectation for getting to a call light was five minutes, with ten minutes pushing it (the time limit). Staff member S stated feeling like the call lights at this facility did seem to go off longer than ten minutes, and there were often two CNAs and two nurses for the full unit of 34 rooms. Staff member S stated there were times when the facility only had one nurse and two CNAs, and the best staffing was when there were two nurses and three CNAs. Staff member S stated they had not heard of any residents feeling bad about pushing the call button, but stated, I would feel pretty bad. They should feel like this is their home no matter what. Staff member S also stated less mobility and turning could lead to more skin breakdown with residents. During an interview on 5/20/25 at 10:25 a.m., staff member E stated the call light system was down, and the facility was unable to show the survey team the requested call light times past the date 4/20/25. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/25 at 10:35 a.m., staff member T stated the facility was often short staffed. Staff member T stated if the unit was full, there was usually only two CNAs working on the floor. Staff member T stated if there were not two CNAs on the floor, one of the nurses would help with CNA work. Staff member T stated the facility had eight residents that required two people to operative a mechanical lift in order to transfer a patient.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50245 Based on observation, interview, and record review, the facility failed to ensure prescribed medications were given for 2 (#s 7 and 79) and failed to follow physician ordered parameters for one medication, digoxin, for 1 (#80) of 13 sampled residents. The facility's medication error rate was calculated at nine percent. This deficient practice had the potential to cause harm for a resident if their pulse was too low and the medication was given, or if the medications were not given at all. Findings include: 1. During an observation and interview on 5/18/25 at 8:16 a.m., resident #80's medication, digoxin, was given at 8:34 a.m. Staff member N stated they had taken resident #80's pulse prior to the medication administration and stated the pulse was taken first thing in the morning. Review of resident #80's Flowsheets and TAR, in the EHR, showed no vitals (including resident #80's pulse) were taken on 5/18/25. Review of resident #80's MAR showed: digoxin . Hold for pulse less than 50. 2. During an interview and observation on 5/18/25 at 8:24 a.m., resident #79's medication, Lotrimin cream, was documented as given on the MAR, at 8:04 a.m., along with all of the other scheduled medications. Staff member N stated they went back and gave the other medications that were not pills (for example: inhalers, medicated creams, etc.) after all of the resident's pills were all given. Staff member N stated they just remembered which residents need their creams, inhalers, etc. During an interview on 5/18/25 at 1:43 p.m., resident #79 stated he had not been given his Lotrimin cream for the day. Review of resident #79's EHR showed a BIMS of 15, cognitively intact. Review of resident #79's diagnoses showed resident #79 had seborrheic dermatitis and a long-term skin disorder. During an interview on 5/20/25 at 8:51 a.m., resident #79 stated he had to use the cream for eczema, but it seemed to him like he only received it every other day. 3. During an interview on 5/18/25 at 4:30 p.m., resident #7 stated he did not receive his inhaler (Bevespi Aerosphere) that day. He stated he stopped reminding staff about it. Review of resident #7's MAR showed Bevespi Aerosphere was documented as given on 5/18/25 at 7:33 a.m. Review of resident #7's EHR showed a BIMS of 15, cognitively intact. Review of a facility policy, titled BSS-Medication Pass/Pre-Pouring Medications, last approved on 4/2025, showed: . Proper administration of medications includes medication-specific monitoring, including apical pulse, laboratory values, blood pressure .