

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/18/2026
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)		
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure there were eight consecutive (onsite) hours of registered nursing coverage provided each day, seven days a week. This failure affected all residents in the facility when an RN was not available on-site. Findings include. Review of the facility's Payroll-Based Journal report showed the facility had eight days without the required registered nurse coverage during the Fiscal Year Quarter 2 2026 (January 1-March 31). The following dates showed no registered nurse coverage for eight consecutive hours: - 1/17/26,- 1/31/26,- 2/1/26,- 2/14/26,- 2/28/26,- 3/1/26,- 3/14/26 and,- 3/28/26. During an interview on 6/17/26 at 2:32 p.m., staff member A said the facility had a registered nurse who had terminated employment. Staff member A said the staffing coordinator did not identify that a registered nurse had terminated employment, so the position hours were not replaced with another RN.		

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: 275158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
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)		
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 altercation 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.		

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 06/18/2026
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)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to independently carry out activities of daily living (ADL) for self-grooming was provided assistance with removal of facial hair for 1 (#1) of 19 sampled residents. This had the increased risk of negatively affecting the residents self-esteem when in a public area. Findings include: During an observation and interview on 6/15/26 at 3:08 p.m., resident #1 was observed with facial hair, which was approximately one-half inch long. When asked if the resident preferred to have facial hair, resident #1 said he preferred to be clean-shaven. Resident #1 said he could not shave himself and needed help. Resident #1 said the staff did not offer to shave his facial hair. During an interview and observation on 6/16/26 at 12:04 p.m., resident #1's facial hair was unchanged from the day before. Resident #1 said the staff had not offered to help him shave. During an interview and observation on 6/17/26 at 8:10 a.m., resident #1 said the staff assisted with getting him up, dressed, and out of bed, but they had not offered to shave him that morning. During the observation, it was noted that resident #1's facial hair was similar to the day prior. During an interview on 6/17/26 at 8:52 a.m., staff member F said that at the change of shifts, nurses received a verbal shift report. The certified nursing assistants complete walking rounds to be updated on the information for each resident. During an interview on 6/18/26 at 9:48 a.m., staff member J said he did not usually work on the unit. Staff member J said residents should be shaven when showered or as needed. Staff member J said he was not familiar with resident #1's personal preferences because he did not receive that information during walking rounds. Review of resident #1's minimum data set with an assessment reference date of 5/6/26 showed personal hygiene was the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands. Resident #1 was assessed with a score of two. A score of two showed resident #1 needed substantial/maximal assistance, and the helper did more than half the effort. Review of resident #1's current care plan dated 5/22/26 showed the staff was to assist resident #1 with activities of daily living.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/18/2026
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)		
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.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/18/2026
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)		
F 0812 Level of Harm - Potential for minimal harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure safe food labeling and storage in accordance with professional standards of practice. These deficient practices affected all residents receiving food services from the facility, placing all residents at risk for a foodborne illness or negative outcomes. Findings include: During an interview on 6/15/26 at 12:53 p.m., staff member N stated the nursing department was responsible for ordering, labeling, dating, and disposing of any expired food and or drinks in the dining room kitchen. During an interview on 6/17/26 at 9:30 a.m., staff member H stated the CNAs were responsible for preparing and distributing resident snacks. Staff member H stated the nursing department re-ordered the supplies for the dining room kitchen. Staff member H was not sure who was responsible for disposing of the expired items. During an observation on 6/15/26 at 1:40 p.m., the following items had incomplete, missing, or expired food dates:- Two covered black soup bowls, not labeled, not dated,- Three covered Styrofoam disposable cups, not labeled, not dated,- Three, 16-ounce sweet cream butters with a best by date of 6/7/26,- Seven, two-ounce covered containers with a dry brown substance, not labeled, not dated, - 17 four-ounce prune juices, no expiration date; and,- The bin labeled flour was not dated, During an observation on 6/18/26 at 9:30 a.m., the following items had incomplete, missing, or expired food dates, showing the facility did not address the items from the prior observation:- Three, 16-ounce sweet cream butter with a best by date of 6/7/26,- Four, two-ounce covered containers with a brown liquid substance, not labeled, not dated,- Three, two-ounce covered containers with a brown dry substance, not labeled, not dated, and- 17 four-ounce prune juices, with no expiration date.		