STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275140	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Meadows Health and Rehabilitation Center	3155 Ave C Billings, MT 59102

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41652 Based on observation, interview, and record review, the facility failed to provide wound care as ordered by the provider; and failed to implement and document physician ordered interventions intended to mitigate worsening of a pressure ulcer, for 1 (#14) of 3 sampled residents with pressure wounds. These deficient practices contributed to the worsening of a pressure ulcer from nearly healed to a Stage III ulcer on the resident's heel. Findings include: 1. Pressure ulcer dressing changes not done as ordered Review of resident #14's provider orders, dated 8/23/24, showed the dressing change was, LEFT HEEL: cleanse ulcer with vashe wash, . pack with silver alginate rope, cover with opti-foam dressing. one time a day every Mon, Wed, Fri. [sic] Review of resident #14's provider progress note, dated 9/18/24, showed the resident's left heel ulcer had worsened with increased sloughing of yellow green tissue. The note also showed, Continued to emphasize to [resident #14 First Name] regarding the importance of offloading this ulcer to support wound healing. Educated that these types of ulcers are significantly pressure and weight related. Educated that without strict guidance to above, will likely never heal . Prevalon boot for offloading when supine and sitting. Review of resident #14's TAR, dated September of 2024, showed no dressing change was signed off as completed on 9/20/24. Review of resident #14's provider order, dated 9/25/24, showed, LEFT HEEL: Cleanse stage III with Vashe wash, pat dry, . apply foam to wound bed . cover all foam with transparent dressing. Wound vac to run continuously at 125mmHG. [sic] Review of resident #14's TAR, dated September of 2024, showed no dressing change was signed off as completed on 9/27/24. During an observation on 10/21/24 at 8:50 a.m., resident #14 was lying in bed and had a bulky Coban (special tape) dressing on his left heel with a date of 10/16 on it. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of resident #14's provider order, dated 10/17/24, showed the dressing change was, LEFT HEEL: Cleanse wound and periwound with Vashe wound solution, apply gentian violet to peri wound, add metronidazole powder and silver alginate rope to wound bed, cover with ABD pad. one time a day every Mon, Wed, Fri for stage III. [sic] Review of resident #14's TAR, dated October of 2024, showed the dressing change on 10/18/24 was documented as completed by staff member F. During an interview on 10/21/24 at 9:32 a.m., staff member F stated she documented the completion of the dressing change on 10/18/24. But, did not actually do the dressing change. Staff member F stated the wound care nurse was there on that day and did the dressing change. During an interview on 10/21/24 at 9:55 a.m., staff member G stated she was responsible for wound care. But, she was only in the facility for a short time on Friday (10/18/24), but did not work. Staff member G stated it was the responsibility of the floor nurse to do their own treatments (dressing changes) when the wound nurse is not available. 2. Use of heel protector boots and a bolster pillow used for pressure ulcer prevention. During an observation and interview on 10/14/24 at 1:57 p.m., resident #14 was heard yelling Help from his room. Resident #14 was sitting up in his wheelchair and was not wearing the heel protector boot on his right foot. The resident's left foot had the heel protector boot on. However, his left foot had slipped off the footrest and was wedged between the footrests on his wheelchair. Resident #14 stated he was in pain and needed to go back to bed. Resident #14 stated he had been up in his wheelchair since about 10:30 (a.m.). During an observation and interview on 10/21/24 at 8:50 a.m., resident #14 was lying on his back in bed with his eyes closed and the head of the bed elevated. Resident #14 had a blue bolster pillow measuring approximately six inches thick and 18 inches wide place under both of his legs, and centered at his knees. There were also two regular bed pillows on top of the bolster pillow. When asked why he did not have the heel boots on, the resident stated, They say they don't have time. During an interview on 10/21/24 at 11:00 a.m., NF2 said she tried to attend #14's wound clinic appointments. NF2 stated she had been complaining to the facility staff for months about the improper placement of the bolster pillow, under the knees rather than under the calves, and the use of heel protector boots on both feet. NF2 stated she was told, by the wound clinic provider, the purpose of the bolster pillow was to allow the resident's heels to float and thereby minimize pressure. NF2 stated the wound clinic provider had ordered the heel protector boots to be on both feet at all times, except when ambulating. NF2 stated when she asked the facility staff about the heel protector boots, she was told resident #14 refused to have them on. During an interview on 10/21/24 at 3:15 p.m., staff member C stated she was not able to find documentation of the order for, or the consistent use of, the heel protector boots and the bolster pillow. Staff member C stated there were some refusals documented, but it was not documented consistently. Review of resident #14's nursing progress notes, dated between 8/21/24 and 10/17/24, showed the heel protector boots were refused by the resident on 8/21/24, 9/18/24, 9/23/24, 9/24/24, 9/26/24, and 10/17/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of resident #14's nursing progress notes, dated between 8/20/24 and 10/16/24, showed the resident's heels were floated on 8/20/24, 8/21/24, 9/18/24 at 1:51 p.m., and the presence of a pressure ulcer was found on the resident's left heel. No other documentation of the use of heel protector boots was found in the EHR.