STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER: Aspen Meadows Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3155 Ave C, Billings, MT 59102	

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 48262 Based on observation, interview, and record review, facility staff failed to identify care concerns for a resident who was restricted to right lower extremity non-weight bearing status, and failed to develop and implement a baseline care plan within 48 hours of admission, to address resident care needs, for 1 (#4) of 20 sampled residents. Findings include: During an interview on 1/15/25 at 9:52 a.m., resident #4 was observed in her room sitting in her wheelchair. Resident #4 stated she admitted to the hospital on 12/22/24. Resident #4 stated she was admitted to the hospital after falling, while out on a walk, and the resident sustained a right hip fracture. Resident #4 stated she admitted to the long-term care center on 12/30/24, for additional physical and occupational therapy services, due to her restricted right lower extremity non-weight bearing status. During an interview on 1/16/25 at 12:47 p.m., staff member B stated the MDS nurse had been responsible to complete the resident baseline care plan. The process has since changed and baseline care plans are reviewed by the interdisciplinary team during the facility's morning meeting. Staff member B stated she was not aware if the computer software would allow an entry for a resident's weight bearing status on a baseline care plan and would need to go back and review the options within the system. Staff member B stated the baseline care plan was to be completed within 48 hours of a resident's admission. Review of resident #4's history and physical, from the hospital, dated 12/22/24, showed resident #4 had a fall and sustained a fracture of the right acetabulum which was non-operable. Resident #4 was placed on non-weight bearing status to the right lower extremity for six weeks. Review of resident #4's baseline care plan, dated 1/2/25, showed a focus, goals, and interventions for bathing, advance directives, and discharge planning. The baseline care plan failed to identify or address a focus, goals, or interventions for nutrition, pain, weight bearing status, and therapy needs. The facility failed to complete resident #4's baseline care plan within 48 hours of the resident's admission to the facility.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 14005 Based on observation, interview, and record review, the facility failed to provide assistance with ADL's for dependent residents, for 4 (#s 8, 23, 39 and 65) of 20 sampled residents, and the residents were found to be unkempt, there was noticable body odor, and one voiced concerns of feeling neglected. Findings include: During an interview and record review on 1/14/25 at 11:56 a.m., resident #8 said he would like to have five baths per week like he used to get. Resident #8 said he is lucky to get three a week but usually just two. Resident #8 is alert and oriented and able to make his needs and wishes known. Review of resident #8's current care plan directed the staff to give him five baths per week. Resident #8 said he does not get washed up between baths. During an interview and record review on 1/16/25 at 9:05 a.m., resident #65 was observed with her blouse pulled away from her body and with her nose pointed down her shirt. Resident #65 said she was checking to see if she smelled bad because she missed her shower. Resident #65 said I need a shower, and my hair washed. Resident #65's hair was in small ponytails pulled back and away from her face, and then put into a braid down the back of her head. During the ten minute conversation, resident #65 frequently ran her hand over her hair trying to get it to stay down. Strands of loose hair was observed fluttering around her face. Resident #65 said she would like a bath twice a week, and resident #65's care plan directed the staff to bathe her twice weekly. The certified nurse assistant task list showed resident #65 had only received one bath from 1/1/25 through 1/15/25. Resident #65 said the facility had hired a new bath aide, and the schedule was messed up because the facility must re-do the schedules. Resident #65 said she does not get showers twice a week because the staff doesn't offer to bathe her. During an observation, record review, and interview on 1/16/25 at 11:15 a.m., resident #23 said the facility must help him with most of his care. Resident #23 said he wants one shower a week. During observation, resident #23, appeared unkempt with oily hair, and an unshaven face. Resident #23 was sitting in the Timbers dining room near several other residents. From where the surveyor sat across the table from resident #23, a strong body odor could be smelled. Resident #23's shower schedule was reviewed from 12/18/24 through 1/15/25 and showers were noted as having been provided on 12/18/24 and on 1/1/25. No further showers were noted to have been offered. Resident #23's care plan showed resident #23 was dependent with bathing and was to have one bath a week. During an interview and record review on 1/16/25 at 11:40 a.m., resident #39 said she would like two baths a week. Resident #39's care plan showed the staff are to bathe resident #39 twice a week. Resident #39 said the facility is short staffed and she had not had a bath in over ten days. Resident #39 said not getting her baths, made her head itch and made her feel neglected by the staff. During an interview on 1/16/25 at 11:25 a.m., staff member O said the facility occasionally had staff call off's from work. This left the units without enough CNAs (certified nurse assistants). Staff member O said when the staffing was short, the bath aides are pulled from completing the scheduled baths and are reassigned to assist with providing routine resident care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/16/25 at 12:50 p.m., staff member B said the facility recently hired a new bath aide. The schedule was changed from eight-hour shifts to working twelve hour shifts, for the bath aides. Staff member B said one bath aide has requested a significant amount of personal time off and giving the time off has caused the scheduled baths to not get done. Staff member B said the bathing schedules are being re-vised to meet the resident's personal needs.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 14005 Based on interview and record review, licensed nurses failed to uphold and provide competent nursing services by failing to administer medication by following the professional standards of medication administration, for 2 (#s 6 and 13) out of 20 sampled residents. Findings include: 1. Review of resident #13's physician order, dated 9/17/24, included documentation on the medication administration record which directed the resident to have Diazepam 5mg/ml, intramuscularly, every 15 minutes, as needed for seizures. The narcotics medication log showed resident #13 was to be given Diazepam 5mg/5ml, one ml by mouth for seizures. No order was found on the medication administration record for the oral dose of Diazepam. Review of resident #13's nursing note, dated 11/19/24, showed a nurse identified a medication error was made when two doses of seizure medication diazepam was given instead of the prescribed pain medication, hydromorphone. Staff member Q signed the narcotics medication log for the oral Diazepam. On 11/19/24 at 10:06 a.m., and 5:00 p.m., staff member Q signed out resident #13's oral Diazepam from the narcotics medication log. Staff member Q documented on resident #13's medication administration record that the Diazepam was given intramuscularly on 11/19/24 at 5:00 p.m. Review of nurse's notes, dated 11/19/24, did not show seizure activity for resident #13. Review of resident #13's medication administration record showed no documentation was completed for the 10:06 a.m. dose of Diazepam. Resident #13's medication administration record showed staff member Q signed the 8:00 a.m. and 2:00 p.m. , doses of Hydromorphone as given per the order. Review of resident #13's narcotics log showed Hydromorphone was not removed from the locked cabinet at 8:00 a.m. and 2:00 p.m., on 11/19/24. Review of staff member Q's skills competency rating, dated 2/26/24, showed staff member Q was proficient in administering oral and intramuscular medications. Competency for skills regarding documentation was not assessed. The self assessed skills competency rating was completed and signed by staff member Q. The skills competency rating was not co-signed or verified by a registered nurse identifying the nurse was competent in administering medication or documenting accurately. During an interview on 1/16/25 at 12:50 p.m., staff member B was aware of the medication error for resident #13. Staff member B said some of the medication errors were due to the times the medications were scheduled to be administered. The residents were scheduled for narcotics at the time when staff would be doing a shift change and the staff would be confused as to whose responsibility it was to administer the medication. Staff member B said resident #13 would get Diazepam orally as there was not an order for intramuscular medication. 48262 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 1/15/25 at 1:36 p.m., resident #6 stated on 12/25/24 at 12:00 a.m., a nurse entered her room holding what appeared to look like a pen in her hand. Resident #6 asked the nurse what was in her hand. Resident #6 stated the nurse said the pen was insulin. Resident #6 stated she told the nurse, I have never taken insulin in my life. Resident #6 stated by the time she had completed her sentence the nurse had injected the insulin in the right upper quadrant of her abdomen. Resident #6 stated she had no ill effects from the incident. During an interview on 1/16/25 at 12:47 p.m., staff member B stated the facility immediately terminated staff member NF5's contract. Staff member B said NF5 worked 12/25/24 from 6:00 p.m. until 1:00 a.m. on 12/26/24 and did not tell any staff that insulin was administered to a non diabetic resident. Review of a facility document titled Medication Error Report, dated 12/25/24, showed resident #6 reported to the certified medication aide the nurse on the prior shift gave her insulin during the night. Resident #6 said she told the nurse she was not a diabetic and had never received insulin in her life. Resident #6 said the nurse did not respond to her and administered the insulin anyway.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 14005 Based on interview and record review, the facility failed to ensure all controlled substance medications were accurately administered, accounted for, and documented, for 2 (#s 13 and 35) of 20 sampled residents. Findings include: Review of resident #13's nursing notes, dated 11/19/24, showed the nurse made a medication error and administered two doses of diazepam instead of the prescribed hydromorphone. Resident #13's medication administration record for 11/19/24, showed one dose of diazepam was given, and not two as shown in the nurse's notes. Review of the narcotics sign out log for 11/19/24, showed the nurse signed out two doses of diazepam. The narcotics log for resident #13, showed one dose of diazepam was signed out on 11/30/24, and there were no doses of diazepam documented in the medication administration record as being given to resident #13 on 11/30/24. Resident #13's medication administration record showed resident #13 received three doses of hydromorphone on 11/19/24. Review of resident #13's nurse's note, dated 11/19/24, showed the resident missed two of the three ordered doses of hydromorphone. Resident #13's hydromorphone narcotics log showed only one dose of hydromorphone signed out on 11/19/24. Review of resident #35's current physician orders showed resident #35 was to receive Tramadol 50mg tablets by mouth three times a day related to pain. Resident #35's December 2024 medication administration record showed the medication had been signed as administered three times a day for the entire month of December 2024. Review of the narcotic medication logs for resident #35 showed only two tablets were given on 12/12/24 and 12/23/24 and only one tablet was documented as used on the log on 12/9/24. None of those three medication errors were identified and investigated by the facility as part of the quality assurance process. During an interview on 1/16/25 at 12:50 p.m., staff member B said the facility had undergone a narcotics diversion investigation not long ago. Staff member B said due to the problems found with the system during the investigation, the facility completed audits consistently for a time. Staff member B said she completed audits as needed, and one nurse completed audits routinely. Staff member B said the pharmacy also completed audits and staff member B was alerted with any issues. Staff member B did not identify any problems with narcotics counts not matching the medication administration record and said she had not been alerted by the pharmacy of any discrepancies found. Staff member B was aware of the medication error for resident #13. Staff member B said some of the medication errors were due to the times the medications were scheduled to be administered. The residents were scheduled for narcotics at the time when staff would be doing a shift change, and the staff would be confused as to whose responsibility it was to administer the medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 14005 Based on interview and record review, licensed nurses failed to uphold and provide competent nursing services by failing to administer medication by following the professional standards of medication administration, for 2 (#s 6 and 13) out of 20 sampled residents. Findings include: 1. Review of resident #13's physician order, dated 9/17/24, included documentation on the medication administration record which directed the resident to have Diazepam 5mg/ml, intramuscularly, every 15 minutes, as needed for seizures. The narcotics medication log showed resident #13 was to be given Diazepam 5mg/5ml, one ml by mouth for seizures. No order was found on the medication administration record for the oral dose of Diazepam. Review of resident #13's nursing note, dated 11/19/24, showed a nurse identified a medication error was made when two doses of seizure medication diazepam was given instead of the prescribed pain medication, hydromorphone. Staff member Q signed the narcotics medication log for the oral Diazepam. On 11/19/24 at 10:06 a.m., and 5:00 p.m., staff member Q signed out resident #13's oral Diazepam from the narcotics medication log. Staff member Q documented on resident #13's medication administration record that the Diazepam was given intramuscularly on 11/19/24 at 5:00 p.m. Review of nurse's notes, dated 11/19/24, did not show seizure activity for resident #13. Review of resident #13's medication administration record showed no documentation was completed for the 10:06 a.m. dose of Diazepam. Resident #13's medication administration record showed staff member Q signed the 8:00 a.m. and 2:00 p.m. , doses of Hydromorphone as given per the order. Review of resident #13's narcotics log showed Hydromorphone was not removed from the locked cabinet at 8:00 a.m. and 2:00 p.m., on 11/19/24. Review of staff member Q's skills competency rating, dated 2/26/24, showed staff member Q was proficient in administering oral and intramuscular medications. Competency for skills regarding documentation was not assessed. The self assessed skills competency rating was completed and signed by staff member Q. The skills competency rating was not co-signed or verified by a registered nurse identifying the nurse was competent in administering medication or documenting accurately. During an interview on 1/16/25 at 12:50 p.m., staff member B was aware of the medication error for resident #13. Staff member B said some of the medication errors were due to the times the medications were scheduled to be administered. The residents were scheduled for narcotics at the time when staff would be doing a shift change and the staff would be confused as to whose responsibility it was to administer the medication. Staff member B said resident #13 would get Diazepam orally as there was not an order for intramuscular medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 1/15/25 at 1:36 p.m., resident #6 was observed in her room sitting in her wheelchair. Resident #6 stated on 12/25/24 at 12:00 a.m., a nurse entered her room holding what appeared to look like a pen in her hand. Resident #6 asked the nurse what was in her hand. Resident #6 stated the nurse said the pen was insulin. Resident #6 stated she told the nurse, I have never taken insulin in my life. Resident #6 stated by the time she had completed her sentence the nurse had injected the insulin in the right upper quadrant of her abdomen. Resident #6 stated she was angry because no regard was given to what she had told the nurse. Resident #6 stated she was able to go to sleep after she received the injection and told the day shift nurse what had happened before she received her morning medications, on 12/25/24. Resident #6 stated she had no ill effects from the incident. During an interview on 1/16/25 at 12:47 p.m., staff member B stated the NF5 worked 12/25/24 from 6:00 p.m. , until 1:00 a.m. on 12/26/24. Staff member NF5 failed to report that insulin was given to a non diabetic resident. Staff member B immediately terminated staff member NF5's contract. Staff member B stated, she reported the incident to NF5's contract agency, and the State Board of Nursing. Staff member B said the facility has included training for subcutaneous injection of medication to all travel nurses and the new hire nurse orientation packets. Review of a facility document titled Medication Error Report, dated 12/25/24, showed resident #6 reported to the certified medication aide the nurse on the prior shift gave her insulin during the night. Resident #6 said she told the nurse she was not a diabetic and had never received insulin in her life. Resident #6 said the nurse did not respond to her and administered the insulin anyway. Resident #6 was not aware of how much insulin she received. The facility nurse checked resident #6's blood glucose level, which was 60 mg/dL. Resident #6 was given orange juice and breakfast to raise her glucose level. The medication error was reported to the medical provider and interdisciplinary team. Resident #6 required no additional interventions.