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	09/10/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a resident who had medications left at bedside was assessed, and a physician's order was obtained for the safe self-administration of medications, for 1 (#5) of 7 sampled residents. Findings include:During an observation and interview, on 9/9/25 at 7:14 a.m., staff member E prepared resident #5's medication and put them into a medication cup. Staff member E opened resident #5's door and placed the medications in the resident's room on the bedside table. Staff member E stated, She's (resident #5) sleeping, I leave them in there for her to take when she wakes up, most of the time she won't take them in front of me and says she will take them when she is ready to take them.During an interview on 9/9/25 at 9:20 a.m., resident #5 stated, Staff often leave my medication in my room for me to take when I'm ready to take them. Sometimes they will watch me take them, but not always.During an interview on 9/9/25 at 3:25 p.m., staff member A stated it was not okay to leave medications at the bedside for residents unless they had been assessed for the self-administration of medications.Review of resident #5's electronic medical record failed to show a physician's order for the self-administration of medications and failed to show that a safety assessment had been completed to determine if resident #5 was safe to self-administer her own medications.Review of a facility document titled Medication Administration: Self-Administration by Resident, dated January 2023, showed: Policy: Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration.Procedures: 1. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process. [sic]

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 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. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to schedule sufficient staff to ensure call lights were answered timely for 3 (#s 1, 2, and 3) of 7 sampled residents, and staff were using mechanical lifts with the appropriate number of staff for 1 (#5) of 7 sampled residents. This deficient practice had the potential to negatively impact all residents who use a call light by causing incontinent episodes and increases the risk of injury for all residents who need a mechanical lift for transfers. Findings include: 1. During an interview on 9/9/25 at 7:32 a.m., staff member D stated, I think the facility is understaffed 80 percent of the time. We (staff) try to get all our tasks done but some days it is hard. The facility is always trying to get people to pick up extra shifts. During an interview on 9/9/25 at 9:31 a.m., resident #1 stated, I do not feel as though the facility has enough staff. I don't always get the care I need due to the staff being too busy. The call lights are not always answered promptly. It takes a while to get help sometimes.During an interview on 9/9/25 at 9:35 a.m., resident #2 stated, I don't think there is enough staff to assist all of us (residents). Sometimes it takes 30 to 40 minutes to get the call light answered. That is a long time when you need to use the bathroom. During an interview on 9/9/25 at 9:37 a.m., resident #3 stated, There isn't enough staff, it is slow to get the call light answered most of the time. It takes 20 minutes or longer most times. During an interview on 9/9/25 at 3:25 p. m., staff member A stated she did not specifically have a policy on call lights. Staff member A stated It is the expectation of the facility staff that on most occasions, call lights are to be answered in at least 15 minutes. Staff member A stated that the facility has offered incentive bonuses for individuals who pick up extra shifts. Staff member A stated it is hard to find people who want to work. The facility covers employee call-offs and unfilled shifts with travel agency staff. During an interview on 9/10/25 at 7:19 a.m., staff member B stated, I have worked in other facilities, and I do not think this facility has enough staff for the acuity of the residents. Staff member B stated, the on-call person sends text messages all the time to see if we (staff) can pick up extra shifts. The facility has offered bonuses to staff to pick up shifts. Review of a facility document titled Call Light Response Audit, showed: . 8/3/25 - room [ROOM NUMBER]-2 - Time Light Turned ON: 0900 (9:00 a.m.) - Time Light Turned OFF: 0935 (9:35 a.m.) (35 minutes) .room [ROOM NUMBER]-1 - Time Light Turned ON: 0915 (9:15 a.m.) - Time Light Turned OFF: 0945 (9:45 a.m.) (30 minutes),room [ROOM NUMBER]-1 - Time Light Turned ON: 0917 (9:17 a.m.) - Time Light Turned OFF: 0935 (9:35 a.m.) (18 minutes) .room [ROOM NUMBER] - Time Light Turned ON: 0931 (9:31 a.m.) - Time Light Turned OFF: 0955 (9:55 a.m.) (24 minutes),8/30/25 - room [ROOM NUMBER] - Time Light Turned ON: 1:02 (1:02 a.m.) - Time Light Turned OFF: 1:23 (1:23 a.m.) (21 minutes) .A facility policy on call lights was requested on 9/8/25 at 3:52 p.m., no call light policy was received from the facility by the end of the survey.2. During an interview on 9/9/25 at 7:32 a.m., staff member D stated, It takes two staff members to use the lifts. I do use them (lifts) by myself when we are short-staffed or when I cannot get assistance. I know I'm not supposed to, but I do.During an interview on 9/9/25 at 7:43 a.m., staff member C stated, All lifts (mechanical) are a two-person transfer. I will do a lift transfer by myself when I can't get someone to assist me. I know we (staff) aren't supposed to but what else can we do? We don't want to make the residents wait longer than they need to. During an interview on 9/9/25 at 9:20 a.m., resident #5 stated, . Sometimes there is only one staff member to assist me with transfers. At other times there are two.Review of resident #5's care plan with a revision date of 5/14/25 showed: Transfer: Transfer between bed and chair or wheelchair: dependent assist of two . Transfers: Hoyer .During an interview on 9/9/25 at 3:25 p.m., staff member A stated she thought it would take two people to use a lift and stated, I will look for a policy on lifts. During an interview on 9/10/25 at 7:24 a.m., staff member A stated, I cannot find a policy on lifts and have reviewed the manuals and cannot find where it says how many people it should take to use them. Staff member A said she had watched a video about the lift they have, and in the video, it showed one person using the Hoyer lift. Staff member A stated she would still require two people to use the Hoyer lifts as she feels it is safest. A facility policy on lift use was requested on 9/8/25 at 3:52 p.m., and no lift use policy was received from the facility by the end of the survey.