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Form Approved OMB
No. 0938-0391

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	04/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on observation and interview, the facility failed to provide clean resident rooms for 6 (#s 10, 11, 19, 26, 40, and 41), of 28 sampled residents, and failed to provide clean public restrooms, which had the potential to affect all staff and visitors who use the facility's public restrooms. Findings include: 1. During an observation on 4/8/24 at 1:56 p.m., a plastic water cup, two medication cups, and one round yellow pill was under resident #41's bed. During an observation on 4/10/24 at 8:30 a.m., a plastic water cup, two medication cups, and one round yellow pill was under resident #41's bed, in the same location as the observation made on 4/8/24. During an interview on 4/10/24 at 8:30 a.m., resident #41 stated the staff did come in and clean her room several times per week, but it was not done very well. Resident #41 stated the room was swept, mopped, around the middle of the room and the bathroom was cleaned. Resident #41 stated she did not remember staff ever moving her bed to really clean, sweep, or mop like it should be done. During an observation on 4/10/24 at 10:05 a.m., staff member I was shown the pill under resident #41's bed. Staff member I removed the yellow pill, two medication cups, a plastic water cup, and a plastic wrapper from under resident #41's bed. These items were located near the edge of the bed and in the same location as previously noted on 4/8/24 and on 4/10/24 at 8:30 a.m. During an interview on 4/10/24 at 5:20 p.m., staff member F stated the resident rooms were swept and mopped daily which included under the beds. Staff member F stated the beds are moved weekly in order to clean the floor. During an interview on 4/10/24 at 10:08 a.m., staff member G stated she has been employed at the facility for almost a month. Staff member G stated she had a good orientation and deep cleaning was done everyday in the residents' rooms. Staff member G stated she had not ever moved resident beds to clean the floor. She said that moving the beds was not a part of her cleaning duties. 2. During an observation on 4/8/24 at 2:04 p.m., in resident #40's room, orange-colored pieces of debris were noted on the floor at the foot of her bed. (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 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an observation on 4/9/24 at 11:50 a.m., during a wound dressing observation, the floor near the foot of resident #40's bed was noted to be soiled with orange-colored pieces of debris. This was the same debris that had been observed on 4/8/24.

3. During an observation on 4/8/24 at 3:55 p.m., the first public restroom located east of the main entrance lobby was observed to have brown splattered debris in the toilet bowl. Pieces of toilet tissue and paper towels were observed on the floor around the toilet. The mirror was splattered with water stains.

During an observation on 4/10/24 at 11:32 a.m., the same bathroom was observed to have brown splattered debris in the toilet bowl, and pieces of toilet tissue and paper towel on the floor. The mirror was splattered with water stains. The bathroom observations appeared unchanged from the prior observation on 4/8/24. In addition, the counter was wet with water, and a crumpled and wet paper towel was observed on the counter.

During an interview on 4/11/24 at 8:25 a.m., staff member F stated the facility public restrooms are cleaned three times a day, but sometimes only twice a day. Staff member F stated the facility public restrooms probably had not been cleaned that week because the housekeeping department was short staffed, and she was the only one in housekeeping for the week.

48268

4. During an observation and interview on 4/8/24 at 3:22 p.m., with roommate residents #10 and #26, both residents reported housekeeping sweeps and mops the floors in their room [ROOM NUMBER]-3 times per week. Resident #26 stated, Maybe not even that often. Sometimes it's once a week and it's just a quick sweep.Resident #10 stated, I have been asking them to clean these black (anti-slip) strips for months now. All it would take is a little scrubbing and I don't think they are doing any good if they are dirty like that! Observation of the room shared by residents #10 and #26, showed streaks of sticky clear substance on the wall near the sink, dirty hand prints on the cabinet doors, and dirt and debris on the floor at all corners in the room. Behind and underneath both beds in the room, dust and debris were observed. Resident #10 stated, They never sweep under there. The non-slip strips next to resident #10's bed showed white fuzzy material and other debris covering the non-slip surface. The shared bathroom in resident #10 and #26's room showed multiple dark yellow/brown streaks coming down the front of the toilet bowel from the rim to the caulking on the floor. The caulking around the toilet base was dirty, and not adhered to the floor. Dead ants were observed on the floor near the base of the toilet. There was a large brown/yellow stain on bathroom light switch.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation and interview on 4/10/24 at 10:15 a.m., the bathroom in resident #11's room showed dirty caulking around the base of the toilet. There were several large gaps in the caulking, and ants were observed carrying dark yellow debris through the gaps into the area underneath the toilet base. The over-bed table was covered with the resident's phone, three large drink cups, an open bottle of a protein shake, and a spoon. Several areas of dark brown wet stains, food crumbs, and an open and wet sugar packet were observed on the table. There was a recliner in the room, piled with equipment and supplies, including two wheelchair footrests, pressure relieving boots, an open container of personal wipes, an open box of tissues, two chair cushions, and one wedge cushion. The pile of equipment and supplies extended above the headrest on the chair. There were no other chairs in the room at the time of the observation. The recliner had an unidentifiable white material splattered on the leg rest. Resident #11 stated, They don't clean up after themselves much. It got so bad that they finally moved me out of here for a week and re-did the room. During an observation of resident #11's room and bathroom, on 4/11/24 at 9:48 a.m., ants were again visualized crawling into and out of the large gaps in the caulking at the base of the toilet. The recliner remained piled with supplies and equipment. There was a wheelchair in the corner of the room. The wheelchair seat and left arm were streaked with an unidentifiable light beige substance. No chair cushion was observed on the seat, although two were observed on the bottom of the pile which remained on the recliner. The recliner had unidentifiable white material splattered on the leg rest. Two dirty blue gloves were observed on the floor in the bathroom. 6. During an observation and interview on 4/10/24 at 4:06 p.m., the floor in resident #19's room contained an area approximately 2 feet by 3 feet of dried clear or cloudy liquid. There were dried pink liquid streaks on the wall near the sink. Resident #19 stated, No housekeeper was here today yet. The toilet had splattered brown substance in the toilet bowl, from the water line to the rim, that appeared to be feces. The bathroom floor contained a large area of sticky yellow substance extending from the toilet to the door of the bathroom. The substance had a concentrated urine-like odor. Resident #19 stated, That (pointing to areas of staining and sticky floor in the bathroom) has all been there quite a while. I don't remember how long, but well over a week; maybe much longer. There was a stain or dirt mark on the bathroom light switch. During an observation and interview on 4/11/24 at 10:46 a.m., the floor in resident #19's room contained an area approximately 2 feet by 3 feet of dried clear or cloudy liquid. There were dried pink liquid streaks on the wall near the sink. Resident #19 stated the housekeeper had been in earlier and emptied the trash but did not mop or sweep. The bathroom floor contained a large area of sticky yellow substance extending from the toilet to the door of the bathroom. The substance had a concentrated urine-like odor. There was a stain or dirt mark on the bathroom light switch. Splattered brown substance remained in the toilet bowl, from the water line to the rim. During an interview on 4/11/24 at 10:12 a.m., staff member F reported resident rooms are cleaned once daily. Staff member F stated, I am the only one (in housekeeping) right now. Well, I have one other person but she only works ten hours per week, so I can only do so much until we have more help. One person was just hired, but then didn't show for work.

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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. 49554 Based on interview and record review, the facility failed to report a facility reported incident within the required timeframe for 1 (#38) of 28 sampled residents. Findings include: Review of a facility-reported incident, submitted on 2/2/24, showed staff were arguing in front of residents, causing the residents to be fearful. Review of resident #38's nurse progress note, dated 1/28/24, showed an incident where staff were arguing in front of resident #38 and her roommate. During an interview on 4/8/24 at 2:19 p.m., resident #38 stated, I told the nurse about the aides arguing. It really scared me how loud they both were and how they wouldn't stop arguing, even when I told them it was inappropriate . During an interview on 4/11/24 at 8:27 a.m., staff member A stated, The initial report should have been submitted on time. I think this incident is the one that I accidentally hit delete instead of the other button. Review of a facility document titled, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, with a revision date of October 2022, showed: Mandatory Reporter: Anyone who is an employee, manager, agent, operator, owner, or contractor of a Medicare or Medicaid-certified nursing facility, intermediate care facility, intellectual disabilities or hospice . -Immediately: means as soon as possible, in the absence of a shorter state time frame requirement, but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The incident was reported five days late and was reported at the same time as the findings of the investigation.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on interview and record review, the facility failed to provide a written transfer/discharge notice to a resident or resident representative at the time of transfer from the facility for 3 (#s 9, 23, and 40) of 28 sampled residents. Findings include: During an interview on 4/11/24 at 9:15 a.m., staff member B stated the facility completed transfer/discharge notices prior to all resident discharges. Staff member B stated there were usually two nurses who could complete transfer/discharge notices as needed. Staff member B said that she or one of the nurse managers would help the other nurses complete the assessments and bed hold forms. She stated the bed holds have not been completed, occasionally. Staff member B stated if the transfer was an emergency, a verbal bed hold consent would be completed. 1. Review of resident #9's medical record failed to show a transfer/discharge notice had been provided to the resident prior to a hospitalization on [DATE]. 2. Review of resident #23's medical record failed to show a transfer/discharge notice had been provided to the resident prior to a hospitalization on [DATE]. 3. Review of resident #40's medical record failed to show a transfer/discharge notice had been provided to the resident, prior to hospitalization s on 9/27/23 and 11/13/23. During an interview on 4/11/24 at 10:30 a.m., staff member H stated no transfer/discharge notifications were located within the medical records for resident #9 and #40. No additional information was received by the end of the survey.

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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. 48268 Based on interview and record review, the facility failed to consistently provide and document restorative nursing services for residents with a decline in functional status, for 2 (#s 12 and 49) of 4 sampled residents with restorative service concerns. Findings include: 1. During an interview on 4/9/24 at 2:12 p.m., resident #49 stated, I feel like I am losing ground. I used to be able to walk with some assistance to the nurse's station, and now I doubt I could do that anymore. I was supposed to get help with exercises, but it doesn't happen often. I lost my therapy benefit through Medicaid and ever since then I have lost a lot of my strength. During an interview with staff members C and D, on 4/10/24 at 4:27 p.m., staff member D stated she oversees the restorative program for the facility and was responsible for obtaining the referrals, initiating the orders, and flow sheets for the restorative aides. Staff member C stated she currently was the only restorative aide, as they had one staff member leave. Staff member D stated she hadn't updated the referral and restorative orders to reflect the limited availability of restorative aides. Staff member D stated she had been recommending the CNAs could take on some of the restorative tasks and document them on the restorative flow sheet, but it wasn't being completed. Review of resident #49's Annual MDS, with an ARD of 11/3/23, showed resident #49's functional status as needing assistance for sitting to lying, and sit to stand. The MDS also showed resident #49 was using both a wheelchair and walker for mobility. Review of resident #49's Quarterly MDS, with an ARD of 1/31/24, showed resident #49's functional status as dependent for sitting to lying, and sit to stand. The MDS also showed resident #49 was no longer able to use a walker for mobility. Review of resident #49's restorative care referral, care plan, and restorative flow sheet, showed resident #49 was to receive restorative services twice daily (AM and PM shift), six days per week for, Bed Mobility Program and Walking Program beginning on 2/19/24. Review of resident #49's electronic medical record showed restorative services were received on the following dates: Bed Mobility Program: - February 2024: February 28 - March 2024: March 2, March 7, March 17, March 20, and March 22 - April 2024: April 4, April 5, and April 8 Walking Program: - February 2024: None (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- March 2024: March 2 and March 20 - April 2024: None Resident #49 received restorative therapy a total of 11 times between 2/19/24 and 4/10/24, with 196 opportunities for restorative services missed. 49554 2. During an interview on 4/9/24 at 8:21 a.m., resident #12 stated, I really want to regain my strength. I used to be able to walk, but now I'm in a wheelchair all the time. I would like to be able to do more for myself, and I feel like they just want me to lay in this bed forever. Review of resident #12's Quarterly MDS, with an ARD of 12/4/23, showed resident #12's functional status as needing substantial assistance with showering, dressing, rolling left to right, sitting to lying, and transferring from bed to chair. Review of resident #12's Annual MDS, with an ARD of 3/5/24, showed resident #12's functional status as being dependent on staff for assistance with showering, dressing, rolling left to right, sitting to lying, and transferring from bed to chair. Which showed a decrease in her functional status. Review of resident #12's care plan, with a revision date of 4/2/24, showed, - Problem: resident #12 has impaired mobility (R/T), decreased ROM, and transfer skills. - Goal: I will improve/maintain my strength, ROM, & transfer abilities through the review date. - Interventions/Tasks: Nursing Rehab/Restorative, Active ROM Program, and Nursing Rehab/Restorative Transfer Program, both with an initiation date of 2/13/24. Review of resident #12's electronic medical record showed restorative services were not received consistently as follows: - February 2024: 28 days no restorative services were received, - March 2024: 28 days no restorative services were received, - April 2024: from April 1-11, 11 days no restorative services were received. Resident #12 received restorative therapy a total of four times in three months, 67 opportunities for restorative services were missed. Review of resident #12's Restorative Program Referral Form dated 2/13/24, showed, Reason for Referral: Resident Request, - Resident Goal: Improve/maintain strength, ROM, and transfer abilities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Frequency: 6 x/week . [sic] During an interview on 4/10/24 at 4:27 p.m., staff member D stated, We are aware there are issues with our restorative program. We recently had one individual quit, and we are working on adjusting the schedules and the whole restorative program.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 14005 Based on observation and interview, the facility failed to remove expired medications from three medication carts. This failure had the potential to affect all residents who receive medication from the three carts. Findings include: During an observation on 4/8/24 at 11:50 a.m., medication cart #1 showed one opened, Novolin insulin pen dated 2/17/24, and one opened Lispro insulin pen, dated 2/26/24. During an interview on 4/8/24 at 11:53 a.m., staff member B stated all insulin pens expire 28 days after being opened. During an observation on 4/8/24 at 11:55 a.m., with staff member J and K, three medication carts were inspected. The following expired medications were found in the three medication carts: One bottle of allergy relief tablet, dated 10/2/23 Two bottles of Geri-dryl, dated 2/24 Two bottles of Aspirin 325 mg, dated 1/24/24 One bottle of Calcium Citrate, dated 12/23 One bottle of Oyster shell, dated 1/24 Two bottles of fiber capsules, dated 10/23 One bottle of Zinc 50 mg, dated 12/23 One bottle of Calcium with Vitamin D, dated 3/24 During an interview on 4/10/24 at 3:30 p.m., staff member B stated the medication carts and medication storage rooms were checked for expired supplies once per month by the pharmacy representative. Staff member B stated nurses also do a monthly med cart review and check for outdated medication. Review of the insulin pen manufacturer's instructions showed: Keep at room temperature only (below 86-degree Fahrenheit) and must be used within 28 days or be discarded even if it has insulin in it .