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	04/10/2025

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 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 41652 Based on observation, interview, and record review, the facility failed to develop and implement a resident-centered baseline care plan for 1 (#115) of 17 sampled residents. Findings include: During an observation and interview on 4/8/25 at 9:10 a.m., resident #115 was sitting in a wheelchair in his room. Resident #115 said he had pins and needles from his toes to his hips. The resident had wraps on both legs, from his toes to just below his knees. Resident #115 said they (the staff) were changing the wraps every couple of days. The resident said he was using the sit-to-stand lift for transfers and was working with therapy to get stronger. Review of resident #115's baseline care plan, initiated on 4/6/25, showed a template had been used to provide a list of functional activities with choices for how much assistance was needed. The care plan showed the list of functional activities, but failed to specify the amount of assistance needed. The care plan also failed to address the resident's use of a lift for transfers and his lower leg infection with associated dressing changes. During an interview on 4/10/25 at 9:26 a.m., staff member C stated it was the floor nurse's responsibility to complete the template used to do the baseline care plan. Staff member C stated the level of assistance would be documented by the nurse and revised by physical therapy as needed.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48268 Based on observation, interview, and record review, the facility failed to implement a comprehensive, resident-centered care plan which identified residents' physical and psychosocial needs to reach their highest practicable level of well-being for 1 (#9) of 17 sampled residents. Findings include: During an observation and interview on 4/7/25 at 1:44 p.m., resident #9 was seated in a wheelchair in his room. Resident #9's voice was observed to be at the level of a strained whisper. Resident #9 was having difficulty speaking louder than a whisper, and was straining to enunciate his words. Resident #9 stated, It's hard for people to understand me. A long time ago, I saw an ENT, but the voice was better then, and I don't remember much about that visit. I would like to go see someone about my voice again and would like people to understand me better. It's hard to strain all the time for people to hear me. I quit smoking in December, maybe it has to do with that. During an interview on 4/7/25 at 2:05 p.m., staff member D stated, He (resident #9) is really difficult to understand, like he has laryngitis or something, but it's been a long time now. During an interview on 4/8/25 at 9:05 a.m., staff member F stated, I don't have any idea why his (resident #9's) voice is so weak. During an interview on 4/8/25 at 2:12 p.m., staff member G stated, His (resident #9's) voice has been like that as long as I have been here. Review of resident #9's care plan, initiated on 12/5/24, and last updated on 4/6/25, failed to show a focus area or interventions related to resident #9's communication difficulty.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48268 Based on observation, interview, and record review, the facility failed to update a care plan to reflect a new surgical wound, and wound management, for 1 (#14) of 17 sampled residents. The failure placed the resident at risk for improper wound care, wound deterioration, or infection. Findings include: During an observation and interview on 4/7/25 at 4:23 p.m., resident #14 was sitting in a wheelchair facing the door. A right foot dressing was observed. Resident #14 stated his toes were recently amputated and he was unable to walk. During an interview on 4/9/25 at 11:45 a.m., staff member B stated the care plan should reflect all current care concerns for each resident. Staff member B stated the care plans were updated by nurses, the IDT, or administrative staff whenever resident changes occurred. Review of resident #14's physician progress notes showed a surgical amputation of the right toes on 3/3/25. The amputation was related to vascular insufficiency and diabetes. Post-operative wound orders, dated 3/3/25, showed, non-weightbearing with his right lower extremity and wear a postop shoe when out of bed with mobilization using a Hoyer lift. - wound care, podiatry recommended dressing of right amputation with Xeroform, 4 x 4 gauze, Kerlix, Ace bandage with mild compression to be changed twice weekly. - please have wound care NP and wound care nurse follow. [sic] Review of resident #14's care plan, initiated on 3/3/25, with the latest revision on 4/6/25, failed to show any entries regarding the right foot surgical procedure, wound care, wound monitoring, or mobilization requirements.

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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. 48268 Based on observation, interview, and record review, the facility failed to provide timely ADL services to a dependent resident for 1 (#9) of 17 sampled residents. This failure placed the resident at increased risk for falls, injury, psychological distress, and pain. Findings include: During an observation and interview on 4/7/25 at 1:44 p.m., resident #9 was observed in his wheelchair. His call light was lying on the bed. He reached over and pressed his call light at 1:58 p.m., stating, Excuse me, I need to get back to bed. My leg is hurting and I need to get it up. Resident #9 then stated, I can't get up on my own anymore, I am pretty weak . My voice is not good, so I can't call out for help when I need it, and the call lights are a big problem here. I have to wait sometimes up to an hour for help. I have waited at least a half hour in the bathroom alone. They don't want me to try to get into bed by myself, but then they don't come in either. It makes me pretty upset, and then they act like they don't understand why I am mad when they finally do come in. Continued observations were made between the time resident #9 pressed his call light and when the staff entered his room, as follows: At 1:58 p.m., staff members D and E were observed chatting socially with residents in the hall. Three call lights, including resident #9's, were on at this time. Staff member D left the hall at 2:01 p.m., to obtain a sit-to-stand lift device. Staff member E continued to chat with a unidentified resident in the hall. Staff member D returned at 2:04 p.m., and both staff entered a room to assist a resident. Both staff exited the first room at 2:14 p.m. and entered another room shortly afterward. At 2:20 p.m., both staff exited the second room, and were observed chatting and laughing with two residents in the hall. At 2:31 p.m., both staff entered resident #9's room and assisted him to the bathroom and then to bed. The observation revealed resident #9 waited a total of 33 minutes for assistance, and at no time, between 1:58 p.m. and 2:31 p.m., did a staff member check to ensure resident #9 was not having an emergency or to assess his needs. During an interview on 4/8/25 at 2:32 p.m., staff member B stated the facility was currently fully staffed for CNAs, and her expectation for call light response time would be 15 minutes or less. Staff member B stated the facility's call light system did not generate a historical log which could have been reviewed. Review of resident #9's care plan fall prevention focus area, dated 12/15/24, and updated on 12/24/24, showed resident #9 had a history of falls, and was at risk to fall. Care plan fall Interventions included the following: . Anticipate and meet [resident #9's] needs. . Be sure [resident #9's] call light is within reach and encourage [resident #9] to use it for assistance as needed. . Encourage and remind [resident #9] to use call light for staff assist as needed. [sic] (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #9's care plan ADL focus area, dated 12/15/24, and updated on 2/21/25, showed resident #9 was dependent on staff for ADLs for most basic needs, including mobility, toileting, bathing, and repositioning. Resident #9's care plan ADL goal was listed as, [Resident #9] will have ADL/Functional Ability needs met. [sic]

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41652 Based on interview and record review, the facility failed to ensure a pharmacist's recommendation for gradual dose reductions were addressed for two psychotropic medications ordered by a provider for 1 (#40) of 5 sampled residents for medication regimen review. Findings include: Review of resident #40's medication regimen review, dated 10/9/24, showed the pharmacist recommended gradual dose reductions for quetiapine 150 mg at bedtime and clonazepam 0.5 mg twice daily. The medication regimen review form showed a handwritten note, follows psych, which was dated 10/16/24. During an interview on 4/10/25 at 10:30 a.m., staff member B stated the previous DON was responsible for the medication review follow-up. Staff member B stated the previous DON no longer worked for the facility. When asked, staff member B stated she was not able to locate medical record documentation which addressed the recommended gradual dose reductions for resident #40. A request was made on 4/9/25 for documentation which addressed the recommended gradual dose reductions for resident #40. None was received prior to the end of the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48268 Based on observation, interview, and record review, the facility failed to ensure staff practiced appropriate use of personal protective equipment (PPE), during care of a resident on enhanced barrier precautions (EBP) for 1 (#9) of 17 sampled residents. The failure increased the risk of MDRO infections within the facility. Findings include: During an observation and interview on 4/7/25 at 1:44 p.m., resident #9 was seated in a wheelchair in his room. A dressing was noted to his left foot. A yellow door-mounted PPE holder was attached to resident #9's door. Pointing to the PPE holder, resident #9 stated, I don't know what that is for, it just appeared while I was at lunch today. Resident #9 stated the staff did not wear gowns when providing personal care or when changing his wound dressing. During an observation on 4/7/25 at 2:31 p.m., staff members D and E entered resident #9's room, assisted him to the bathroom, and then assisted him to bed. Neither staff member wore gowns while providing care for resident #9. During an interview on 4/7/25 at 2:40 p.m., staff member E stated, Those yellow (PPE) holders are new. Most of them were hung up today. I have been off for a week, so I don't know anything about them. They (the PPE holders) don't really apply to us, but I am sure the nurses use them for dressing changes. During an interview on 4/9/25 at 3:44 p.m., staff member B stated the staff were not using EBP consistently in the facility and had been re-educated during the survey period. Review of resident #9's EHR diagnoses list, showed a history of MRSA infection in the past, and a current Stage 3 pressure ulcer, of the left foot. Review of the facility document titled, Infection Control Policies and Practices, revised on 3/19/25, showed: Enhanced Barrier Precautions (EBP) are designed to reduce transmission of multidrug-resistant organisms (MDROs). EBP involve the use of gowns and gloves by care providers, during high-contact resident care activities. EBP are used when caring for residents with colonization of infection with a targeted and epidemiologically MDRO, chronic wounds, or indwelling medical device/s. [sic]