STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275140	A. BUILDING **01** B. WING _____	**04/19/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN MEADOWS HEALTH AND REHABILITATION CENTER	**3155 AVE C** **BILLINGS, MT 59102**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Based on the regulatory requirements and standards of 42 Code of Federal Regulations (CFR) 483.73 Emergency Preparedness (EP) Final Rule Requirement for Long Term Care Facilities effective 11/15/17, an EP survey was performed on 4/19/21. The EP plan was last reviewed and updated on 01/08/21. Under these regulatory requirements, no deficiencies were cited.	E 000		
K 000	INITIAL COMMENTS Based on the regulatory requirements and standards of 42 Code of Federal Regulations (CFR) 483.70(a) for Long Term Care Facilities (LTC), a life safety code (LSC) recertification survey was performed on 4/19/21. Under this regulatory requirement, the facility must meet the applicable provisions of the National Fire Protection Association's (NFPA) 101 LSC, 2012 Edition, and those mandatory Codes referenced by that edition. The facility was surveyed specifically using Chapter 19 Existing Health Care Occupancies. The building construction type was found to be Type V (111) and contains five smoke compartments. No new construction has occurred since the last survey of the facility on 6/19/19. There are three, 2-hour separations in the facility, one for the administrative area, one for support areas (e.g. kitchen, laundry, etc.) and one for the assisted living. The assisted living and support areas were not surveyed. The facility is licensed for 90 beds and at the time of survey 64 residents was the census.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/07/2021

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K 000	Continued From page 1 These requirements were not met as evidenced by the following deficiencies:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to provide emergency lighting per NFPA 101-2012, Sections 19.2.9.1 and 7.9.3.1.1. These deficiencies affect the entire facility. Findings include: 1. Review of the facility records for testing of the emergency lighting documentation showed the facility had not performed the required 90 minute annual test. The last annual 90 minute test was conducted on 07/26/19.	K 291	This Plan of Correction is prepared and submitted as required by law. By submitting this plan of correction, Aspen Meadow Health and Rehabilitation Center does not admit that the deficiencies listed on this form exist, nor does the center admit to any statements, findings, facts or conclusions that the basis form the alleged deficiencies. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, fact, and conclusions that form the basis for the deficiencies. 1) The annual 90 minute emergency lighting test was performed by Maintenance Director by 5/22/21. 2) Maintenance Director or designee will conduct annual 90 minute emergency lighting test on an annual basis and have supporting documentation. 3) Executive Director will reeducate the Maintenance Director on conducting the annual 90 minute emergency lighting test and to have supporting documentation of	5/23/21

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K 291	Continued From page 2	K 291	the test by 5/22/21. 4) Maintenance Director will conduct the annual 90 minute test by 4/19/22. Quality Assurance will monitor for compliance.	
K 342 SS=E	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the operable part of each manual fire alarm box shall not be less than 42 in. and not more than 48 in. above floor level per NFPA 72, 2010 Edition, Section 17.14.4. This deficiency affects 2 of 5 smoke compartments in the facility. Findings include: 1. During an observation on 04/19/21 at 12:17 p.m., the rehab exit to the coutyard area was inspected. The manual pull station next to the doors leading to the courtyard was observed to	K 342	1. Pull Stations located next to the doors leading to the courtyard and outside room 102 have been relocated by a contracted company to be accessible no less than 42 inches from the floor and no more than 48 inches from the floor by 5/22/21. 2. The Maintenance Director or designee validated that 0thern pull stations located in the building were no less than 42 inches from the floor and no more than 48 inches from the floor by 5/22/21. 3. Executive Director reeducated the Maintenance Director on pull stations needing to be accessible no less than 42	5/23/21

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K 342	Continued From page 3 be mounted at 53 inches. 2. During an observation on 04/19/21 at 12:20 p.m., the manual fire alarm pull station outside of resident room 102 was inspected. The manual pull station was observed to be mounted at 53 inches.	K 342	inches from the floor and not more than 48 inches from the floor by 5/22/21. 4. Maintenance Director or designee will conduct audits to validate that pull stations are no less than 42 inches and no more than 48 inches from the floor weekly x4, then monthly x2. Maintenance Director or designee will bring audit results to QAPI by 5/22/21 and monthly thereafter to identify trends and sustain compliance.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain the sprinkler system by installing sprinkler heads too close to walls in accordance with NFPA 13 Standard for Automatic Sprinkler	K 351	1) The sprinkler head located in the main dining room has been relocated by a contracted company to be at least 4 inches from the wall by 5/22/21.	5/23/21

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K 351	Continued From page 4 Systems, 2010 Edition, Section 8.5.5.2.2. This deficiency affects 1 of 5 smoke compartments in the facility. Findings include: 1. During an observation on 04/19/21 at 12:09 p.m., the main dining room was inspected. There was a sprinkler head observed in the room that was installed less than 4 inches from the wall.	K 351	2) Maintenance Director or designee validated that other sprinkler heads located in the building are at least 4 inches from the wall by 5/22/21. 3) Executive Director reeducated the Maintenance Director on sprinkler heads being located at 4 inches from the wall by 5/22/21. 4) Maintenance Director or designee will conduct audits weekly x4, then monthly x2. Maintenance Director will bring audit results to QAPI by 5/22/21 and then monthly thereafter to identify any trends and to sustain compliance.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363		5/23/21

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K 363	Continued From page 5 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain corridor doors to ensure a means suitable for keeping the doors closed in accordance with NFPA 101, 2012 Edition, Section 19.3.6.3.5. This deficiency affects 1 of 5 smoke compartments in the facility. Findings include: 1. During an observation on 04/19//21 at 12:28 p.m., the corridor door to resident room 113 was exercised. The door would not close and positively latch.	K 363	1) Maintenance Director or designee has adjusted the corridor door on room 113 to close and positively latch by 5/22/21. 2) Maintenance Director or designee will validate that all corridor doors in the building will close and positively latch by 5/22/21. 3) Executive Director has reeducated the Maintenance Director on making sure all corridor doors close and positively latch by 5/22/21. 4) Maintenance Director or designee will conduct audits weekly x4, then monthly x2 to ensure all corridor doors close and positively latch. Audit results will be presented to QAPI by 5/22/21 and then monthly thereafter to identify any trends and to sustain compliance.	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101	K 911		5/23/21

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K 911	Continued From page 6 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain electrical rooms with sufficient working space around electrical panels in accordance with NFPA 70 National Electric Code, 2011 Edition, Article 110-26 (E) (1) (a) through (E) (1) (d). This deficiency affects 1 of 5 smoke compartments. Findings include: 1. During an observation on 04/19/21 at 12:41 p.m., the charting room was inspected. The electrical panels in the room was blocked from easy access by a black office chair being stored in front of it.	K 911	1) Maintenance Director or designee removed black office chair in front of the electrical panels located in the charting room by 4/20/21. 2) Maintenance Director or designee will ensure that no objects parked in front of any electrical panels located in the building by 5/22/21 3) Executive Director has reeducated Maintenance Director on ensuring no objects are parked in front of electrical panels located in the building by 5/22/21 4) Maintenance Director or designee will conduct audits weekly x4, then monthlt x2 to ensure no objects are located in front of electrical panels located in the building. Audit results will be presented to QAPI by 5/22/21. Then monthly to identify any trends and to sustain compliance.	