| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **ASPEN MEADOWS HEALTH AND REHABILITATION CENTER** | **3155 AVE C**<br>**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 |
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| E 000 | Initial Comments<br><br>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 03/08/22. The facility's last review of their plan was completed on January 8, 2021.<br><br>Under these regulatory requirements, the following deficiencies were cited: | E 000 | | |
| E 004 SS=F | Develop EP Plan, Review and Update Annually<br>CFR(s): 483.73(a)<br><br>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).<br><br>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:<br><br>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:<br><br>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, | E 004 | | 4/22/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/27/2022

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| E 004 | Continued From page 1<br>State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.<br><br>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.<br><br>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.<br><br>.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, the facility failed to establish an emergency preparedness plan that is maintained, reviewed annually and updated as needed. The deficiency affects all of the staff and the residents who work and/or reside in the facility.<br><br>Findings include:<br><br>1. Review of the facility EP plan on 03/08/22, reflected the facility did not have an updated Emergency Preparedness Plan. There was no evidence the plan had been reviewed in the past year. | E 004 | 1.Executive Director or designee will develop, update, and review the EP plan on or before 4/22/22.<br><br>2.No further item question's in regards to the EP plan.<br><br>3.Executive Director will re-educate the maintenance team and the IDT on the requirements of having an EP plan developed, updated and reviewed annually on or before 4/8/22.<br><br>4.Executive Director or designee will audit the EP plan quarterly for 4 quarters to validate the plan has been developed, updated, and reviewed annually. Audits will be brought to QAPI on or before | |

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| E 004 | Continued From page 2 | E 004 | 4/11/22 to identify trends and sustainability, then monthly thereafter.<br><br>5.4/22/22 | |
| E 013 SS=F | Development of EP Policies and Procedures<br>CFR(s): 483.73(b)<br><br>§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).<br><br>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.<br><br>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.<br><br>*Additional Requirements for PACE and ESRD Facilities:<br><br>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness | E 013 | | 4/22/22 |

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| E 013 | Continued From page 3<br>policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.<br><br>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to update, implement, and annually review emergency preparedness (EP) policies and procedures. This deficiency has the potential to affect all residents and staff of the facility.<br><br>Findings include:<br><br>1. A review of the facility EP program on 03/08/22 | E 013 | 1.Executive Director or designee will review and update EP policies and procedures on or before 4/22/22.<br><br>2.No further item question's in regards to the EP plan.<br><br>3.Executive Director will re-educate the maintenance team and the IDT on the | |

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| E 013 | Continued From page 4<br>showed, the facility's EP programs policies and procedures lacked annual reviews and updates. | E 013 | requirements of having an EP policies and procedures reviewed annually on or before 4/8/22.<br><br>4.Executive Director or designee will audit the EP plan quarterly for 4 quarters to validate the policies and procedures have been reviewed annually. Audits will be brought to QAPI on or before 4/11/22 to identify trends and sustainability, then monthly thereafter.<br><br>5.4/22/22 | |
| E 029 SS=F | Development of Communication Plan<br>CFR(s): 483.73(c)<br><br>§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).<br><br>(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, the facility failed to maintain, and annually review its emergency preparedness (EP) communications plan. This deficiency has the potential to affect all residents and staff of the facility.<br><br>Findings include:<br><br>1. A review of the facility EP plan on 03/08/22 | E 029 | 1.Executive Director or designee will review and update EP communications Plan on or before 4/22/22.<br><br>2.No further item question's in regards to the EP plan.<br><br>3.Executive Director will re-educate the maintenance team and the IDT on the | 4/22/22 |

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| E 029 | Continued From page 5<br>showed, the facility had not reviewed or updated the facility communications plan in the last year. The communication plan reflected outdated information. | E 029 | requirements of having an EP communication plan that is current on or before 4/8/22.<br><br>4.Executive Director or designee will audit the EP communication plan monthly for 3 months, then quarterly for 3 quarters to validate the communication plan is current. Audits will be brought to QAPI on or before 4/11/22 to identify trends and sustainability, then monthly thereafter.<br><br>5.4/22/22 | |
| E 036 SS=F | EP Training and Testing<br>CFR(s): 483.73(d)<br><br>§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. | E 036 | | 4/22/22 |

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| E 036 | Continued From page 6<br><br>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.<br><br>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).<br><br>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and | E 036 | | |

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| E 036 | Continued From page 7<br>updated at every 2 years.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, the facility failed to develop and maintain an EP training and testing program that is based on the facility's Emergency Preparedness plan. This deficiency has the potential to affect all staff, volunteers, and residents of the facility.<br><br>Findings include:<br><br>1. Review of the facility EP plan on 03/08/22 showed, the facility did not have a completed Emergency Preparedness Plan. No documentation of testing and staff training on the facility EP plan was available for review. | E 036 | 1.Executive Director or designee will validate the staff have been tested and trained on the EP plan on or before 4/22/22.<br><br>2.No further item question's in regards to the EP plan.<br><br>3.Executive Director will re-educate the maintenance team and the IDT on the requirements of having an EP plan testing and training on or before 4/8/22.<br><br>4.Executive Director or designee will audit the EP plan testing and training quarterly for 4 quarters to validate the testing and training have been completed annually. Audits will be brought to QAPI on or before 4/11/22 to identify trends and sustainability, then monthly thereafter.<br><br>5.4/22/22 | |
| E 037<br>SS=F | EP Training Program<br>CFR(s): 483.73(d)(1)<br><br>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] | E 037 | | 4/22/22 |

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| E 037 | Continued From page 8<br>(1) Training program. The [facility] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and | E 037 | | |

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|---|---|---|---|---|
| E 037 | Continued From page 9<br>procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE | E 037 | | |

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|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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|---|---|---|---|---|
| E 037 | Continued From page 10<br>must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF | E 037 | | |

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|---|---|---|---|
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| **ASPEN MEADOWS HEALTH AND REHABILITATION CENTER** | **3155 AVE C**<br>**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 |
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| E 037 | Continued From page 11<br>must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, the facility failed to | E 037 | 1.Executive Director or designee will | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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

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| E 037 | Continued From page 12<br>implement the annual training of the EP program to all staff members, consistent with each team members' expected roles during an emergency or a disaster. This deficiency affects all of the occupants and staff in the facility.<br><br>Findings include:<br><br>1. Record review of the facility EP plan and training documents on 03/08/22 showed, the facility failed to show evidence that staff training for the EP plan was conducted initally for new staff and annually for all current staff. | E 037 | validate the staff have been trained on the EP plan on or before 4/22/22.<br><br>2.No further item question's in regards to the EP plan.<br><br>3.Executive Director will re-educate the maintenance team and the IDT on the requirements of having an EP plan staff training on or before 4/8/22.<br><br>4.Executive Director or designee will audit the EP plan testing and training weekly x4 weeks, then monthly x2 months to validate staff training have been completed annually and upon hire. Audits will be brought to QAPI on or before 4/11/22 to identify trends and sustainability,then monthly thereafter.<br><br>5.4/22/22 | |
| E 039 SS=F | EP Testing Requirements<br>CFR(s): 483.73(d)(2)<br><br>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).<br><br>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: | E 039 | | 4/22/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **ASPEN MEADOWS HEALTH AND REHABILITATION CENTER** | **3155 AVE C**<br>**BILLINGS, MT 59102** |

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| E 039 | Continued From page 13<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.<br>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For Hospices at 418.113(d):]<br>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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

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| E 039 | Continued From page 14<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(B) If the hospice experiences a natural or | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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

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| E 039 | Continued From page 15<br>man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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

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| E 039 | Continued From page 16<br>required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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

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| E 039 | Continued From page 17<br>event.<br>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.<br><br>*[For LTC Facilities at §483.73(d):]<br>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| E 039 | Continued From page 18<br>following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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

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| E 039 | Continued From page 19<br>functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.<br><br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:<br>(i) Participate in a full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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

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| E 039 | Continued From page 20<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.<br>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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

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| E 039 | Continued From page 21<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, the facility failed to develop and implement an emergency preparedness testing program to annually participate in a full-scale exercise, and a table top exercise. This deficiency affects everyone in the facility.<br><br>Findings include:<br><br>Record review of the facility EP plan on 03/08/22 showed there was not documentation regarding a full-scale exercise or a table-top exercise completed by the facility. | E 039 | 1.Executive Director or designee will validate the facility has conducted a full-scale or table top exercise for the EP plan on or before 4/22/22.<br><br>2.No further item question's in regards to the EP plan.<br><br>3.Executive Director will re-educate the maintenance team and the IDT on the requirements of having 2 EP plan tests, table top or full scale, annually on or before 4/8/22.<br><br>4.Executive Director or designee will audit the EP plan testing quarterly for 4 quarters to validate 2 tests, table top or full scale, have been completed annually. Audits will be brought to QAPI on or before 4/11/22 to identify trends and sustainability,then monthly thereafter.<br><br>5.4/22/22 | |
| K 000 | INITIAL COMMENTS | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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

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| K 000 | Continued From page 22<br>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 03/08/21. 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.<br><br>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 04/19/21. 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 57 residents was the census.<br><br>These requirements were not met as evidenced by the following deficiencies: | K 000 | | |
| K 920 SS=E | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity | K 920 | | 4/22/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ASPEN MEADOWS HEALTH AND REHABILITATION CENTER** | **3155 AVE C**<br>**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 |
|---|---|---|---|---|
| K 920 | Continued From page 23<br>may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the facility failed to ensure power strips were used per NFPA 99-2012, Health Care Facilities Code, Section 10.2.4.<br><br>Findings include:<br><br>1. During an observation on 03/07/22 at 9:18 a.m., the dining room was inspected. A power strip being used in the room did not have a UL 1363 rating.<br><br>2. During an observation on 03/07/22 at 9:30 a.m., bathing room 1 was inspected. A surge protecter was observed dangling from the wall in the room. | K 920 | 1.Maintenance Director or designee replaced surge protector in the dining room with a UL 1363 rating and secured the surge protector in the bathing room on or before 4/22/22.<br><br>2.Maintenance Director or designee inspected other surge protectors to validate the surge protectors had the appropriate UL rating and were properly secured on or before 4/15/22.<br><br>3.Executive Director re-educated staff the requirements of surge protectors having the appropriate UL rating and that surge protectors are properly secured on or before 4/11/22.<br><br>4.Executive Director or designee will audit 5 rooms weekly x4 weeks, then monthly x2 months to validate appropriate UL | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 275140 | A. BUILDING **01**<br>B. WING _____ | **03/08/2022** |

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|---|---|---|---|---|
| K 920 | Continued From page 24 | K 920 | rated surge protectors are used and secured properly. Audits will be brought to QAPI on or before 4/11/22 to identify trends and sustainability, then monthly thereafter.<br><br>5.4/22/22 | |