PRINTED: 04/11/2022 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		275140	B. WING _			03/	08/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 1155 AVE C BILLINGS, MT 59102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
E 004 SS=F	standards of 42 Code (CFR) 483.73 Emerger Final Rule Requirement Facilities effective 11/performed on 03/08/2 of their plan was comulated Under these regulator following deficiencies Develop EP Plan, RecFR(s): 483.73(a) \$403.748(a), \$416.54 \$441.184(a), \$460.84 \$483.475(a), \$485.625(a), \$485.72 \$486.360(a), \$491.12 The [facility] must correderal, State and loop preparedness required develop establish and emergency prepared requirements of this spreparedness progral limited to, the following: * [For hospitals at \$48 \$485.625(a):] Emerger	were cited: view and Update Annually (a), §418.113(a), (a), §482.15(a), §483.73(a), (a), §485.68(a), (a), §494.62(a). Imply with all applicable cal emergency ements. The [facility] must domaintain a comprehensive mess program that meets the section. The emergency ements include, but not be ag elements: The [facility] must develop regency preparedness planed], and updated at least lan must do all of the	E	004			4/22/22
ABORATORY (SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed

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

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.

PRINTED: 04/11/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		275140	B. WING _			03/0	08/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		31	REET ADDRESS, CITY, STATE, ZIP CODE 55 AVE C LLINGS, MT 59102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD I		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 004	requirements of this sall-hazards approach. * [For LTC Facilities at Plan. The LTC facility an emergency prepar reviewed, and update. * [For ESRD Facilities Plan. The ESRD facilimaintain an emergen must be [evaluated], at years. . This REQUIREMENT by: Based on record reviestablish an emergen maintained, reviewed needed. The deficienthe residents who wo facility. Findings include: 1. Review of the facility demergency Prepared.	gency preparedness ospital or CAH] must a comprehensive ness program that meets the ection, utilizing an t §483.73(a):] Emergency must develop and maintain edness plan that must be d at least annually.	E	004	1.Executive Director or designee will develop, update, and review the EP platon or before 4/22/22. 2.No further item question's in regards the EP plan. 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. 4.Executive Director or designee will at 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	to	

	ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) A. BUILDING 01			(X3) DATE SURVEY COMPLETED			
		275140	B. WING			03/	08/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 004	Continued From page	2 2	E	004	4/11/22 to identify trends and sustainability, then monthly thereafter.		
E 013 SS=F	•	olicies and Procedures	E	013	5.4/22/22		4/22/22
	§403.748(b), §416.54 §441.184(b), §460.84 §483.475(b), §484.10 §485.625(b), §485.72 §486.360(b), §491.12	(b), §482.15(b), §483.73(b), 12(b), §485.68(b), 17(b), §485.920(b),					
	develop and impleme policies and procedur plan set forth in paragassessment at paragrand the communication this section. The policies and development at the communication that section.	edures. [Facilities] must int emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least every 2 years.					
	procedures. The LTC implement emergency procedures, based or forth in paragraph (a) assessment at paragrand the communication this section. The poli	§483.73(b):] Policies and facility must develop and y preparedness policies and in the emergency plan set of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least annually.					
	*Additional Requirem Facilities:	ents for PACE and ESRD					
	*[For PACE at §460.8 procedures. The PAC develop and impleme						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01		LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		275140	B. WING		03/08/2022
	ROVIDER OR SUPPLIER EADOWS HEALTH AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102	,
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
E 013	plan set forth in parassessment at para and the communication this section. The paddress manageme emergencies, inclue equipment, power, emergencies; and inthreaten the health staff, or the public. must be reviewed a years. *[For ESRD Faciliting procedures. The dand implement emergencies and procedures, baset forth in paragra assessment at parassessment at parasessment at parases	ge 3 lures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of policies and procedures must ent of medical and nonmedical ding, but not limited to: Fire; or water failure; care-related natural disasters likely to or safety of the participants, The policies and procedures and updated at least every 2 es at §494.62(b):] Policies and italysis facility must develop ergency preparedness policies used on the emergency plan poh (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of policies and procedures must obtated at least every 2 years. It is include, but are not limited or power failures, care-related or supply interruption, and ely to occur in the facility's endiess (EP) policies and efficiency has the potential to and staff of the facility.	E 01	1.Executive Director or designee will review and update EP policies and procedures on or before 4/22/22. 2.No further item question's in regard the EP plan. 3.Executive Director will re-educate the maintenance team and the IDT on the second content of the secon	ds to

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		275140	B. WING _			03/	08/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 013	showed, the facility's	e 4 EP programs policies and nual reviews and updates.	E	013	requirements of having an EP policies a procedures reviewed annually on or before 4/8/22. 4.Executive Director or designee will at 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.	udit	
E 029 SS=F	CFR(s): 483.73(c) §403.748(c), §416.54 §441.184(c), §460.84 §483.475(c), §484.10 §485.625(c), §485.72 §486.360(c), §491.12 (c) The [facility] must emergency prepared that complies with Fe and must be reviewed 2 years [annually for Intis REQUIREMENT by: Based on record reviewed 2 years [annually for Intis REQUIREMENT by:	(c), §418.113(c), (c), §482.15(c), §483.73(c), 2(c), §485.68(c), 7(c), §485.920(c), (c), §494.62(c). develop and maintain an ness communication plan deral, State and local laws	E	029	1.Executive Director or designee will review and update EP communications		4/22/22
	preparedness (EP) co deficiency has the po and staff of the facility Findings include:	ommunications plan. This tential to affect all residents			Plan on or before 4/22/22. 2.No further item question's in regards the EP plan. 3.Executive Director will re-educate the maintenance team and the IDT on the	to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		275140	B. WING _			03/	08/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 155 AVE C ILLINGS, MT 59102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 029	the facility communication	e 5 ad not reviewed or updated ations plan in the last year. lan reflected outdated	E	029	requirements of having an EP communication plan that is current on a before 4/8/22. 4.Executive Director or designee will at the EP communication plan monthly for months, then quarterly for 3 quarters to validate the communication plan is current. Audits will be brought to QAPI or before 4/11/22 to identify trends and sustainability, then monthly thereafter.	udit r 3 o	
E 036 SS=F	§483.475(d), §484.10 §485.625(d), §485.72 §486.360(d), §491.12 *[For RNCHIs at §403 Hospice at §418.113, at §460.84, Hospitals §484.102, CORFs at "Organizations" unde §485.920, OPOs at § §491.12:] (d) Training must develop and ma preparedness training based on the emerge paragraph (a) of this s paragraph (a)(1) of th procedures at paragra the communication pl section. The training	(d), §418.113(d), (d), §482.15(d), §483.73(d), 2(d), §485.68(d), 7(d), §485.920(d), (d), §494.62(d). 8.748, ASCs at §416.54, PRTFs at §441.184, PACE at §482.15, HHAs at §485.68, CAHs at §486.625, r 485.727, CMHCs at 486.360, and RHC/FHQs at and testing. The [facility] intain an emergency g and testing program that is	E	036	5.4/22/22		4/22/22

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		275140	B. WING			03/	08/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		3155	ET ADDRESS, CITY, STATE, ZIP CODE AVE C NGS, MT 59102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 036	and testing. The LTC maintain an emergen and testing program to emergency plan set for section, risk assessment is section, policies at (b) of this section, and paragraph (c) of this section ground must least annually. *[For ICF/IIDs at §483 testing. The ICF/IID in an emergency preparates program that is based forth in paragraph (a) assessment at paragraph (b) of this section, and the comparagraph (c) of this section, and the comparagraph (c) of this section ground maintain preparedness training orientation program the emergency plan set for section, risk assessment this section, and paragraph (c) of this section.	§483.73(d):] (d) Training action facility must develop and cy preparedness training that is based on the orth in paragraph (a) of this tent at paragraph (a) (1) of and procedures at paragraph device the communication plan at section. The training and the reviewed and updated at the communication plan set of this section, risk raph (a)(1) of this section, risk raph (a)(1) of this section, rese at paragraph (b) of this munication plan at section. The training and the reviewed and updated at the ICF/IID must meet the country of the country of the country of the section of the country of the communication plan at section. The training, testing of the communication plan at section. The training, testing	E	036	DEFICIENCY		
	and onemation progra	am must be evaluated and					

	IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01		l ` ′			(X3) DATE SURVEY COMPLETED	
		275140	B. WING _			03/	08/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		31	REET ADDRESS, CITY, STATE, ZIP CODE 55 AVE C ILLINGS, 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	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
E 036	updated at every 2 ye This REQUIREMENT by: Based on record revi develop and maintain program that is based Preparedness plan. T potential to affect all s residents of the facilit Findings include: 1. Review of the facilit showed, the facility di Emergency Prepared	ears. is not met as evidenced ew, the facility failed to an EP training and testing I on the facility's Emergency this deficiency has the staff, volunteers, and y. ty EP plan on 03/08/22 d not have a completed ness Plan. No ing and staff training on the	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. 2.No further item question's in regards the EP plan. 3.Executive Director will re-educate the maintenance team and the IDT on the requirements of having an EP plan test and training on or before 4/8/22. 4.Executive Director or designee will at the EP plan testing and training quarter 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.	ing udit Iy	
	EP Training Program CFR(s): 483.73(d)(1)		ΕC)37	5.4/22/22		4/22/22
	§441.184(d)(1), §460 §483.73(d)(1), §483.4 §485.68(d)(1), §485. §485.920(d)(1), §486 *[For RNCHIs at §403 Hospitals at §482.15, at §484.102, "Organiz	.54(d)(1), §418.113(d)(1), .84(d)(1), §482.15(d)(1), .75(d)(1), §484.102(d)(1), .625(d)(1), §485.727(d)(1), .360(d)(1), §491.12(d)(1). .748, ASCs at §416.54, ICF/IIDs at §483.475, HHAs .24tions" under §485.727, .HC/FQHCs at §491.12:]					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED				
		275140	B. WING _		03/08/2022		
	ROVIDER OR SUPPLIER EADOWS HEALTH AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
E 037	the following: (i) Initial training in er policies and procedu staff, individuals provarrangement, and vo expected roles. (ii) Provide emergence least every 2 years. (iii) Maintain docume preparedness training (iv) Demonstrate staff procedures. (v) If the emergency procedures are signiff must conduct training procedures. *[For Hospices at §4 hospice must do all of (i) Initial training in er policies and procedu hospice employees, services under arrange expected roles. (ii) Demonstrate staff procedures. (iii) Provide emergency least every 2 years. (iv) Periodically reviee emergency prepared employees (including special emphasis plat procedures necessariothers. (v) Maintain docume preparedness training tra	n. The [facility] must do all of mergency preparedness res to all new and existing riding services under lunteers, consistent with their cy preparedness training at ntation of all emergency g. If knowledge of emergency preparedness policies and ficantly updated, the [facility] g on the updated policies and 18.113(d):] (1) Training. The of the following: mergency preparedness res to all new and existing and individuals providing gement, consistent with their facility is knowledge of emergency cy preparedness training at w and rehearse its ness plan with hospice g nonemployee staff), with need on carrying out the ry to protect patients and intation of all emergency	EO	37			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
		275140	B. WING _		03/08/2022
	ROVIDER OR SUPPLIER EADOWS HEALTH AND	REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE COMPLETION
E 037	must conduct training procedures. *[For PRTFs at §441 program. The PRTF (i) Initial training in er policies and procedu staff, individuals provarrangement, and vo expected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain docume preparedness training (v) If the emergency procedures are signiff must conduct training procedures. *[For PACE at §460.8 organization must do (i) Initial training in er policies and procedu staff, individuals provarrangement, contract volunteers, consister (ii) Provide emergency least every 2 years. (iii) Demonstrate staff procedures, including what to do, where to case of an emergency (iv) Maintain docume (v) If the emergency	icantly updated, the hospice g on the updated policies and a 184(d):] (1) Training must do all of the following: mergency preparedness res to all new and existing riding services under lunteers, consistent with their g, provide emergency g every 2 years. If knowledge of emergency g, preparedness policies and ficantly updated, the PRTF g on the updated policies and side of the following: mergency preparedness res to all new and existing riding on-site services under ctors, participants, and at with their expected roles. The provided of the following at the follo	EO	37	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				
		275140	B. WING _			03/	08/2022
	ROVIDER OR SUPPLIER EADOWS HEALTH AND	REHABILITATION CENTER		315	REET ADDRESS, CITY, STATE, ZIP CODE 55 AVE C LLINGS, MT 59102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 037	*[For LTC Facilities a Program. The LTC fa following: (i) Initial training in er policies and procedur staff, individuals provarrangement, and vo expected role. (ii) Provide emergence least annually. (iii) Maintain docume preparedness training (iv) Demonstrate staff procedures. *[For CORFs at §485 CORF must do all of (i) Provide initial train preparedness policie and existing staff, indunder arrangement, a with their expected ro (ii) Provide emergence least every 2 years. (iii) Maintain docume (iv) Demonstrate staff procedures. All new pand assigned specification the CORF's emergence their first workday. The include instruction in alarm systems and sequipment. (v) If the emergency	t §483.73(d):] (1) Training cility must do all of the mergency preparedness res to all new and existing iding services under funteers, consistent with their expreparedness training at metation of all emergency g. If knowledge of emergency g. If kno	E	037			

	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED				
		275140	B. WING			03/	08/2022
NAME OF PE	ROVIDER OR SUPPLIER		ı	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASPEN ME	EADOWS HEALTH AND	REHABILITATION CENTER			I55 AVE C ILLINGS, MT 59102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
E 037	*[For CAHs at §485.6 The CAH must do all (i) Initial training in empolicies and procedur reporting and extinguland where necessary personnel, and guests cooperation with firefi authorities, to all new individuals providing and volunteers, consi roles. (ii) Provide emergence least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. (v) If the emergency procedures are signiffi must conduct training procedures. *[For CMHCs at §485 CMHC must provide in preparedness policies and existing staff, ind under arrangement, a with their expected rodocumentation of the demonstrate staff knot procedures. Thereaft emergency preparedry years.	on the updated policies and 25(d):] (1) Training program. of the following: nergency preparedness res, including prompt ishing of fires, protection, r, evacuation of patients, ss, fire prevention, and ghting and disaster and existing staff, services under arrangement, stent with their expected ry preparedness training at thation of the training. If knowledge of emergency preparedness policies and icantly updated, the CAH on the updated policies and 5.920(d):] (1) Training. The nitial training in emergency s and procedures to all new ividuals providing services and volunteers, consistent	E	037			
	,	ew, the facility failed to			1.Executive Director or designee will		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
		275140	B. WING		03/	08/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE
E 037	to all staff members, a members' expected readisaster. This defici occupants and staff in Findings include: 1. Record review of the training documents of facility failed to show	I training of the EP program consistent with each team ples during an emergency or ency affects all of the in the facility. The facility EP plan and in 03/08/22 showed, the evidence that staff training onducted initally for new	EC	validate the staff have been trained or EP plan on or before 4/22/22. 2.No further item question's in regards the EP plan. 3.Executive Director will re-educate the maintenance team and the IDT on the requirements of having an EP plan statraining on or before 4/8/22. 4.Executive Director or designee will at the EP plan testing and training weekl weeks, then monthly x2 months to validate staff training have been completed annually and upon hire. Au will be brought to QAPI on or before 4/11/22 to identify trends and sustainability, then monthly thereafter.	e aff audit y x4	
E 039 SS=F	\$416.54(d)(2), §418.7 \$460.84(d)(2), §482.1 \$483.475(d)(2), §484 \$485.625(d)(2), §485 \$491.12(d)(2), §494.6 *[For ASCs at §416.5 "Organizations" unde \$485.920, RHCs/FQF Facilities at §494.62]:	113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .727(d)(2), §485.920(d)(2), .62(d)(2). 4, CORFs at §485.68, OPO, r §485.727, CMHCs at HCs at §491.12, and ESRD (ty] must conduct exercises r plan annually. The [facility]	EC	5.4/22/22		4/22/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		275140	B. WING			03/08/2022	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 155 AVE C BILLINGS, MT 59102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	community-based ever (A) When a commun accessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the emerexempt from engagin community-based or functional exercise for actual event. (ii) Conduct an additional exercise or functional exercise under this section is conducted in the followord of the follow	a-scale exercise that is ery 2 years; or ity-based exercise is not a facility-based functional res; or experiences an actual emergency that requires regency plan, the [facility] is g in its next required individual, facility-based llowing the onset of the conal exercise at least every 2 ear the full-scale or or or paragraph (d)(2)(i) of or	E	039	DEFICIENCY		
		e must do the following:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		275140	B. WING		03/08/2022	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
E 039	community based ev (A) When a communaccessible, conduct functional exercise of (B) If the hospice ex man-made emergenthe emergency plantengaging in its next community-based extendity-based functionset of the emerge (ii) Conduct an addition opposite the year the exercise under parais conducted, that must to the following: (A) A second full-socommunity-based or exercise; or (B) A mock disaster (C) A tabletop exercise a facilitator and inclusion and a set of directed messages, designed to challenge (3) Testing for hospic care directly. The hospice in an is community-based (A) When a community-based (A) When a community-based (A) When a community-based function accessible, conduct facility-based functions.	ill-scale exercise that is very 2 years; or nity based exercise is not an individual facility based every 2 years; or periences a natural or cy that requires activation of the hospital is exempt from required full scale vercise or individual anal exercise following the ncy event. tional exercise every 2 years, a full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited ale exercise that is a facility based functional drill; or sise or workshop that is led by indes a group discussion using relevant emergency of problem statements, or prepared questions are an emergency plan. The state provide inpatient to be an emergency plan twice per nust do the following: annual full-scale exercise is not an annual individual	E 039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED				
		275140	B. WING		03/08/2022	
	ROVIDER OR SUPPLIER EADOWS HEALTH AND	REHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102	, 00.00.2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE COMPLETIC	NC
E 039	the emergency plan, engaging in its next rebased or facility-based following the onset of (ii) Conduct an additionary include, but is not (A) A second full-scatcommunity-based or exercise; or (B) A mock disaster (C) A tabletop exercifacilitator that include narrated, clinically-reland a set of problem messages, or prepare challenge an emerge (iii) Analyze the hosp maintain documentate exercises, and emerge hospice's emergency *[For PRFTs at §441. §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in an ais community-based; (A) When a community accessible, conduct a facility-based functior (B) If the [PRTF, Hospot actual natural or man requires activation of	ey that requires activation of the hospice is exempt from equired full-scale community of functional exercise the emergency event. onal annual exercise that of limited to the following: a facility based functional drill; or see or workshop led by a see a group discussion using a evant emergency scenario, statements, directed ed questions designed to not plan. Dice's response to and ion of all drills, tabletop pency events and revise the plan, as needed. 184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must nnual full-scale exercise that or ty-based exercise is not an annual individual,	E 03	39		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		275140	B. WING _		03	/08/2022	
	ROVIDER OR SUPPLIER EADOWS HEALTH AND I	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
E 039	required full-scale cor facility-based function onset of the emergen (ii) Conduct an [and that may include, following: (A) A second full-sca community-based or if functional exercise; of (B) A mock of (C) A tabletop existed by a facilitator and discussion, using a nate emergency scenario, statements, directed in questions designed to plan. (iii) Analyze the [maintain documentatic exercises, and emergency [facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE of (2) Testing. The PACE of (3) When a community accessible, conduct a facility-based function (B) If the PACE experimental emergency plan, engaging in its next rebased or individual, facility-based or individual, facil	mmunity based or individual, all exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based or disaster drill; or ercise or workshop that is includes a group arrated, clinically-relevant and a set of problem messages, or prepared or challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed. 4(d):] E organization must conduct emergency plan at least organization must do the innual full-scale exercise that or ty-based exercise is not in annual individual,	EO	39			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		275140	B. WING		03/08/2022
	ROVIDER OR SUPPLIER EADOWS HEALTH AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
E 039	years opposite the year exercise under paragis conducted that mathe following: (A) A second full-scar community-based or functional exercise; of (B) A mock disaster (C) A tabletop exercise a facilitator and includusing a narrated, clin scenario, and a set of directed messages, of designed to challenge (iii) Analyze the PAC maintain documentate exercises, and emerge PACE's emergency procedured (I) The [LTC facility] test the emergency procedured (I) Participate in an ais community-based; (A) When a community accessible, conduct a facility-based function (B) If the [LTC facility actual natural or man requires activation of LTC facility is exempting required a full-scale of the conduction of the conduction of LTC facility is exempting a full-scale of the conduction of the condu	dditional exercise every 2 ear the full-scale or functional graph (d)(2)(i) of this section by include, but is not limited to alle exercise that is individual, a facility based or drill; or see or workshop that is led by des a group discussion, ically-relevant emergency of problem statements, or prepared questions and ear ear emergency plan. E's response to and ion of all drills, tabletop gency events and revise the plan, as needed. It §483.73(d):] must conduct exercises to all an at least twice per year, ed staff drills using the es. The [LTC facility, following: annual full-scale exercise that or ity-based exercise is not an annual individual, anal exercise. I facility experiences an imade emergency plan, the temergency plan, the temergency plan, the temergency its next	E 039		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		1, ,	(X3) DATE SURVEY COMPLETED	
		275140	B. WING _			03/08/2022	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 039	following the onset of (ii) Conduct an additi may include, but is not (A) A second full-scal community-based or a functional exercise; o (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-rel and a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerg [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/I to test the emergency The ICF/IID must do to (i) Participate in an ar is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the ICF/IID exper man-made emergency the emergency plan, the emergency event. (ii) Conduct an addition may include, but is no (A) A second full-scal	the emergency event. conal annual exercise that at limited to the following: le exercise that is an individual, facility based drill; or se or workshop that is led by a group discussion, using a evant emergency scenario, statements, directed ad questions designed to ancy plan. facility] facility's response to antation of all drills, tabletop ency events, and revise the emergency plan, as needed. 3.475(d)]: ID must conduct exercises a plan at least twice per year. The following: anual full-scale exercise that for ty-based exercise is not an annual individual, al exercise; or. feriences an actual natural or any that requires activation of the ICF/IID is exempt from equired full-scale andividual, facility-based and annual exercise that but limited to the following:	EO	39			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		275140	B. WING			03/	08/2022
	ROVIDER OR SUPPLIER EADOWS HEALTH AND	REHABILITATION CENTER		3′	TREET ADDRESS, CITY, STATE, ZIP CODE 155 AVE C ILLINGS, MT 59102	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and includusing a narrated, clin scenario, and a set of directed messages, of designed to challengy (iii) Analyze the ICF/I maintain documentate exercises, and emergic ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The HI to test the emergency least annually. The HI to test the emergency least annually. The HI (i) Participate in a full community-based; or (A) When a community-based function or. (B) If the HHA error or man-made emergency plaengaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under paragis conducted, that limited to the followin (A) A second full	Irill; or se or workshop that is led by des a group discussion, ically-relevant emergency f problem statements, or prepared questions e an emergency plan. ID's response to and ion of all drills, tabletop gency events, and revise the plan, as needed. O2] HA must conduct exercises / plan at HA must do the following: -scale exercise that is munity-based exercise is not an annual individual, hal exercise every 2 years; experiences an actual natural ency that requires activation n, the HHA is exempt from equired full-scale individual, facility based llowing the onset of the onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section t may include, but is not g: -scale exercise that is an individual, facility-based	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG 01	1, ,	(X3) DATE SURVEY COMPLETED	
		275140	B. WING _		0	3/08/2022	
	ROVIDER OR SUPPLIER EADOWS HEALTH AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 3155 AVE C BILLINGS, MT 59102			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
E 039	led by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. (iii) Analyze the HHA documentation of all emergency events, a emergency plan, as not emergency events, and led by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. If the OPO experimental emergency plan, engaging in its next not following the onset of (ii) Analyze the OPO documentation of all emergency events, and OPO's] emergency plan. *[RNCHIs at §403.74 (d)(2) Testing. The R	ster drill; or sercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency 's response to and maintain drills, tabletop exercises, and nd revise the HHA's needed. 360] PO must conduct exercises y plan. The OPO must do the exaced, tabletop exercise or nually. A tabletop exercise is d includes a group arrated, clinically relevant and a set of problem messages, or prepared o challenge an emergency eriences an actual natural or cy that requires activation of the OPO is exempt from equired testing exercise for the emergency event. Its response to and maintain tabletop exercises, and nd revise the [RNHCI's and lan, as needed. 48]: NHCI must conduct emergency plan. The RNHCI emergency plan. The RNHCI	E	039			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED		
		275140	B. WING		03/08	03/08/2022	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3155 AVE C BILLINGS, MT 59102			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE	
E 039	least annually. A table discussion led by a facilinically-relevant emotor of problem statement prepared questions demergency plan. (ii) Analyze the RNHO maintain documentati and emergency event emergency plan, as not a record revided to the prepared ness testing participate in a full-sc exercise. This deficie facility. Findings include: Record review of the	ased, tabletop exercise at etop exercise is a group cilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an CI's response to and on of all tabletop exercises, is, and revise the RNHCI's eeded. The is not met as evidenced ew, the facility failed to not an emergency program to annually ale exercise, and a table top not affects everyone in the facility EP plan on 03/08/22 to documentation regarding a latable-top exercise	E 03	1.Executive Director or designee will validate the facility has conducted a full-scale or table top exercise for the Eplan on or before 4/22/22. 2.No further item question's in regards the EP plan. 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. 4.Executive Director or designee will at the EP plan testing quarterly for 4 quart to validate 2 tests, table top or full scale have been completed annually. Audits be brought to QAPI on or before 4/11/2 to identify trends and sustainability, the monthly thereafter. 5.4/22/22	to udit ters e, will		
K 000	INITIAL COMMENTS		K 00				

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		275140	B. WING	B. WING		03/	08/2022
NAME OF PROVIDER OR S ASPEN MEADOWS HI		REHABILITATION CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 155 AVE C BILLINGS, MT 59102		
	CH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Based or standards (CFR) 483 (LTC), a li survey wa regulatory applicable Protection Edition, at by that ed specificall Occupant. The buildi Type V (1 compartm since the There are one for the areas (e.g. assisted li areas wer for 90 bed was the or These received by the foll Electrical CFR(s): N Electrical Extension Power striused for or patient-ca (PCREE) by qualifier	of 42 Code 3.70(a) for L fe safety co as performe requireme e provisions a Associatio and those ma ition. The fa y using Cha cies. In g construct and con elast survey three, 2-ho e administra b. kitchen, la ving. The a re not surve ls and at the ensus. Juirements cowing defic Equipment IFPA 101 Equipment Cords ips in a pati components re-related e assembles ed personne	tory requirements and e of Federal Regulations. Long Term Care Facilities ode (LSC) recertification d on 03/08/21. Under this nt, the facility must meet the of the National Fire n's (NFPA) 101 LSC, 2012 andatory Codes referenced acility was surveyed apter 19 Existing Health Care ction type was found to be national five smoke ew construction has occurred of the facility on 04/19/21. For separations in the facility, active area, one for support aundry, etc.) and one for the ssisted living and support yed. The facility is licensed et time of survey 57 residents		920			4/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED	
		275140	B. WING _	B. WING		03/08/2022	
	ROVIDER OR SUPPLIER EADOWS HEALTH AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3155 AVE C BILLINGS, MT 59102			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 920	may not be used for relectronics), except in rooms that do not use PCREE meet UL 136 strips for non-PCREE (outside of vicinity) m care rooms, power st standards. All power precautions. Extensis substitute for fixed wi Extension cords used immediately upon corwhich it was installed 10.2.4. 10.2.3.6 (NFPA 99), 1 (NFPA 70), 590.3(D) This REQUIREMENT by: Based on observation power strips were used Health Care Facilities Findings include: 1. During an observation a.m., the dining room strip being used in the 1363 rating.	non-PCREE (e.g., personal non-PCREE, Power strips for 3A or UL 60601-1. Power in the patient care rooms eet UL 1363. In non-patient rips meet other UL strips are used with general on cords are not used as a ring of a structure. It temporarily are removed in meets the conditions of 0.2.4 (NFPA 99), 400-8	KS	1.Maintenance Director or de replaced surge protector in the room with a UL 1363 rating a the surge protector in the bat or before 4/22/22. 2.Maintenance Director or de inspected other surge protectors appropriate UL rating and we secured on or before 4/15/22 3.Executive Director re-educate requirements of surge protectors appropriate UL rating and protectors are properly secured the appropriate UL rating and protectors are properly secured the appropriate UL rating and protectors are properly secured the surge protector of design 5 rooms weekly x4 weeks, the x2 months to validate appropriate appr	ne dining nd secured hing room on esignee tors to had the re properly . ated staff the tors having I that surge ed on or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		275140	B. WING			03/08/2022	
NAME OF PROVIDER OR SUPPLIER ASPEN MEADOWS HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (X5 (EACH CORRECTIVE ACTION SHOULD BE COMPLET C		
K 920	Continued From pag	e 24	K 92	rated surge protectors are used secured properly. Audits will be to QAPI on or before 4/11/22 to trends and sustainability, then rethereafter. 5.4/22/22	e brought identify		