STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135130	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Transitional Rehabilitation	2867 East Copper Point Drive Meridian, ID 83642

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and review of the State Long Term Care Reporting System, it was determined the facility failed to ensure residents were free from abuse, neglect, and misappropriation of resident property and exploitation. This was true for 1 of 3 residents (Resident #50) reviewed for abuse and neglect. The facility failed to protect Resident #50 when she experienced neglect from CNA #1 during transfer from a chair to standing resulting in a fall with injury requiring hospitalization and surgery. Findings include:The facility's Abuse Policy and Procedure, version F1005, documented the facility would protect all residents from any and all forms of abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and /or services.The CMS SOM, Appendix PP, dated 7/23/25, defined:Abuse, as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, in the definition of abuse as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Neglect, as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.Resident #50 was admitted to the facility on [DATE], with multiple diagnoses including congestive heart failure (CHF), bilateral lower leg lymphedema, and diabetes. Resident #50's Discharge MDS assessment dated [DATE], documented under section GG she was a 2-person assistance to transfer from a chair to standing. Resident #50's care plan created on 3/28/25, documented an alteration in mobility/ safety and staff were directed to transfer her using a Hoyer mechanical lift or a 2-person assist. Resident #50's Progress Notes with dates ranging from 4/1/25 through 4/12/25 documented, extensive 2-person assistance required for transferring.Resident #50's Physical Therapy Progress Report dated 4/10/25, documented she had the following precautions in place and were communicated to the Interdisciplinary Team:weight bearing as toleratedextensive assistance of 2 people with four-wheel walkerAn Abuse Investigation Report completed by the facility documented on 4/14/25 at 1:10 PM, Resident #50 had a fall with injury in her room while being assisted by CNA #1 from her chair to standing. As a result of the fall, Resident #50 was sent to the emergency room via Urgent transport and was diagnosed with a fracture of the right distal knee requiring surgical repair.On 12/18/25 at 2:30 PM, the DON with the Administrator present stated, at the time of Resident #50's fall, she was on a 2 person assist for all transfers per Physical Therapy and the care plan. The DON stated CNA#1 was aware of Resident #50's transfer status and chose to transfer her by himself when [Resident #50's] knee buckled, and she fell.These findings represent past non-compliance with these regulatory requirements, and the facility did the following:-Resident was her own representative-Resident was transferred to hospital for higher level of care.-CNA was retrained on resident transfer status and following care plans.-All direct care staff including CNA's and licensed nurses were given an in-service training on transfer status and following resident care plans on 4/16/25.-Transfer audits for all residents completed by therapy on: 5/16/25 6/16/25 7/16/25-Audit of transfer care plans on all patients in building and CNA's performing transfers as care planned dated 4/16/25.There was sufficient evidence the facility corrected the non-compliance as of 4/16/25 as there was no further resident Neglect related to transfer status and following care plans after this date. At the time of the survey, the facility was in substantial compliance and therefore does not require a plan of correction.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined the facility failed to ensure each resident had a person-centered comprehensive care plan developed and implemented to meet his or her preferences, goals, and address the resident's medical, physical, mental and psychosocial needs. This was true for 1 of 2 residents (Resident #50) reviewed for care plans. This deficient practice placed residents at risk for harm when their care plan was not followed. Findings include:Resident #50 was admitted to the facility on [DATE] with multiple diagnoses including congestive heart failure (CHF), bilateral lower leg lymphedema, and diabetes.Resident #50's care plan created on 3/28/25, documented an alteration in mobility/ safety and staff were directed to transfer her using a Hoyer mechanical lift or a 2-person assist. An Abuse Investigation Report completed by the facility documented, on 4/14/25 at 1:10 PM, Resident #50 had a fall with injury in her room while being assisted by CNA #1 from her chair to standing. As a result of the fall, Resident #50 was sent to the emergency room via Urgent transport and while there she was diagnosed with a fracture of the right distal knee requiring surgical repair.On 12/18/25 at 2:30 PM, the DON with the Administrator present stated at the time of Resident 50's fall, she was on a 2 person assist for all transfers per Physical Therapy and the care plan. CNA #1 knew her [Resident #50's] 2-person transfer status and chose to transfer her by himself when her [resident #50's] knee buckled, and she fell.These findings represent past non-compliance with these regulatory requirements, and the facility did the following:-Resident was her own representative-Resident was transferred to hospital for higher level of care. -CNA was retrained on resident transfer status and following care plans.-All direct care staff including CNA's and licensed nurses were given an in-service training on transfer status and following resident care plans on 4/16/25.-Transfer audits for all residents completed by therapy on: 5/16/25 6/16/25 7/16/25-Audit of transfer care plans on all patients in building and CNA's performing transfers as care planned dated 4/16/25. There was sufficient evidence the facility corrected the non-compliance as of 4/16/25 as there was no further resident Neglect related to transfer status and following care plans after this date. At the time of the survey, the facility was in substantial compliance and therefore does not require a plan of correction.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure nurses followed provider orders in accordance with professional standards of practice. This was true for 3 of 12 residents (#4, #27, and #38) reviewed for professional standards of care. This failure created the potential for uncontrolled pain, sedation and adverse health outcomes. Findings include:1.Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including osteoporosis with pathological fracture and a history of falls. Review of Resident #4's MAR dated 12/1/25 through 12/17/25 documented the following provider order:Oxycodone 2.5 mg by mouth three times a day for pain level 6-10, as needed. The MAR documented the following oxycodone 2.5 mg administrations outside the ordered pain range: 12/3/25 - pain level 5 (outside ordered range) 12/4/25 - pain level 5 (outside ordered range) 12/7/25 - pain level 4 (outside ordered range) 12/10/25 - pain level 5 (outside ordered range) 12/11/25 - pain level 3 (outside ordered range) 12/16/25 - pain level 5 (outside ordered range) 2. Resident #27 was admitted to the facility on [DATE] with multiple diagnoses including displaced fracture of the right femur and compression fracture of the fourth lumbar vertebra. Review of Resident #27's MAR dated 12/1/25 through 12/17/25 documented the following provider orders:Ibuprofen 200 mg by mouth every 6 hours for pain level 1-4, as needed.Oxycodone 5 mg by mouth every 4 hours for pain level 5-10, as needed.The MAR documented: 12/2/25 - Ibuprofen 200 mg administered for pain level 6 (outside ordered range). 12/9/25 - Oxycodone 5 mg administered for pain level 4 (outside ordered range). 3. Resident #38 was admitted on [DATE] with multiple diagnoses including periprosthetic fracture around an internal prosthetic right knee joint and displaced fracture of the right femur. Review of Resident #38's MAR dated 12/4/25 through 12/17/25 documented the following provider order:Oxycodone 5 mg by mouth every 4 hours for pain level 1-4, as needed. The MAR documented two consecutive PRN administrations of Oxycodone 5 mg on 12/5/25 for a pain level of 5, which was outside the ordered range. On 12/18/25 at 8:44 AM, the DON stated the nurse did not fail to follow the provider's order because the nurse followed the resident's preference. When asked whether a resident's preference supersedes a provider's order, the DON stated, no.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and staff interview, the facility failed to ensure the presence of a registered professional nurse for at least 8 consecutive hours per day, as required. This failure had the potential to affect all residents in the facility who may require a higher level of nursing assessment or intervention. Findings include: Review of the facility's nursing schedule dated 11/23/25 through 12/13/25 documented the facility did not provide 8 consecutive hours of registered professional nursing coverage on the following dates: 11/23/25 - No consecutive hours 11/29/25 - No consecutive hours 11/30/25 - No consecutive hours 12/6/25 - No consecutive hours 12/7/25 - No registered nurse hours 12/13/25 - No consecutive hours On 12/18/25 at 12:12 PM, the DON stated she was unaware that the required 8 hours of registered professional nursing must be consecutive. She also confirmed the facility did not have a registered professional nurse on duty on 12/7/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of the CMS SOM-Appendix PP, and staff interview, it was determined the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. This was true for 1 of 2 medication carts observed and 1 of 1 medication storage rooms. This deficient practice had the potential for harm to a resident if they were to obtain medications which were left unattended and unsecured by staff. Findings include:CMS SOM-Appendix PP, revised on 7/24/25 and accessed on 12/19/25, documents, in accordance with State and Federal laws, the facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.1) On 12/17/25 at 7:25 AM, the medication cart located in Hall One was observed to be unlocked and unmonitored by staff for several minutes. On 12/17/25 at 7:30 AM, LPN #1 stated, Yes, I guess I did leave the cart unlocked and unsupervised and I should not have done that. On 12/17/25 at 8:45 AM, The DON with the CNM present stated, the expectation was that the medication cart was always locked when not in sight of the nurse. 2) On 12/17/25 at 7:40 AM, after a resident refused most of her morning medications, citing she wanted to wait until after breakfast to eat. LPN #1 stated she would label the medication cup with resident's initials and store them in the medication cart until the resident was ready to take them later. LPN #1 stated that was what she normally does when residents don't want their medications after she has prepared them. On 12/17/25 at 8:48 AM, The DON with the CNM Present stated, the expectation was that the prepared medications that were refused be disposed of, and the nurse prepare the residents medications again when the resident was ready for them. The DON further stated the nurse should not store prepared medications in the medication cart as it could lead to a medication error. 3) On 12/17/25 at 7:55 AM, LPN #1 was observed preparing medications for a resident when she found she needed to retrieve a stock medication from the medication room, she placed prepared medications in the cart, locked the cart and walked away leaving a liquid mixture resembling orange juice, (cholestyramine 4 gram mixed in water) on the med cart unsupervised. She entered a closed room out of sight of the cart. When she returned the SA asked if she should have left the medication unattended on her med cart, LPN #1 stated No I should not have left resident medications unattended on top of the medication cart.12/17/25 at 8:50 AM, The DON with the CNM present stated, the expectation is for the nurse to not ever leave medications unattended on the med cart for safety. 4) On 12/17/25 at 8:30 AM, with the DON and CNM present, observed the following in facility's medication storage room: narcotic storage refrigerator was unlocked and unmonitoreda black metal box inside the refrigerator labeled Lorazepam 2 mg/ml was not permanently affixed inside the refrigerator.On 12/17/25 at 8:35 AM, the DON with the CNM present stated, the narcotic box does not need to be secured inside the refrigerator because the door to the medication room was locked.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, CDC recommendation review, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained during medication preparation and administration. This failure had the potential to impact all residents in the facility by placing them at risk for cross contamination and transmission of infection. Findings include:The Centers for Disease Control and Prevention (CDC) web page titled, Clinical Safety: Hand Hygiene for Healthcare Workers, updated 2/27/24, documented hand hygiene should be performed:Immediately before touching a patient.Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices.Before moving from work on a soiled body site to a clean body site on the same patient.After touching a patient or patient's surroundings.After contact with blood, body fluids, or contaminated surfaces.Immediately after glove removal. The following was observed for hand hygiene and Personal Protective equipment (PPE):On 12/17/25 at 8:08 AM, LPN #1 was observed preparing a resident's insulin at the medication cart. She donned gloves, picked up the resident's insulin pens, walked to his room, knocked on the door and pressed the door open with her gloved hand. No hand hygiene was observed. She proceeded to administer the resident's insulin injections. LPN #1 removed her gloves and performed hand hygiene prior to leaving the resident's room.On 12/17/25 at 8:15 AM, LPN #1 stated she should have performed hand hygiene prior to donning gloves after entering the resident's room and prior to administering the insulin injections.On 12/17/25 at 9:00 AM, the DON with the CNM present stated the expectation for her nurses would be that they perform hand hygiene and don fresh gloves after entering a resident's room and prior to administer injections.