STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205018	A. BUILDING _____ B. WING _____	09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AROOSTOOK HEALTH CENTER	15 HIGHLAND AVE MARS HILL, ME 04758

(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
F 000	INITIAL COMMENTS From 9/18/23 through 9/21/23, on-site visits were conducted at Aroostook Health Center for the purpose of completing the annual Long Term Care Survey Process. It was determined that Aroostook Health Center was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide Resident #13 (R13) with oral care on 2 of 3 morning observations. (9/19/23 and 9/21/23) Findings: On 9/19/23 at 08:13 a.m. during dining room observations R13 was brought to the dining room for breakfast. When surveyor attempted to interview resident, it was observed that his/her mouth care had not been completed. His/her mouth was noted to be covered in a sticky substance, his/her his lips were coated with a dried substance, and he/she was having a difficult time to talk (his/her tongue and lips sticking together). As surveyor was talking with R13 a staff person asked if him/her if they were thirsty. R13 stated he/she was very thirsty, and staff provided him/her a glass of water. A surveyor confirmed with staff that R13's mouth care had	F 677	Corrective action for those affected by the deficient practice will be managed with education and competency for all staff that provide this care. The education will include oral care expectations, ways to encourage resident to accept oral care and how to document resident outcome. (See attachment #1) The facility will create a report from the EMR that is pulled weekly to evaluate for deficiency in oral care. To prevent other resident from having the potential to be affected by the same deficient practice, the facility will complete a competency with all current staff and new hires. This will also occur on an annual basis to ensure continued compliance with staff.	11/5/2023

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

Kelly M Saunders, RN, Director of Long Term Care | 10/13/23

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.

Attachment #1

Good Oral Hygiene

- Provide physical assistance, remind, or cue residents to perform oral care at least twice daily and/or after meals.
- Ensure that toothbrushes, denture brushes and denture cups are labelled, cleaned daily and replaced every 3 months or as required.
- Replace toothbrushes following any oral infections.
- If you are unable to brush a resident's teeth, try a sponge used to clean the teeth and gums.
- Mouthwash can also be used to freshen the breath and kill bacteria.
- If residents are resistive to care, allow time to calm and try again. Be calm and friendly and smile. Talk clearly and at the resident's pace. Do completion in steps by completing one quadrant at time.
- Residents take medications that can cause dry mouth- provide frequent sips of water.
- Good Oral Health is linked to overall health, self-esteem and quality of life in older adults.
- Oral health can affect the ability to speak and chew comfortably.
- Mouth care is essential for those who wear dentures by removing and rinsing dentures after eating. Cleaning the mouth after removing dentures. Brushing the dentures just as you would your own teeth. Soaking the dentures overnight, rinsing thoroughly before putting them back in the mouth.
- Poor fitting dentures may cause sores in the mouth, loss of appetite, loss of weight, inability to speak well and poor self-esteem.
- Report any changes in the mouth to the charge nurse for follow up. For example, sores, bad breath, or broken teeth.
- Accurate documentation is essential in creating successful plans for our residents.

QUIZ

Attachment #1

Good Oral Hygiene

1. How often should teeth be brushed? _____

2. A toothbrush only needs to be replaced when it is visibly worn?
   True _____ False _____

3. Poor oral health can affect an older adults overall health?
   True _____ False_____

4. We don't need to do mouth care if residents wear dentures?
   True _____ False_____

5. What kind of changes might you recognize during oral care that should be reported to the charge nurse?
   a._____
   b._____
   c._____

6. What should I do if a resident resist having me provide oral care, brushing their teeth or wiping around their mouth.
   a._____
   b._____
   c._____

7. What does good oral care look like to you?
   _____
   _____

8. What should you report to your charge nurse?
   a._____
   b._____
   c._____

9. Accurate documentation is essential to our jobs.
   True_____False_____

10. How can you encourage residents to accept oral care?

a._____ b._____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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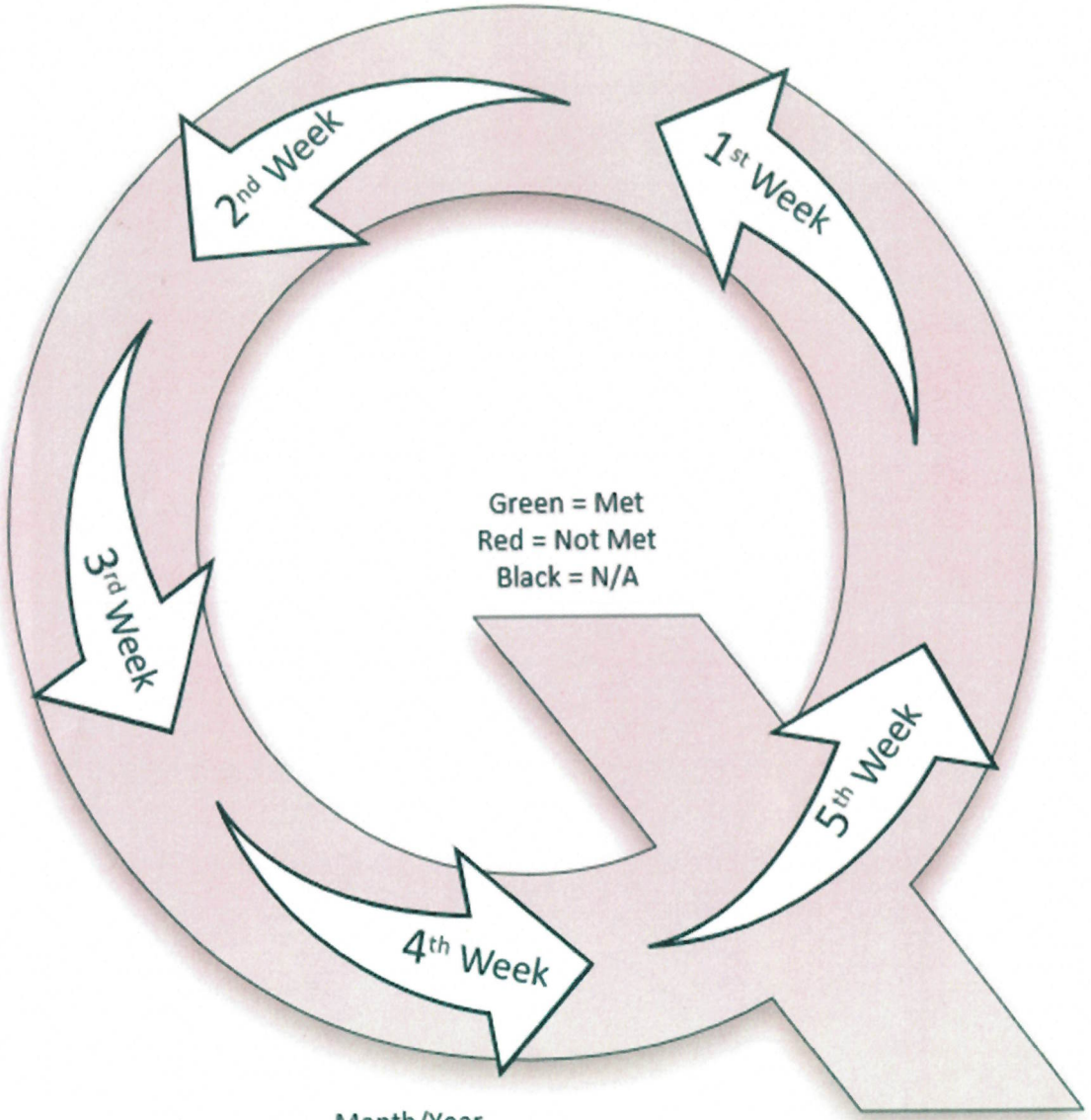
F 677	Continued From page 1 not been completed that morning prior to breakfast. The staff person then took the resident to their room to perform mouth care. When R13 came back to dining room he/she was then able to talk to surveyor with no issues. On 9/21/23 at 9:47 a.m. during morning observations R13 was observed sitting in the common area in his/her wheelchair. A surveyor observed during a conversation with R13 that his/her teeth and mouth were coated in an unknown substance. A surveyor confirmed that R13's mouth care had not been completed. R13 was then taken back to his/her room and mouth care was provided, R13 then stated, "now that feels better". At 9:50 a.m. during an interview with the certified nursing assistants that were assigned to provide care to R13, they stated they had a call out and the night shift had provided him/her with a.m. care. They were told by night shift staff that his/her care was complete and they assumed that included oral care. Review of R13s visual/bedside Kardex report (directs staff for needed care) under the topic of personal hygiene/oral care it directs staff to perform oral care with specifications of in am (morning), pc (after meals), hs (hour of sleep/bedtime) . To brush teeth and to rinse mouth with wash. That he/she has their own teeth, and they require extensive assist of 1 or 2 staff for personal hygiene and oral care.	F 677	The Clinical Supervisor, Director of Nursing or Designee will monitor the corrective action plan through evaluating compliance rates from the EMR reporting. These same leaders will be observing at least ten residents per week providing corrective action should they find oral care not meeting compliance. Results will be posted on the unit for staff to be notified of compliance rates. (See attachment #3) These results will be shared with the quarterly QAPI meeting. (See attachment 2) The correction will be complete by November 5, 2023.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		

Attachment #2

Quality Goal

Northern Light
A.R. Gould Hospital



Department/Location

NURSING

Goal Statement

ORAL HYGIENE

- Resident will receive good oral hygiene
- Alternatives practiced when resident refuses
- Appropriate documentation of refusals or changes
- Alert charge staff of concerns

Month/Year

October 2023

Attachment #3

Personal Hygiene/ ADL Compliance Observation Tool

Auditor Name: _____ Date of audits: October 2023

	WEEK 1			WEEK 2			WEEK 3			WEEK 4		
ADLs:	Yes	No	Comments	Yes	No	Comments	Yes	No	Comments	Yes	No	Comments
Mouthcare												
Feeding assistant: Compliant Practice												

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F 684	Continued From page 2 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a physician order was followed for 1 of 5 residents reviewed for unnecessary medications (Resident #5 [R5]). Finding: On 9/20/23, R5's clinical record was reviewed. The most recent order entered into the electronic clinical record for Trazodone was for 50 mg which was started on 3/23/23. On 8/22/23, the Physician signed a "Pharmacist Consultant to Physician" report that directed staff to trial Trazodone (anti-depressant) at 25 milligrams (mg) from the current 50 mg by checking the box "Yes - Approve implementation of recommendation. Nursing please follow through." On 9/20/23 at 10:59 a.m., during an interview with the Minimum Data Set (MDS) Lead, the surveyor confirmed that this order was not implemented as ordered.	F 684	The resident found to have the deficient practice had an order immediately corrected and the provider was notified. There was no adverse reaction due to the incident and nursing has been educated. The facility has created a twostep verification process where the licensed staff will independently review the pharmacist consult recommendation and make appropriate order changes. This would be completed by the charge nurse and with a second validation completed by Nursing Supervisor, Director of Nursing or Designee. To ensure that the deficient practice will not recur, we have created a process and competency outlining the new twostep verification process that will be provided to all current staff. New hires will receive this competency training during orientation. (See attachment #4) Monthly audits will be completed by Quality Specialist or Designee to assure follow through of all orders and recommendations. This will be reported to Performance Improvement quarterly. (See attachment #5)	11/5/2023
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688	The correction will be complete by November 5, 2023.	

Attachment #4

Two Step Verification Process for Pharmacy Consults

1. Pharmacy consults are sent to the Clinical Supervisor via inner office mail.

2. The Clinical supervisor will deliver the Pharmacy consult to nursing and Pharmacy consult to Provider for completion.

3. The Provider forms are left on his desk for his approval or recommendations for the next day he provides in person support at the facility.

4. The Nursing forms will be appropriately managed by the charge nurse. A note is placed under "Progress Notes" "Pharmacy Chart Review". Family must be need notified of any changes.

5. Once the form is completed it must have the second validation to ensure accuracy. This will be done by the Clinical Supervisor, DON or designee.

6. After the validation process is completed, the forms with recommendations noted are scanned back to the pharmacist and the hard copy is filed in the appropriate resident chart.

7. Monthly audits will be completed by Quality Specialist or designee to assure follow through of all orders and recommendations.

8. Report to Performance Improvement Quarterly of outcomes.

Attachment #4

Pharmacy Two Step Verification Competency

T or F The charge nurse is responsible for implementing new orders from the pharmacy consult sheet that the provider reviews and makes his final responses on.

T or F The Clinical Supervisor, DON or designee is responsible to progress notes regarding new orders and recommendations.

T or F We don't need to call the family on any changes.

T or F ARG Pharmacy will receive all completed recommendation forms as the final reviewer.

T or F No one needs to review the orders after the charge nurse puts them in.

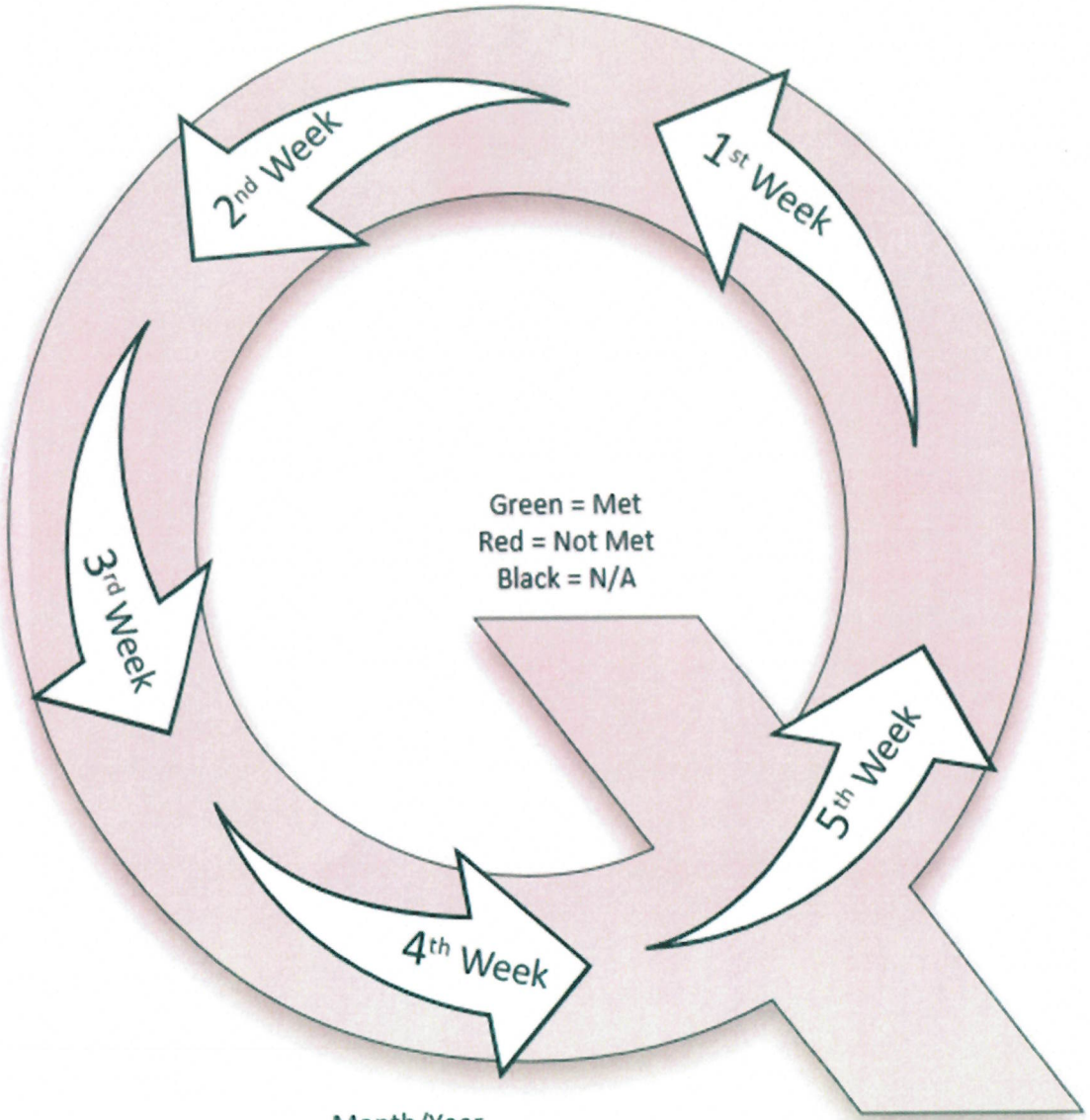
T or F Having a process in place to assure compliance is important.

T or F I have read and understand the Two Step Process for Pharmacy Consults.

Attachment #5

Quality Goal

Northern Light
A.R. Gould Hospital



Department/Location

NURSING

Month/Year

October, 2023

Goal Statement

Residents will receive appropriate treatment and care in accordance with professional standards of practice by ensuring that we follow physician orders.

1) Charge nurse order entry is correct, notes in resident chart, family notified.
2) Nursing leader to audit
3) Scan completion to pharmacy
4) Two Step Verification Process Performed with Accuracy.
5) Monthly Goal

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F 688	Continued From page 3 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide services to maintain and/or improve residents highest level of mobility. The facility failed to provide Restorative services as outlined in the resident's restorative care plan and Kardex for 1 of 2 sampled residents (Resident #3[R3]). Finding: On 9/19/23 at 8:43 a.m., during a resident interview, R3 stated that he/she has asked to ambulate and is supposed to walk everyday but when he/she asked they told him/her they didn't have time. During review of R3's restorative care plan with a revision date of 8/23/23, it has a focus area which documents "I need to work with restorative nursing to help maintain strength, mobility and	F 688	Corrective action for the residents affected has been communicated daily with staff in the morning change of shift, and the communication book. The Clinical Supervisor, Director of Nursing or Designee will run reports from the EMR to validate that residents are receiving restorative services as ordered. In addition, our team is reviewing each care plan to assure that each resident has a plan that is appropriate treatment and service to align with their clinical condition and desire to improve or maintain their mobility and/or ROM. To ensure that the deficient practice will not recur, we will be educating our licensed staff, in conjunction with CNA's of those needing restorative services. Each morning for report to communicate the unique needs of each resident, the Restorative Lead or Designee will provide the duty assignment with the resident specific restorative plan. To ensure this will not recur and has been corrected, our Restorative Rounds Team will review residents on a restorative plan weekly to monitor their current goals to assure accuracy and appropriateness. Residents found to not be receiving services as ordered will be escalated to Director of Nursing or Designee for case review.	11/5/2023

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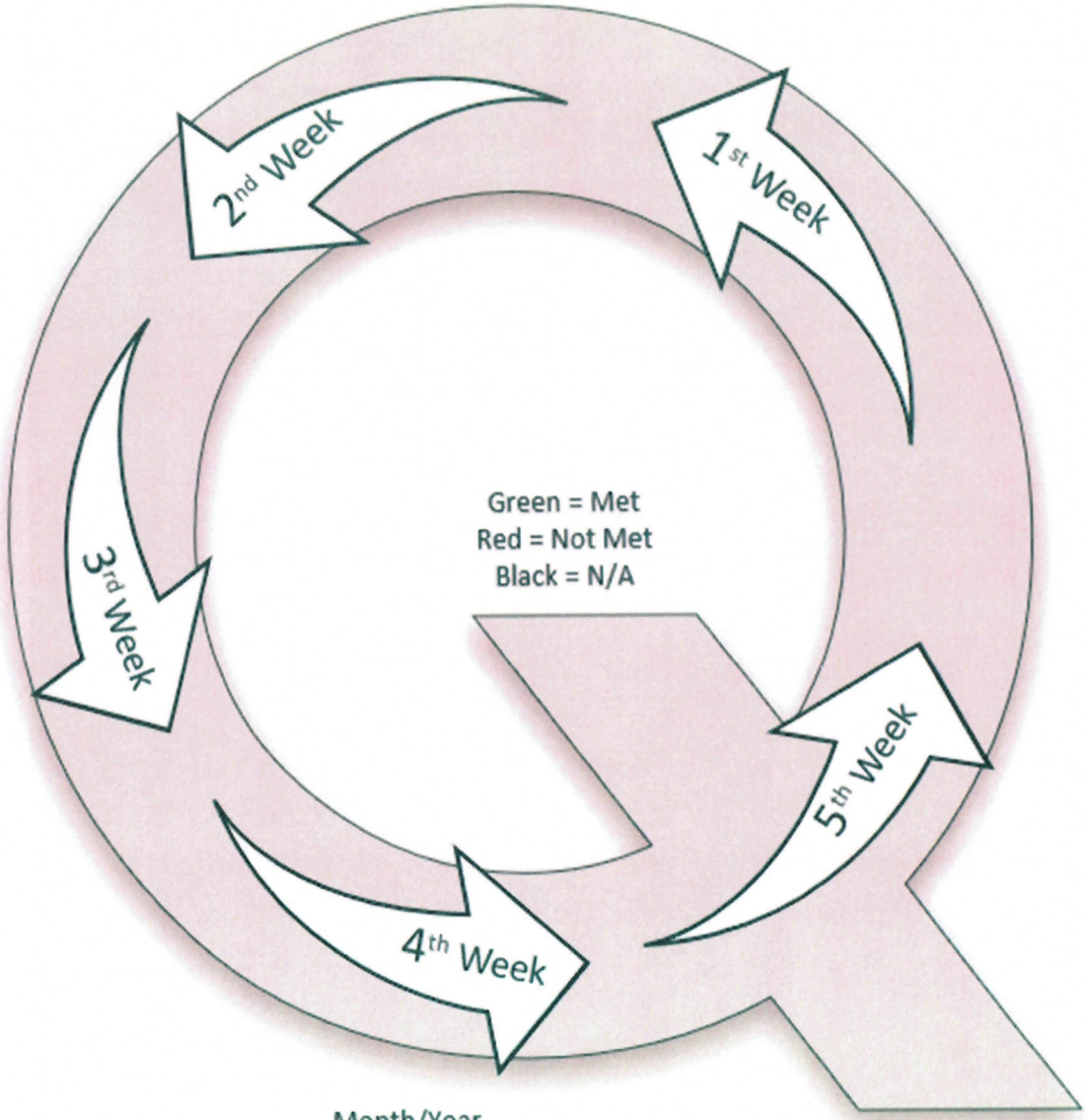
F 688	Continued From page 4 Range of Motion" the goal is documented as "I walk with restorative nursing to maintain the ability to ambulate 5-10 feet, 1 to 6 times a week". The intervention is documented as "Ambulate with restorative nursing 5 to 20 feet with a 4 wheeled walker and follow me with a wheelchair." Review of R3's visual/bedside Kardex report under the section Mobility directs staff that he/she is to ambulate with restorative nursing for 5-20 feet using a 4 wheeled walker to follow with a wheelchair, that he/she requires extensive assist of 2 staff to get to stand. His/her level of participation varies. R3's electronic clinical record for restorative ambulation it shows documentation that reflects he/she has not received his/her restorative ambulation program since 9/8/23 11 days prior to this survey date. On 9/20/23 at 9:40 a.m. during an interview with the Minimum Data Set (MDS) lead, she stated R3 was deemed unsafe to walk with Certified Nursing Assistants (CNAs). R3 does work with the restorative aide for ambulation. The electronic clinical record was reviewed with the MDS lead and it showed the restorative program has not been followed as outlined for the 1-6 times a week. And the last entry date was on 9/8/23. During this interview it was stated that the restorative aide was on vacation and the facility did not have another staff member to take over the restorative program. On 9/2/23 at 9:40 a.m. a surveyor confirmed that R3 has not received their restorative ambulation as outlined in their care plan and Kardex.	F 688	Results will be reported out at Performance Improvement on a Quarterly basis. (See attachment #6) The correction will be complete by November 5, 2023.	

Attachment #6

Quality Goal

Northern Light
A.R. Gould Hospital



Department/Location

NURSING- RESTORATIVE

Goal Statement

Residents who have a restorative plan shall receive the appropriate treatment and service to align with their clinical condition and desire to improve or maintain their mobility and/or ROM.

Month/Year

October 2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 756 F 756 SS=E	Continued From page 5 Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756 F 756	Corrective action for those who may have been affected by the deficient practice, received an updated AIMS assessment on 9/27/23. The facility has initiated a review of all residents on psychotropic medications to assure that other residents are not affected by the deficient practice. To ensure the deficient practice will not recur, the consulting pharmacy has initiated AIMS assessment review on all residents who receive psychotropic medications during their medication reviews. The policy for Drug Regimen Review has been updated to include AIMS assessment review to be performed in accordance with regulation to assure any irregularities are noted and this report is passed on to the attending physician through pharmacy consult sheets, the facility Medical Director, Director of Nursing or Designee. (See attachment #7 & #8)	11/5/2023

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F 756	Continued From page 6 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the pharmacist identified an irregularity for a psychotropic medication for 1 of 5 residents reviewed for unnecessary medications (Resident [R] 5). Finding: On 9/20/23, R5's clinical record was reviewed and it was noted that the resident was on an anti-psychotic medication, Olanzapine, with the last increase 9/26/20. R5's current care plan contained an intervention that was last revised on 8/27/19, to complete Abnormal Involuntary Movement Scale (AIMS) testing per facility policy. The last AIMS test completed for R5 was done on 12/28/19. On 9/20/23 at 12:23 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated that she spoke with pharmacy and the reason the pharmacist did not pick up the missing AIMS assessment was because the pharmacist was not checking for it. The DON stated that the AIMS test is supposed to be done every 6 months. Free	F 756	The facility will monitor its corrective action with each gradual dose Reduction quarterly meeting that supports the documentation of AIMS assessment being completed timely. The correction will be complete by November 5, 2023.	
F 758 SS=E	from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		

Attachment #7

Northern Light A.R. Gould Hospital

Title: Drug Regimen Review at Northern Light Continuing Care	
Policy/Procedure #: 36-094	**Date Posted:**
Initial Effective Date: 03/07/1984	Date Last Revised: 01/30/2023
Author: Kayla H. Bates, PharmD, BCPS – Director: Pharmacy	
Leadership Sponsor: Director of Pharmacy	Final Approver: Senior Physician Executive
Supersedes: Drug Regimen Review at Northern Light Continuing Care	Dated: 01/30/2023

SCOPE

- ARG Consultant Pharmacist
- Northern Light Continuing Care Physicians
- Northern Light Continuing Care Nursing Supervisors and Administrators.

RELATED POLICIES/PROCEDURES

None

DEFINITIONS

None

PURPOSE

To monitor medication use, for each resident, to avoid unwanted medication events and assure safe medication practices, based on current regulations.

POLICY

The ARG Pharmacy Department shall provide monthly pharmacist conducted drug regimen reviews for each long-term-care resident. Recommendations from such reviews shall be forwarded to the attending physician and the facility Director of Nursing or designee. {17.C.3}

PROCEDURE

- Reviews will be conducted to ensure that each resident receives a monthly review.
- The drug regimen review will include a review of the use of unnecessary drugs in accordance with the intent of the federal OBRA '87 guidelines. It will also include review of medication identified on the ARG/NLCC psychotropic drugs list in accordance with CMS regulations. {483.45(c)(3)}
    - Psychotropic drug is defined as any drug that affects brain activities associated with mental processes and behavior including but not limited to antipsychotics, antidepressants, anti-anxiety, and hypnotic drug classes. See list below for example medications/classes (not exhaustive list).
    - Residents receiving psychotropic drugs must receive gradual dosage reductions and behavioral interventions unless clinically contraindicated {483.45(e)(2)}

- The consultant pharmacist shall document the drug regimen review in a progress note with the pharmacist's signature. {17.C.3.a}
- The consultant pharmacist shall review the resident's health record to ensure timely Abnormal Involuntary Movement Scale (AIMS) assessments are performed.
- A *Consultant Pharmacist Drug Regimen Review Report* form, developed by the Director of Pharmacy, and which includes a section for pharmacist comments, physician response, and signatures of the Director of Nursing or designee, will be used to report the findings of the review for each resident, including but not limited to issues and irregularities of psychotropic medications. Drug regimen review report will be sent monthly (more frequently if needed) and shall be acted upon by the physician or nursing supervisors prior to the next monthly chart review. Urgent action items will be communicated to provider the day of discovery by pharmacist for prompt follow up. Pharmacist will follow up on previous drug regimen review reports at the due time of the next monthly report. {483.45(c)(5)}
- The report, complete with pharmacist comments and physician or nursing response, will be filed in the Resident's chart under the pharmacy tab.
- A summary of all reviews completed will be filed in the Pharmacist Consult Summary binder.

Psychotropic Drug List

MEDICATION	RATIONALE
Antidepressants (SSRIs, SNRIs, TCAs, MAOIs)	anticholinergic, sedating; Beers list
Antipsychotics (first and second generation)	Increased risk of cognitive decline with dementia; beers list
atomoxetine	Strattera - stimulant
Benzodiazepines	increased risk of cognitive impairment, delirium, falls, fractures; beers list
Benztropine	strong anticholinergic properties; beers list
Carbamazepine	mood stabilizer
Carisoprodol	anticholinergic effects, sedation; beers list
Clonidine	High risk of adverse CNS effects; beers list
Cyclobenzaprine	anticholinergic effects, sedation; beers list
Darifenacin	strong anticholinergic properties; beers list
Dicyclomine	anticholinergic; Beers list
Diphenhydramine	anticholinergic; Beers list
Divalproex	mood stabilizer can cause dizziness
gabapentin	side effects - excessive drowsiness
guanfacine	side effects - excessive drowsiness/dizziness
H2- receptor antagonists	contraindicated in delirium as can produce delirium; beers list
Hydroxyzine	anticholinergic; Beers list
Meclizine	Anticholinergic; Beers list
Meperidine	higher risk of neurotoxicity including delirium than other opioids; beers list

Resident Name	GDR Due	Medication Order	AIMS Score	Indication	Order Date	Last GDR	Dose Modification History	Pharmacy Note	Psychotropic IDT Meeting Notes	Recommendation

Attachment #8

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205018	A. BUILDING _____ B. WING _____	09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AROOSTOOK HEALTH CENTER	15 HIGHLAND AVE MARS HILL, ME 04758

(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
F 758	Continued From page 7 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758	Corrective action for those residents who may have been affected by the deficient practice received an updated AIMS assessment on 9/27/23. The facility has initiated a review of all residents on psychotropic medications to assure that other residents are not affected by the deficient practice. To ensure the deficient practice will not recur, the consulting pharmacy has initiated AIMS assessment review on all residents who receive psychotropic medications during their medication reviews. The policy for Drug Regimen Review has been updated to include AIMS assessment review to be performed in accordance with regulation to assure any irregularities are noted and this report is passed on to the attending physician through pharmacy consult sheets, the facility Medical Director, Director of Nursing or Designee. Our facility policy has been updated to reflect the requirements of the AIMS assessment. (See attachment #9) The facility will monitor its corrective action with each gradual dose reduction quarterly meeting that supports the documentation of AIMS assessment being completed timely. The correction will be complete by November 5, 2023.	11/5/2023

Attachment #9

Northern Light A.R. Gould Hospital

Title: NLCC AIMS Testing	formal committee approval set 10/11/23
Policy/Procedure #: N/A	**Date Posted:**
Initial Effective Date: 10/9/23	Date Last Revised: new
Author: Kelly Lundeen, RN – Interim Director of Nursing: Northern Light Continuing Care – Mars Hill	
Leadership Sponsor: Administration: Northern Light Continuing Care	Final Approver: VP Nursing & Patient Care Services

SCOPE
All NLCC Clinical Staff

RELATED POLICIES/PROCEDURES
None

DEFINITIONS
It is the policy of this facility that all residents receiving antipsychotic drugs shall be monitored for extrapyramidal symptoms.

PURPOSE
The AIMS test is used not only to detect tardive dyskinesia but also to follow the severity of a patient's TD over time. It is a valuable tool for clinicians who are monitoring the effects of long-term treatment with neuroleptic medications.

POLICY/PROCEDURE

1. All residents admitted to this facility with orders for antipsychotic medications shall receive an AIMS test (abnormal involuntary movement scale test) within 7 days of admission.

2. All residents receiving initial orders of antipsychotic medications while in the facility shall receive an AIMS test within 7 days of the initial order.

3. All residents receiving antipsychotic medications shall receive AIMS test at least every 6 months while receiving these drugs.

4. All AIMS tests shall be conducted by the charge nurse or their designee. The assessment located in Point Click Care is named: AIMS-ABNORMAL INVOLUNTARY MOVEMENT SCALE.

5. Any significant change in ratings shall be identified and reported to the physician.

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F 758	Continued From page 8 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS), used to monitor for potentially irreversible side effects of anti-psychotic medications, was completed every 6 months for 1 of 5 sampled residents reviewed for unnecessary medications (Resident [R] 5). Finding: On 9/20/23, R5's clinical record was reviewed and it was noted that the resident was on an anti-psychotic medication, Olanzapine, with the last increase 9/26/20. R5's current care plan contained an intervention that was last revised on 8/27/19, to complete AIMS testing per facility policy. The last AIMS test completed for R5 was done on 12/28/19. On 9/20/23 at 11:16 a.m., during an interview with a surveyor, the Minimum Data Set (MDS) Lead stated that there is no policy for the AIMS testing but that it should be done every 3 to 6 months. The surveyor confirmed that the AIMS test was not completed for R5.	F 758		
F 811 SS=E	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that	F 811		

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F 811	Continued From page 9 meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure paid feeding assistants are assisting only those residents without complicated feeding problems and who have been selected as eligible to receive these services from a paid feeding assistant for 2 of 3 breakfast meal observations (9/19/23 and 9/20/23). Finding: During entrance conference on the evening of 9/18/23 that was completed with the	F 811	Corrective action for those residents found to have the deficient practice were identified and an updated list of those residents who are appropriate to be fed by a feeding assistant has been posted for all clinical staff. The Supervisor, Director of Nursing or Designee will identify residents who are appropriate to be fed by the feeding assistants and provide this information on the daily duty list. To ensure the deficient practice will not recur, the Supervisor, Director of Nursing or Designee will provide a competency to staff on scope of practice for feeding assistants and supervising clinical staff. This competency will be provided to current staff and in orientation on all new hires. (See attachment #10) The Clinical Supervisor, Director of Nursing or Designee will monitor the corrective action plan through visual auditing of ten opportunities per week. They will provide real time feed back to the feeding assistants. These results will be shared with the quarterly QAPI meeting. (See attachment #3 & #11) The correction will be complete by November 5, 2023.	11/5/2023

Attachment #10

Feeding Assistant Education and Competency

- Feeding assistants help provide nutrition and hydration support to residents who may be at risk for unplanned weight loss and dehydration.
- Feeding assistants may assist residents with no complicated problems associated with eating or drinking, who cannot or do not eat independently due to physical or cognitive disabilities, or those who simply need curing or encouragement to eat.
- Feeding assistants will supplement certified nurse aides, not substitute for nurse aides or licensed nursing staff.
- All trained feeding assistants shall work under the supervision of a registered nurse or licensed practical nurse, and they must call the supervisory nurse in case of emergency.
- The nurse must be located close enough to the resident that he or she can promptly respond but does not need to be in constant visual contact or physically present for adequate supervision, especially if the feeding assistant is assisting a resident to eat in his or her room.
- While the facility is still responsible for ensuring the safety and care of all residents, this does not apply to family members or to volunteers.
- Any staff member who has successfully completed a State approved training program for paid feeding assistants.

QUIZ

T or F Feeding Assistants can feed anyone in the facility.

T or F Feeding Assistants can feed residents in their rooms.

T or F Feeding Assistants must complete a State approved training program before they can feed residents in our facility.

T or F Feeding Assistants will have an updated list of residents who do not have complicated problems associated with eating or drinking.

T or F I understand my role as a Feeding Assistant in this facility.

Attachment #3

Personal Hygiene/ ADL Compliance Observation Tool

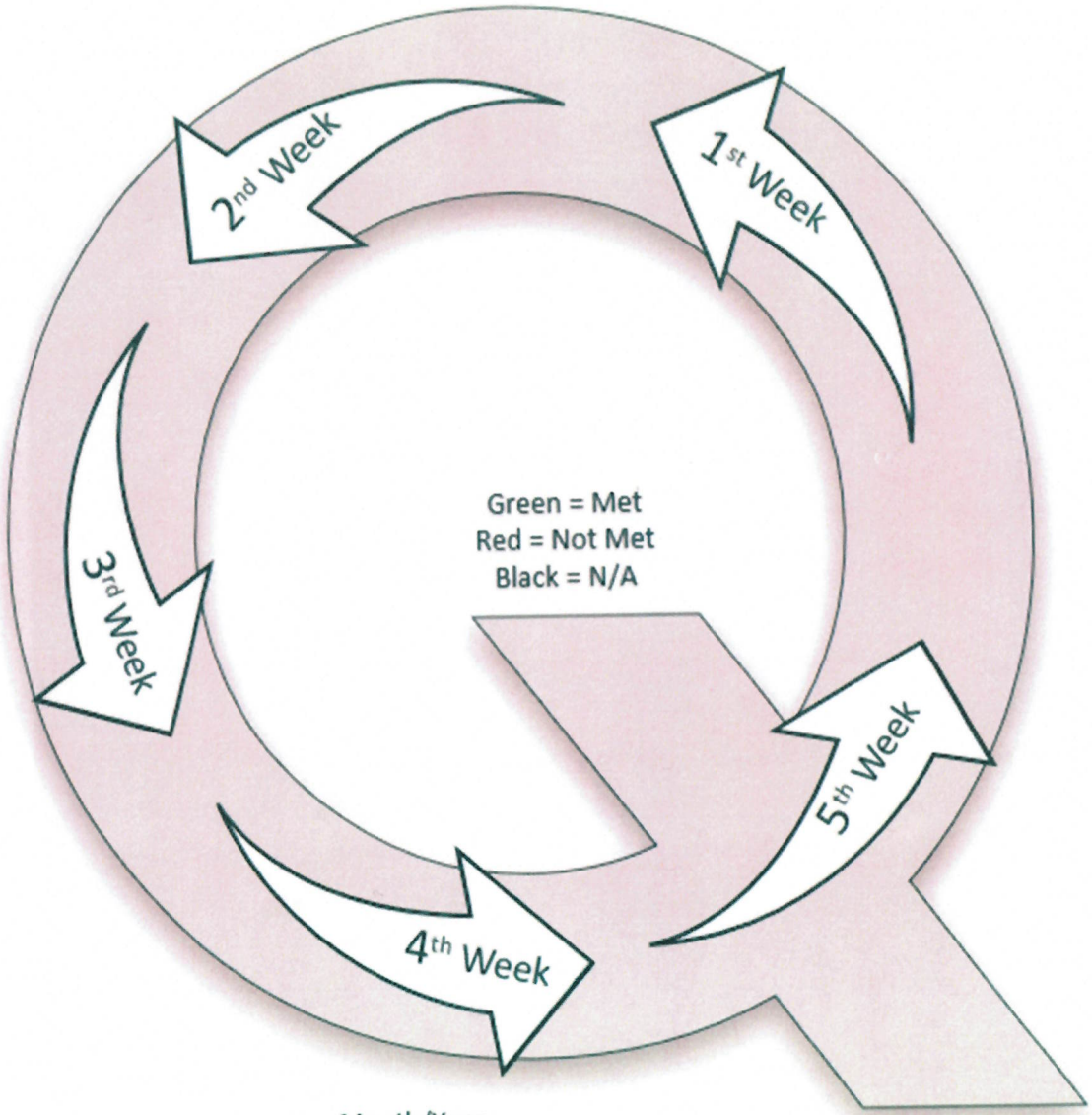
Auditor Name: _____ Date of audits: October 2023

	WEEK 1			WEEK 2			WEEK 3			WEEK 4		
ADLs:	Yes	No	Comments	Yes	No	Comments	Yes	No	Comments	Yes	No	Comments
Mouthcare												
Feeding assistant: Compliant Practice												

Attachment #11

Quality Goal

Northern Light
A.R. Gould Hospital



Department/Location

NURSING

Month/Year

October 2023

Goal Statement

Feeding Assistants must work under the supervision and presence of licensed staff.

Feeding Assistants will only assist residents who have no complicated feeding problems.

The feeding assistants will know what residents are appropriate for dining assistance based on an list provided by nursing for them to feed.

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F 811	Continued From page 10 Administrator/Director of Nursing, a surveyor requested information on paid Feeding Assistants (FA) and a list of residents the FA could assist. On 9/19/23, this information was provided by the Administrator and reviewed by a surveyor. The surveyor also reviewed Resident (R) #23's clinical record which included diagnoses of Dysphagia, unspecified and Dysphagia following Cerebral Infarction (stroke) and observed that R23 had a Dysphagia (difficulty swallowing) evaluation completed 6/1/23 due to worsening symptoms. On 9/19/23 at approximately 8:50 a.m., a surveyor observed a staff member assisting R23 with eating while in the resident's room. On 9/19/23 at 9:40 a.m., during an interview with a surveyor, Certified Nursing Assistant (CNA) #2 stated that Activities Specialist (AS) fed R23 breakfast this morning. The surveyor reviewed the feeding assistant list and list of residents that could be assisted by a feeding assistant and discovered that AS was qualified as a FA but R23 was not qualified to be assisted by a FA due to a swallowing condition. On 9/20/23 at 8:45 a.m., a surveyor observed R23 in bed in his/her room, with AS assisting R23 with eating. The meal tray was in front of FA. During an interview with a surveyor, AS stated that R23 asked for assistance today and yesterday also so she was helping him/her. On 9/20/23 at 8:57 a.m., during an interview with a surveyor, the Administrator that residents were added to the feeding assistant list per discussion. The surveyor explained the two observations of R23 being assisted by AS. The Administrator stated that AS should not be feeding R23.	F 811		

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