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	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aroostook Health Center	15 Highland Ave Mars Hill, ME 04758

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35904 Based on observation and interviews, a facility staff failed to speak to residents in a manner that maintains and promotes each resident's dignity and respect for 1 of 3 days of survey (10/15/24). Findings: On 10/15/24 at 2:00 p.m., a surveyor observed Certified Nursing Assistant #1 (CNA1) having a back-and-forth argument with Resident #1 (R1) during Bingo. CNA1 then turned her head away from R1 and continued to call Bingo letters/numbers to the residents playing Bingo while ignoring R1 while he/she was attempting to talk to CNA1. Another resident asked a question of CNA1, and CNA1 said, have some patience please [R15]. CNA1 was observed by a surveyor to be irritated and was speaking in a sharp voice to R15. On 10/15/24 at 2:18 p.m. in an interview with the Director of Nursing, a surveyor confirmed that R1 and R15 were not spoken to in a dignified manner when CNA1 argued with R1, ignored R1, and spoke sharply to R15.

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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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 32540 Based on record review and interview, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR), including a current diagnosis, and was updated for 1 of 1 resident reviewed (Resident #29 [R29]). Finding: On 10/15/24, during review of R29's clinical record, contained a PASRR Level I Screen dated 4/25/24 has a letter attached that he/she does not have a reason for a level II assessment. The PASRR Level I Screen in the diagnosis section did not include a current diagnosis of Post Traumatic Stress Disorder (PTSD). R29's current diagnosis list included a diagnosis of PTSD. The resident record lacked evidence that the PASRR Level I Screen was updated and resubmitted to include his/her diagnosis of PTSD and was not forwarded to the State-designated authority to determine if a Level II assessment was needed. On 10/16/24 at 2:45 p.m., during an interview with the Director of Nursing, a review of R29's PASRR was done and a surveyor confirmed that his/her diagnosis of PTSD was not included on the PASRR for a level II determination.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 33242 Based on record review and interviews, the facility failed to update a care plan to reflect a resident's current needs for 1 of 2 residents reviewed for falls (Resident #19 [R19]). Findings: 1. On 10/15/24, R19's clinical record was reviewed. R19's current care plan last revised on 10/9/24, included a problem area of osteoporosis that was developed on 3/4/24, with an intervention Resident/Family/Caregiver teaching - Fall Prevention: Hold railing when using stairs. If unsteady on feet, use cane, walker, or have someone help you walk. Keep away from icy streets, sidewalks, wet/ waxed floors. Keep inside well lit at night. Remove things that could make you trip i.e. loose rugs or electrical cords. Wear low-heeled soft-soled shoes. Wear padded hip protectors to prevent hip fractures. On 10/16/24 at 12:05 p.m., during an interview with a surveyor, Certified Nursing Assistant # 1 stated that R19 does not wear hip protectors. On 10/16/24 at 12:39 p.m., during an interview with a surveyor, Clinical Supervisor (CS) stated that R19 does not wear hip protectors. CS and the surveyor reviewed R19's care plan at this time for the interventions listed for fall prevention under this topic and the surveyor confirmed that R19's care plan for this intervention was not updated to reflect the resident's current needs.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35904 Based on record review and interview, the facility failed to assess a residents current diagnosis of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 1 of 2 sampled resident's reviewed with a current diagnosis of PTSD (Resident #16 [R16]). Finding: R16 was admitted to the facility on [DATE] to include a diagnosis of PTSD. On 10/17/24, a review of R16's clinical record, in the Minimum Data Set (MDS) 3.0, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate R16 has an active diagnosis for PTSD. The surveyor was unable to find information in the clinical record that indicates what R16's PTSD was caused by, what trigger(s) might cause re-traumatization, and measures to avoid trigger(s) that might cause re-traumatization. On 10/17/24 at 11:13 a.m., in an interview with a surveyor, the Clinical Supervisor stated she did not find a care plan (goal and trauma interventions) for PTSD other than it being mentioned as one of the problems under focus in the care plan. The Clinical Supervisor confirmed that R16 did not have a Trauma Assessment completed to address R16's PTSD. On 10/18/24 at 3:48 p.m., in a follow-up electronic mail communication, a surveyor reviewed R16's Clinical Admission - V17 - initial admission form that lists AS_15. Screening 1. Trauma Informed Care. The screening does not indicate what R16's PTSD was caused by, what trigger(s) might cause re-traumatization, and measures to avoid trigger(s) that might cause re-traumatization.

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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. 35904 Based on observations and interviews, the facility failed to ensure opened insulin and opened/activated inhaler was labeled with an open date in 1 of 3 medication/treatment carts (South wing). Findings: On 10/15/24 at 10:26 a.m., a surveyor and a Licensed Practical Nurse (LPN) observed an opened Basaglar Kwik Pen (Lantus, insulin) for Resident #6 [R6] that was in the South wing medication cart that did not have an open or discard date (Lantus is good for 28 days once opened and at room temperature). On 10/15/24 at 10:30 a.m., a surveyor and LPN observed an opened Spiriva Respimat inhaler for R32 that was in the South wing medication cart that did not have an open or discard date (Spiriva Respimat inhaler, is good for 3 months after first use or when the locking mechanism is engaged, whichever comes first). On 10/15/24 at 10:54 a.m. , in an interview with LPN, a surveyor confirmed that the Basaglar Kwik Pen Lantus and the Spiriva Respimat inhaler were not labeled with an open or discard date. On 10/15/24 at 10:55 a.m., in an interview with the Clinical Supervisor, a surveyor confirmed that medications were not labeled with an open or discard date, and the Clinical Supervisor stated that the Basaglar Kwik Pen Lantus and the Spiriva Respimat inhaler should have been labeled with an open date and discard date to ensure use according to manufacturer's directions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32540 Based on observations and interviews, the facility failed to ensure that the kitchen equipment/dishware were stored in a sanitary manner by having mixing bowls and a colander wet stacked for 1 of 3 days of survey ([DATE]) and they failed to ensure that the correct 3 step process to manually wash, rinse and sanitize dishware was done correctly by failing to have sufficient concentration of the sanitizing solution in their 3 bay sink used to manually wash their dishware for 2 of 3 days of survey ([DATE] and [DATE]). In addition the facility failed to ensure that food was removed from use by the expiration date for 1 of 3 days ([DATE]). Findings: On [DATE] at 9:15 a.m., during the initial tour of the kitchen, a surveyor observed water drops dripping from a mixing bowl. Upon further observation it was observed by the surveyor and the Kitchen Lead that 4-mixing bowls and a colander were wet stacked on the shelf above the food preparation area. This finding was confirmed by the surveyor with the Kitchen Lead at the time of the observation. On [DATE] at 10:00 a.m. an observation of a dietary staff manually washing dishware in the 3 bay sink area was made. The surveyor asked if they could test the sanitizing section, and the dietary staff redirected the request to the Kitchen Lead. There was a poster on the wall directing staff how to complete the test and what the sanitizing level should be. The instructions direct staff to hold the test strip in the sanitizing section for 10 seconds and directed them to compare the color of the strip to the chart on the test strip bottle. The correct range should be 272 and turn the test strip into a teal color. When the Kitchen Lead person removed the test strip from the sanitizer the strip color was not teal but a light blue indicating the sanitizer was not at the correct concentration, the light blue indicated the level was at 170 and not the desired 272. The Kitchen Lead explained that the sanitizer comes from an automatic dispenser and Eco Lab manages that system. The facility called Eco Lab to have them come evaluate the system. In the meantime, the Kitchen Lead stated they will use their high temp ware washer to clean and sanitize all dishware. The logbook for the 3 Bay Sink was reviewed, all days were marked as ok, and the test strips were tapped on the pages. All strips were not in the correct levels all showing a light blue at 170 PPM. The test strips being used expired since February 2023. On [DATE] at 2:15 p.m., The Eco Lab manager arrived, the surveyor, the Food Service Supervisor and the Kitchen Lead entered the kitchen. The sanitizing sink was filled and tested with a new bottle of test strips. The test was done 3 times by the Eco Lab manager, all were not at the correct levels. The Eco Lab manager stated that putting the test strips in the binder would fade over time to the wrong color. Eco lab manager found the automatic dispenser had the wrong pump being used and the aspirator had a crack causing the inaccurate sanitizer levels being dispensed. The parts were replaced and the correct sanitizer levels were dispensed. On [DATE] at 2:45 p.m. 2 surveyors confirmed all kitchen findings with the Food Service Supervisor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	35904 On [DATE] at 10:52 a.m., during an observation of 1 of 3 medication carts (South Unit), a surveyor observed, on the medication cart, 1 open/covered container of chocolate pudding with a date written on the lid of [DATE]. The LPN states she is not sure how long the pudding is good for and a few residents, including R41 received the chocolate pudding with his/her medications this morning. In an interview with the LPN at this time, a surveyor confirmed that the chocolate pudding was given beyond the expiration date. On [DATE] at 10:30 a.m., in an interview with a surveyor, the Food Service Supervisor stated pudding made for use with medications are good for 5 days, and the date made is on the container. The chocolate pudding was given 3 days beyond expiration 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on observation, record reviews and interviews, the facility failed to ensure a resident's right to formulate an advanced directive regarding code status (cardiopulmonary resuscitation [CPR]) was accurate in the electronic record for (Resident #26 [R26] and [R295]) Findings: 1. On [DATE] at 1:40 p.m., a surveyor observed R26's medical chart read DNAR [Do Not Attempt Resuscitation]/Full Treatment on the spine. The record contained 2 POLST forms. Both POLST forms have the word Void written across the front and back. Review of R26's electronic medical record indicated a code status of DNAR /Full treatment (Do not provide CPR). The record also indicated Special Instructions: . FULL CODE (Provide CPR). On [DATE] at 1:45 p.m., in an interview with a surveyor, the Registered Nurse (RN2) stated the code status of DNAR/Full Treatment means the resident would accept antibiotics and intravenous fluids but not CPR. On [DATE] at 1:48 p.m., in an interview with the surveyor, the Clinical Supervisor stated the code status was unclear and would need to be clarified with the provider. At this time the surveyor confirmed R26's clinical record contained two different directions for code status. 32540 2. On [DATE] at 2:22 p.m., review of R295's electronic record revealed a physician order indicated R295 was a Full Code. Review of R295's electronic chart revealed an Advanced Directive form signed by R295 prior to admission on [DATE] indicating that his/her wish is to not be kept alive and does not want treatment to be kept alive. On [DATE] at 11:50 a.m., during an interview, the Clinical Supervisor and a surveyor reviewed Resident # 295's advanced directives and the signed physician orders for full code status. The surveyor confirmed that the Code status on his/her signed physician orders do not match R295's Advanced Directives.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 33242 Based on observations, record review, and interview the facility failed to ensure that the Water Management Plan was fully developed/implemented to prevent the growth and spread of legionella and other water-borne pathogens, and failed to maintain an Infection Control Program designed to prevent the development and transmission of disease and infection related to urinary catheter drainage bags for 2 of 3 residents reviewed with a foley catheter (Resident #38[R38], and [R4]). Findings: 1. On 10/16/24, the surveyor was provided with the facility's new Water Management Plan,, dated 9/19/23, for Northern Light Health Continuing Care. The surveyor reviewed this plan and requested documentation that indicated what areas were to be monitored where potential Legionella bacteria could grow, how the areas were monitored, and last time the facility had the water tested . On 10/17/24, the surveyor was provided with an updated Water Management Plan, dated 9/18/24, for Northern Light Health Continuing Care which included photographs of areas that were to be monitored where potential Legionella bacteria could grow. The Water Management Plan (WMP) indicated the following under Overview: Processes - The procedures (control measures) are outlined in the Control Measures section. The person responsible for verifying the implementation of the control measures are also listed in that section; and Risk Assessment and Management Strategy directed the facility to assess risk by identifying and describing all water systems on the property and that present a significant risk of Legionella growth and transmission, establish control locations (determine points and processing steps at which control measures can and should be applied (see Risk Assessment per Hazard Analysis). The facility should implement control measures to check for, minimize, and/or mitigate conditions favorable for growth or transmission of Legionella and listed for each control measure are a monitoring procedure, control limit, and corrective action (see control measures). The facility should verify implementation - control measures must be documented and the documentation must be reviewed on a schedule to verify implementation and to validate effectiveness of the WMP. The WMP indicated the following under Confirmation (Verification and Validation): Verification - For this water management plan to be most effective in preventing disease, it must be fully implemented. The persons responsible for verifying implementation of control measures, and the verification frequency, are listed within each control measure; and Validation - The effectiveness of the WMP will be validated by routinely testing certain building water systems by a laboratory and to test domestic water systems and other drinking water for Legionella at least four times yearly initially and then more frequently if indicated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The policy included a Risk Assessment Per Hazard Analysis which identified areas that should be a control location and reasoning but what control measure was needed was not identified. The policy did not have a Control Measures section which identified the monitoring procedure, control limit, and corrective action. The facility had no written documentation of areas checked to ensure control measures were within normal limits or evidence that the program was reviewed to verify and validate effectiveness of the program. The last time the facility had the water tested for Legionella was June 2023. On 10/18/24 at 11:38 a.m., the facility provided information that the last completed water test submitted by the facility for a Legionella test was resulted on 6/19/23. The facility discovered that the contract had been canceled and a new contract was made on yesterday (10/17/24). At 11:51 a.m., the Administrator stated that Nursing Home Maintenance has been doing a daily temperature check in different areas, and he does a daily running/flushing of water to make sure the S traps fresh have water in them, but there is no documentation. 49635 2. Review of the Prevention of Catheter-associated Urinary Tract Infections Policy revised on 9/27/24, states Purpose To outline the minimum standards of care based on evidenced-based methods to prevent Catheter Associated Urinary Tract Infections (CAUTI), under the Techniques for [indwelling urinary catheter] maintenance it states, urine collection containers shall not be allowed to rest on the floor or a grossly contaminated surface. On 10/15/24 at 9:10 a.m., a surveyor observed R38's urinary catheter drainage bag resting on floor. On 10/16/24 at 11:38 a.m., a surveyor observed R38's urinary catheter drainage bag resting on floor. On 10/17/24 at 10:52 a.m., during an interview with the Director of Nursing and the Administrator, a surveyor confirmed R38's urinary catheter drainage bag was not maintained in a manner that would prevent catheter associated urinary tract infections. 32540 On 10/17/24 at 11:00 a.m., a surveyor observed R4's urinary catheter drainage bag resting on the floor. On 10/17/24 at 11:10 a.m. a surveyor confirmed with the charge nurse RN1. R4's catheter drainage bag was not covered and on the floor.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on facility policy review, record reviews, and interview, the facility failed to notify the physician when residents were eligbile to receive the PCV20 (a vaccine that protects against Pneumococcal bacteria) and ensure residents were offered Pneumococcal vaccinations upon admission, annually, or in accordance with the Centers for Disease and Prevention Control (CDC) recommendations, for 3 of 5 residents reviewed for immunizations (Resident #19 [R19], R33, and R14). Findings: The facility's policy, Immunization Screening for Pneumococcal, Influenza and/or COVID-19 Vaccination for Adult Patients, last revised 5/2/2023, indicated: Under the section: Screening for Influenza and Pneumococcal Immunization - Long Term Care patients will be screened upon admission and annually thereafter. Under the section: Criteria for Eligibility, Pneumococcal Vaccine - Centers for Disease Control (CDC) criteria, the policy indicated that Northern Light Health offers PCV20 when either PCV15 or PCV20 is indicated and shared clinical decision-making will be utilized when indicated per provider discretion and that the timing of the vaccination is based on the person's Pneumococcal vaccine history, medical history and age. CDC guidance using the PneumoRecs VaxAdvisor website or application is recommended to determine this timing and the type of vaccine the person should receive. 1. On 10/15/24, R19's clinical record was reviewed and indicated that R19 was admitted to the facility on [DATE] and R19's last Pneumococcal vaccine was documented as received in 2015. The PneumoRecs VaxAdmisor website indicated that based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last Pneumococcal vaccine dose. 2. On 10/15/24, R33's clinical record was reviewed and indicated that R33 was admitted to the facility on [DATE] and R33's last Pneumococcal vaccine was documented as received in 2016. The PneumoRecs VaxAdmisor website indicated that based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last Pneumococcal vaccine dose. 3. On 10/15/24, R14's clinical record was reviewed and indicated that R14 was admitted to the facility on [DATE]. The PneumoRecs VaxAdmisor website indicated to give one dose of PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23 (Pneumococcal vaccine) which was documented as given on 5/22/2014. On 10/17/24 at 10:54 a.m., during an interview with a surveyor, the Director of Nursing (DON) stated that there is no shared evidence to indicate the provider was notified that R19 and R33 could receive the vaccine, to determine whether to offer it. The DON also stated that for R14, the consent for the vaccine was just sent to family last month and not at the time of admission.