STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0161	A. BUILDING: _____ B. WING _____	C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK RESIDENTIAL CARE	**158 RUSSELL ST LEWISTON, ME 04240**

(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) COMPLETE DATE
R 000	Initial Comments On 6/21/23, an onsite visit was completed at Russell Park Residential Care, for the purpose of conducting complaint investigation #ME00043971. It was determined that Russell Park Residential Care is not in substantial compliance with 10/144, Chapter 113-Regulations Governing the Licensing and Functioning of Assistive Housing Programs-Level IV, Private Non-Medical Institutions.	R 000		
R 299	7.1.1 Medications and Treatments Residents shall receive only the medications ordered by his/her duly authorized licensed practitioner in the correct dose, at the correct time, and by the correct route of administration consistent with pharmaceutical standards. [Classes I/II/III] This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that a resident received the correct medications ordered by the licensed practitioner for 1 of 1 residents reviewed (#1). Findings: A review of the facility's Incident Report, dated 6/19/23, stated that on 6/16/23, "Resident was given the meds that were for another resident. Resident #1 was given Acetaminophen (also known as Tylenol, for pain), Pravastatin (to treat high cholesterol), Clonazepam (to treat anxiety), Keflex (an antibiotic), and Clozapine (an antipsychotic)." The report indicated the physician was notified on 6/16/23 at 10:30 p.m. A review of the facility's policy, "6.0 General Dose Preparation and Medication Administration,	R 299		

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R 299	Continued From page 1	R 299		

Section 4.1, Facility staff should: (Section 4.1.1) Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident." And, Section 5. "During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: (Section 5.1) Identify the resident per facility policy."

A review of Resident #1's clinical record revealed diagnoses that included: dementia, chronic pain, hypertension, GERD (gastroesophageal reflux disease), and depression. Medications ordered by the provider included: Sertraline (an antidepressant), Atenolol (an antihypertensive), Omeprazole (to treat GERD), Lisinopril (an antihypertensive), Gabapentin (an anticonvulsant to treat pain), Amlodipine (an antihypertensive), and Tramadol (an opioid to treat pain).

A Review of Resident #1's medication administration record (MAR) revealed on the evening of 6/16/23, Resident #1 received his/her prescribed medications which included: Amlodipine, Tramadol, and Gabapentin.

A review of the Roommate's MAR revealed on the evening of 6/16/23, the medications given to Resident #1 were Pravastatin, Keflex, Clonazepam, Gabapentin, and Clozapine.

Resident #1's progress notes revealed an entry, dated 6/17/23 at 11:08 a.m., which stated "Resident was a little disoriented this morning when given her morning meds, which is not abnormal for this individual. Resident went back to sleep. This writer was in the office doing med orders and other CRMA (certified residential

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R 299	Continued From page 2	R 299		

medication aide) stated resident was not waking up and was having a hard time talking and was foaming at the mouth." Staff reported to the charge nurse on the nursing unit who instructed to call 911. Resident #1 was then transported by ambulance to the Emergency Department.

A review of Resident #1's MAR indicated on the morning of 6/17/23, Resident #1 received his/her prescribed medications, which included: Sertraline, Atenolol, Omeprazole, Lisinopril and Gabapentin.

A review of Emergency Department records, History and Physical, dated 6/17/23, stated under "Plan: Acute encephalopathy: Most likely secondary to polypharmacy from accidental overmedication."

A review of the Hospital Discharge Summary, dated 6/20/23, stated Resident #1 "was admitted with acute toxic encephalopathy following accidental poisoning with the medications that were address(ed) to his/her roommate." And, "However, following this event, he/she is debilitated beyond his/her baseline and is discharged to skilled nursing facility with the plans to return to previous residence."

On 6/21/23 at 9:50 a.m., the incident was discussed with and confirmed by the Director of Nursing.

On 6/21/23 at 12:40 p.m., in a telephone interview with the surveyor, the long-term care charge nurse, on duty on the evening of 6/16/23, confirmed he/she had been notified by staff that Resident #1 had received another resident's medications. The nurse stated he/she assessed Resident #1 and notified the physician, who

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R 299	Continued From page 3 advised to monitor Resident #1. On 6/21/23 at 12:44 p.m., in a telephone interview with the surveyor, the staff on duty on the evening of 6/16/23, confirmed he/she had administered the incorrect medications to Resident #1 and had failed to properly identify the resident prior to administering the medications.	R 299		