

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

PRINTED: 02/27/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205052		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2024	
NAME OF PROVIDER OR SUPPLIER RUSSELL PARK REHABILITATION & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 695 SS=E	On 2/13/24 an unannounced on site visit was conducted at Russell Park Rehabilitation & Living Center to investigate complaint ME00046293. It was determined that Russell Park Rehabilitation & Living Center is not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities. Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure that resident care policies and procedures for respiratory care and services, are developed, according to professional standards of practice, for a resident requiring specific types of respiratory care and services in the area of oxygen and nebulizer treatments for 3 of 3 wings reviewed for respiratory. (Wing A, Wing B and Wing C) Findings: The facilities policy and procedure, Oxygen use & Storage Policy, revised 7/22 states, section V. Respiratory care. "A sanitary environment must be maintained to prevent the transmission of			F 695			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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

PRINTED: 02/27/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2024
NAME OF PROVIDER OR SUPPLIER RUSSELL PARK REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE	
F 695	Continued From page 1 disease and infection" with nursing instructions to: "Nebulizer parts should be rinsed after each use and discarded every week." On 2/13/24 from 8:26 a.m., through 9:35 a.m., 2 surveyors observed the following: - Room [REDACTED] had a nebulizer tubing and connected mouth piece stored on a recliner seat underneath a Hoyer pad and a wheelchair leg rest. - Room [REDACTED] had an Oxygen concentrator with a filter that was coated with layer of dust. - Room [REDACTED] had an Oxygen concentrator with the nasal cannula tubing wrapped up and stored underneath the handle. - Room [REDACTED] had an Oxygen concentrator with a filter that was coated with layer of dust and an Oxygen cylinder with the nasal cannula tubing wrapped up and stored over the cylinder. - Room [REDACTED] had an Oxygen concentrator with a filter that was coated with layer of dust. On 2/13/24 at 10:32 a.m., two surveyors, the Administrator and the Quality Improvement Specialists observed the above concerns. On 2/13/24 at 3:00 p.m., during an interview with the Director of Nursing and the Quality Improvement Specialists, the surveyors discussed the facilities current Oxygen policy which lacked instructions on how to prevent the transmission of disease and infection related to Oxygen filter maintenance and storage of nasal cannulas and nebulizer mask/mouth piece when not in use. At approx. 4:10 p.m., in an additional interview, with the Administrator, Director of Nursing and the Quality Improvement Specialists, the Administrator stated she is currently updating the	F 695			

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

PRINTED: 02/27/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2024
NAME OF PROVIDER OR SUPPLIER RUSSELL PARK REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE
F 695	Continued From page 2	F 695			
F 880 SS=E	Oxygen policy for filter maintenance and storage of nasal cannula and nebulizer mask/mouth piece when not in use. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880			

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

PRINTED: 02/27/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2024
NAME OF PROVIDER OR SUPPLIER RUSSELL PARK REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE
F 880	Continued From page 3 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection, on 2 of 3 wings (Wing B and Wing C) for 1 of 1 day of survey (2/13/24).	F 880			

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

PRINTED: 02/27/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2024
NAME OF PROVIDER OR SUPPLIER RUSSELL PARK REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE
F 880	Continued From page 4 Findings: On 2/13/24 from 8:26 a.m. through 9:35 a.m., 2 surveyors observed the following: - Room [REDACTED] had 2 wedge pillows stored the floor, one behind the Oxygen concentrator and the other beside the bed. - Room [REDACTED] shared bathroom had a bed pan stored on the floor next to the toilet. - Room [REDACTED] shared bathroom had a urinal with yellow substance on the bottom, stored on the floor next to the toilet. - Room [REDACTED] had commode bucket stored on the floor under the sink. On 2/13/24 at 10:32 a.m., two surveyors, the Administrator, and the Quality Improvement Specialists (QIS) observed the above concerns. At this time, both Administrator and the QIS confirmed the above observations did not support good infection control practice.	F 880			