Department of Health and Human Services

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 12/18/2024

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
P 000	Initial Comments On 12/18/24, an unannounced visit was made at Russell Park Rehabilitation & Living Center, Residential Care, for the purpose of complaint investigation ME00049882. It was determined that Russell Park Rehabilitation & Living Center, 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.	P 000		
P 317	7.1.6 Medications and Treatments For those residents for whom the facility is responsible for assistance with medication administration, no medications, including those brought into the facility by the resident, family or friends, shall be administered or discontinued without a written order signed by a duly authorized licensed practitioner or other person licensed to prescribe medications. [Class III] This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the clinical record contained a valid, written order, signed by an authorized practitioner, for administration of a psychotropic medication for 1 of 1 residents reviewed. Finding: A review of the clinical record for Resident #1 noted the medication administration record (MAR) with the following entry: Sertraline (an antidepressant), 50 mg, (milligrams), every morning starting 8/21/24. The original date was noted 8/6/24, for a diagnosis of Paranoid Schizophrenia. The surveyor was unable to	P 317	see attached plan of correction 1/13/25	

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P 317	Continued From page 1 locate a signed practitioner's order for the medication in the clinical record. On 12/18/24 at approximately 12:20 pm, during an interview with the Administrator and the Director of Nursing, the surveyor discussed the finding. At this time, the Administrator confirmed the clinical record lacked a valid signed practitioner's order.	P 317		
P 326	7.2.4.1 Medications and Treatments PRN Psychotropic medications. Psychotropic medications ordered "as needed" by the duly authorized licensed practitioner, shall not be administered unless the duly authorized licensed practitioner has provided detailed behavior-specific written instructions, including symptoms that might require use of medication, exact dosage, exact time frames between dosages and the maximum dosage to be given in a twenty-four (24) hour period. Facility staff shall notify the duly authorized licensed practitioner within twenty-four (24) hours when such a medication has been administered, unless otherwise instructed in writing by the duly authorized licensed practitioner. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident receiving an as needed psychotropic medication had a valid order, signed by an authorized licensed practitioner, which included the detailed requirements under the regulation, for 1 of 1 residents reviewed. Finding:	P 326	See attached plan of correction 1/13/25	

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P 326	Continued From page 2 A review of the clinical record for Resident #1 noted the medication administration record (MAR) with the following entry: Haldol (an antipsychotic) 5 mg (milligrams) 1 tab by mouth as needed (PRN) every 6 hours (starting 9/18/24), for a diagnosis of Paranoid Schizophrenia. Further review of the clinical record failed to locate the signed practitioner's order for this medication. On 12/18/24 at approximately 12:20 pm, during an interview with the Administrator and the Director of Nursing, the surveyor discussed that a PRN antipsychotic order also requires the practitioner to include specific instructions for the symptoms that might require use of the medication, exact time frames between doses, and maximum dosing in a 24 hour period. At this time, the Administrator confirmed the clinical record lacked a signed practitioner's order which included the necessary instructions.	P 326	See attached plan of correction	1/13/25 JR

RUSSELL PARK REHABILITATION & LIVING CENTER
RESIDENTIAL CARE COMPLAINT INVESTIGATION
PLAN OF CORRECTION
January 6, 2025

P317 7.1.6 Medications and Treatments

1. A copy of the practitioner's signed order for Sertraline 50 mg every morning starting 8/21/24 was located, and placed in the clinical record of Resident #1.
2. Other residents have the potential to be affected by signed practitioner's order not being located in the clinical record. There were no other allegations or findings of this nature observed.
3. Education will be provided to CRMA staff prior to 1/10/2025 regarding following proper procedure for maintaining written orders of a duly authorized licensed practitioner in the clinical record as defined in 7.1.6.
4. Routine audits will be conducted by the Team Leader, or designee, for the next 3 months. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated
   Completion Date: 01/13/25

P326 7.2.4.1 Medications and Treatments

1. A copy of the practitioner's original signed order for Haldol 5 mg po every 6 hours PRN: agitation/aggressive behaviors was located, and placed in the clinical record of Resident #1. The order contained specific instructions for the symptoms that might require the use of the medication but did not include specific instructions on exact time frames between doses, maximum dosing in a 24 hour period, and a statement regarding notification of the practitioner within 24 hours. This resident no longer resides on the residential care unit.
2. Other residents have the potential to be affected by a signed practitioner's order not being located in the clinical record. There were no other allegations or findings of this nature observed.
3. Education will be provided to CRMA staff prior to 1/10/2025. This education will cover following proper procedure for maintaining written orders by a duly authorized licensed practitioner in the clinical record and ensuring a PRN antipsychotic order includes specific instructions for the symptoms that might require use of the medication, exact time frames between doses, the maximum dosing in a 24 hour period, and whether the duly authorized licensed practitioner wants to be notified within 24 hours as defined in 7.2.4.1.
5. Routine audits will be conducted by the Team Leader, or designee, for the next 3 months. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated
   Completion Date: 01/13/25

Tammela Barnes, Administrator 1/7/2025