STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	**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 From March 11, 2024 to March 14, 2024, on-site visits were conducted at Russell Park Rehabilitation and Living Center for the purpose of completion of the annual Long Term Care Survey Process for Federal Recertification, and complaint investigations #ME00043116, #ME00043885, #ME00043994, #ME00045176, #ME00045717, and #ME00046155. It was determined that Russell Park Rehabilitation and Living Center is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on interview, record review and the facility's bathing documentation, the facility failed to ensure that resident's preferences were being followed in the area of bathing for 1 of 1 residents reviewed for bathing. (Resident #148) Findings: On 6/9/23 at 1:15 p.m., the state agency received a complaint that Resident #148 was not receiving a bath for an extended period of time after admission. A review of the admission record for Resident #148 showed an admission to the facility on 3/7/23 and discharge on 3/31/23.	F 558		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 558	Continued From page 1 On 3/13/24 at 11:30 a.m., in an interview with the Director of Nursing (DON), she stated that the facility gives residents a shower/tub bath once a week. On 3/13/24 at 12:20 p.m., a surveyor and the DON reviewed the facility's bathing documentation for Resident #148. Resident #148 received one shower on 3/24/23. At this time, in an interview, the Director of Nursing stated that the facility had no other bathing documentation and confirmed that Resident #148 had only one shower during his/her stay at the facility from 3/7/23 through 3/31/23.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 578	Continued From page 2	F 578		

facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a resident's right to formulate an advance directive regarding cardiopulmonary resuscitation (code status) was accurate in the clinical record for 1 of 19 sampled residents reviewed for advanced directives (Resident #7).

Findings:

1. On 3/11/24, Resident #7's electronic medical record (EMR) and paper records were reviewed by the surveyor for cardiopulmonary resuscitation (code status). Resident #7's records show he/she was admitted to the facility on 12/13/23. Both the EMR and paper records(face sheet) lacked the code status for the resident.

On 3/11/24 at 1:35 p.m., in an interview, Licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 578	Continued From page 3 Practical Nurse (LPN #1) confirmed that Resident #7's electronic medical record and face sheet did not contain the current code status for the resident.	F 578		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 582	Continued From page 4	F 582		

facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure the Notice of Medicare Provider Non-Coverage (NOMNC) form was provided at least two days prior to the end of Skilled services for 2 of 3 residents whose Medicare Part A Skilled services were discontinued (Residents #302, 303).

Findings:

1. On 10/6/23, Resident #302 was admitted from a hospital to receive skilled services. On 11/3/23, Resident #302 was discharged to the community with benefit days remaining. The medical record lacked evidence that Resident #302 or his/her legal representative received a NOMNC.

2. On 9/11/23, Resident #303 was admitted from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 582	Continued From page 5 a hospital to received skilled services. On 10/13/23, Resident #303 was discharged to the assisted living unit within the facility with benefit days remaining. The medical record lacked evidence that Resident #303 or his/her legal representative received a NOMNC. On 3/13/24 at 2:58 p.m., the Director of Nursing stated to 3 surveyors that the facility did not have the beneficiary notices as requested for Residents #302 and #303.	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	**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 584	Continued From page 6 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable interior for the 2 of 3 units (A unit and B unit) and hallways for 4 of 4 facility tours (3/11/24, 3/12/24, 3/13/24 and 3/14/24). Findings: On 3/11/24, 3/12/24, and 3/13/24, a surveyor made the following observations throughtout the facility and on 3/14/24 from 9:20 a.m. to 9:40 a.m., an environmental tour was conducted with a Maintenance worker and the Administrator in which the following findings were observed. Hallways: > The ceiling vent in the hallway by the administration offices, was heavily soiled with dust/dirt. > The ceiling vent in the A Unit hallway by	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 584	Continued From page 7	F 584		

resident Room #16, was heavily soiled with dust/dirt.
> The wall mounted air conditioning unit on the B Unit was dusty/dirty and the cover was held on with tape.

A Unit
> Resident Room #1 - The standing fan was heavily soiled with dust. The walls had chipped/missing paint and were marred with black marks creating uncleanable surfaces. The privacy curtains were missing hooks and hanging down and in disrepair.
> Resident Room #2 - The privacy curtains were missing hooks and hanging down and in disrepair.
> Resident Room #3 - The privacy curtains were missing hooks and hanging down and in disrepair.
> Resident Room #4 - The standing fan was dusty/dirty. The privacy curtains were missing hooks and hanging down and in disrepair. The edges of the floor were dirty with trash and debris. The base board heater had chipped/missing paint and was rusty creating an uncleanable surface.
> Resident Room #11 - The privacy curtains were missing hooks and hanging down and in disrepair.
> Resident Room #12 - The privacy curtains were missing hooks and hanging down and in disrepair.
> Resident Room #17 - The nightstand for Resident #6 had worn finish along the front and side edges creating uncleanable surfaces.

B Unit
> Resident Room #B1- The cove base in the bathroom was coming away from wall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 584	Continued From page 8 On 3/14/24 at 9:40 a.m., in an interview, the Maintenance Worker and the Administrator confirmed the findings.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and clinical record review, the facility neglected to identify and complete an assessment of a change in condition for 1 of 3 residents reviewed for neglect (#298). Findings: On 3/8/24 at 5:06 p.m., in a telephone interview with a surveyor, a complainant stated that on 8/24/23, two family members found Resident #298 in his/her room talking to him/herself and acting "delirious." The complainant stated concerns were brought to the attention of the nurse who stated staff were waiting for the doctor to visit the next day. The complainant stated the	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 600	Continued From page 9	F 600		

nurse was told the family wanted Resident #298 sent to the hospital.

The complainant stated he/she spoke with another nurse at the facility later in the evening. The second nurse stated the doctor would be in the next day to see Resident #298. The complainant stated he/she voiced concerns that Resident #298 was septic. Within the hour, the second nurse called the complainant and stated Resident #298 was being sent to the hospital.

A review of the clinical record for Resident #298 revealed diagnoses including multiple sclerosis, diabetes, and a previous stroke. Record review lacked any evidence of nursing assessments completed in response to the resident's change in condition. One progress note, dated 8/25/23, stated Resident #298 was sent to the emergency room for a change in condition, and he/she "was admitted to the ICU (intensive care unit) for sepsis and shock." The only other documentation found from 8/24/23, was a telephone order from a nurse practitioner, for a chest xray and urinalysis and culture.

A review of the hospital's discharge summary, dated 9/4/23, stated Resident #298 was admitted to the hospital on 8/24/23, and was diagnosed with hypotension, acute respiratory failure with hypoxia, urinary tract infection, sepsis with acute hypoxic respiratory failure and septic shock.

On 3/12/24 at 10:40 a.m., in an interview with a surveyor, the Director of Nursing and the Quality Improvement Specialist confirmed Resident #298's record lacked documentation of the nurse's assessment or interventions taken in response to the change in condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 656	Continued From page 11 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interview, the facility failed to implement a care plan in the area of grooming for 1 of 1 resident reviewed for Dental. (Resident#30) Finding: Review of Resident #30's care plan, initiated 6/7/23, last revised 12/18/23 for Grooming has an nursing intervention of, "[Resident #30] will brush his/her teeth, wash his/her face and comb his/her hair daily to maintain current level of function." On 3/11/24 at 12:48 p.m. and on 3/12/24 at 8:30 a.m., and 1:01 p.m., Resident #30's teeth were observed to be coated with a thick yellow substance at gum line. On 3/11/24 at 1:05 p.m., the surveyor and the Quality Improvement Specialists (QIS) observed resident #30's teeth coated with a thick yellow substance confirming mouth care/brushing teeth has not been completed.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 657	Continued From page 12 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed update a care plan with interventions for the problem area of safety for 1 of 2 residents reviewed for falls (Resident #22). In addition, the failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative after each assessment (Resident #41, # Resident #46). Findings:	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 657	Continued From page 13	F 657		

The facilities Falls Management Policy, revised 7/19 states under Procedure: "A fall incident report will be completed after a resident has had a fall, whether it is witnessed or not. Residents' care plan will be updated with all new interventions."

1. On 3/12/24, a surveyor reviewed Resident #22's medical record which stated he/she had fallen twice on 2/25/24, one fall at approximtely 6:00 a.m., and the second fall at approximately at1:00 p.m. The medical record lacked evidence of a fall incident report being completed for the 6:00 a.m. fall. Secondly, Resident #22 had additional falls on 2/27/24 and 3/10/24. As of 3/12/24 Resident #22 care plan had not been revised and/or updated with interventions related to his/her multiple falls. A "High risk for injury from falls r/t history of falls" care plan was initiated on 3/13/24. The Director of Nursing and Quality Improvement Specialists confirmed this finding during an interview on 3/13/24 at 11:11 a.m.

2. Review of Resident #41's medical record, the surveyor noted Minimum Data Set (MDS) Annual Comprehensive assessment, dated 10/18/23 was completed. The medical record lacked evidence that a care plan meeting had been held by the IDT for the 10/18/23 assessment. This was confirmed during an interview with the Licensed Social Worker (LSW) on 3/12/24 at 3:43 p.m.

3. Review of Resident #46's medical record, the surveyor noted MDS Quarterly Review assessment, dated 9/29/23 was completed. The medical record lacked evidence that a care plan meeting had been held by the IDT for the 9/29/23 assessment. This was confirmed during an interview with the Socail Worker on 3/14/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 657	Continued From page 14 8:31 a.m.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interviews and clinical record review, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay, a final summary of the resident's status, and	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 661	Continued From page 15 reconciliation of all the resident's pre- and post-discharge medications for 1 of 1 residents reviewed for discharge to the community (Resident #9). Finding: On review of Resident #9's clinical record, a surveyor noted an admission date of 12/19/23 to the skilled unit. On 2/29/24, Resident #9 was discharged back to his/her bed in the residential care unit. The surveyor located an incomplete recapitulation of stay in the clinical record dated 2/29/24. On 3/13/24 at 4:15 p.m., in an interview with a surveyor, the Director of Nursing and the Quality Improvement Specialist confirmed the recapitulation of stay was not completed and did not include the necessary information required at the time of the Resident #9's discharge.	F 661		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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, observations, and interview the facility failed to ensure weights were	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 684	Continued From page 16	F 684		

obtained and monitored as per the facilities policy for 3 of 7 residents reviewed for weights (Resident #7, #15, #30). In addition, the facility failed to ensure mouth care was provided daily for 1 of 1 resident reviewed for dental (Resident #30), and failed to monitor pain for 1 of 1 resident reviewed for hospice services (Resident #35).

Findings:

1. On 3/12/24, Resident #7's clinical record was reviewed by a surveyor. Weights documented by staff showed the following:
12/20/23 - 101.40 pounds(lbs.)
12/27/23 - 114.20 lbs. (a 12.8 lbs. weight gain)
1/29/24 - 90.00 lbs. (a 24.2 lbs. weight loss)
2/6/24 - 93.40 lbs. (a 3.40 lbs. weight gain)
3/6/24 - 85.40 lbs. (an 8 lbs. weight loss)

2. On 3/12/24, Resident #15's clinical record was reviewed by a surveyor. Weights documented by staff showed the following:
5/19/23 - 172.40 pounds (lbs.)
6/2/23 - 163.40 lbs. (a 9 lbs. weight loss)
6/9/23 - 167.30 lbs. (a 3.9 lbs. weight gain)
11/1/23 - 164.40 lbs.
12/14/23 - 159.20 lbs. (a 5.2 lbs. weight loss)
1/29/24 - 166.40 lbs. (a 7.2 lbs. weight gain)
2/6/24 - 165.30 lbs.
3/6/24 - 156.60 lbs. (an 8.7 lbs. weight loss)

3. On 3/12/24, Resident #30's clinical record was reviewed by a surveyor. Weights documented by staff showed the following:
2/6/24 - 195 pounds (lbs.)
3/6/24 - 209 lbs.

Facilities Policy, "A weight that indicates a variance of +/-3 lbs. from the last obtained weight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 684	Continued From page 17	F 684		

will necessitate a re-weight of the resident. The original and second weight should be obtained on the same shift and documented."

On 3/12/24 at 1:39 p.m., in an interview, the Director of Nursing(DON) and the Quality Improvement Specialist had reviewed the residents weights with a surveyor and confirmed that reweights were not completed and that the weights for Residents #7, #15 and #30 were not being recorded correctly and reported to the charge nurse when it happened as per following the policy for the residents for significant weight loss and weight gain.

4. On 3/11/24 at 12:48 p.m., and on 3/12/24 at 8:30 a.m. and 1:01 p.m., Resident #30's teeth were observed to be coated with a thick yellow substance at gum line.

Review of quarterly Minimum Data Set (MDS) dated 12/11/23 indicates Resident #30 had a Brief Interview for Mental Status (BIMS) of 3 of 15 indicating severe impairment.

Review of the Electronic medical record (EMR) lacks evidence of mouth care being provided.

On 3/12/24 at 12:48 p.m., during an interview CNA #1 sated, Resident #30 Is "not able to do anything him/herself other than using the urinal, he/she feeds him/herself." The surveyor asked if Resident #30 is able to perform his/her own personal hygiene, of brushing teeth. CNA #1 stated, "No". At this time, CNA #1 showed surveyor the CNA documentation for personal hygiene, which did not specify the care provided, only the level of assistance provided. CNA#1 confirmed the documentation does not aske

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 684	Continued From page 18	F 684		

CNA's if brushing of teeth was completed.

On 3/12/24 at 12:52 p.m., during an interview, CNA #2 stated, Resident #30 has been declining and is not able to brush his/her own teeth. The surveyor asked if Resident #30 refuses mouth care. CNA #2 stated, "he/she normally doesn't refuse".

On 3/12/24 at 12:58 p.m., during an interview, CNA #3 stated, "Resident #30 doesn't do any care of his/her own care, he/she just giggles." The surveyor asked specifically if he/she can brush his/her own teeth. CNA #3 stated, "no". The surveyor asked if resident he/she refuses mouth care. CNA #3 stated, "no".

On 3/11/24 at 1:05 p.m., the surveyor and the Quality Improvement Specialists (QIS) observed Resident #30's teeth coated with a thick yellow substance confirming mouth care/brushing teeth has not been completed. During this time, a brief interview with Resident #30 was conducted with the QIS present. Resident #30 was asked if he/she is able to brush his/her own teeth and if staff brush his/her teeth, resident answered "no" to both questions.

5. A review of the facility's Pain Management Policy, revised 6/23, stated: "II. Procedure, B. Screening for presence of pain: 1. Daily on every shift, during routine medication passes for residents on scheduled pain medications. 2. Screening will be done using a verbal or non-verbal pain scale; 3. Outcome of daily screening will be recorded on Medication Administration Record (MAR).

A review of Resident #35's clinical record noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 684	Continued From page 19 diagnoses including cerebrovascular accident with right sided weakness, difficulty speaking and swallowing, and severe protein calorie malnutrition. The Admission Minimum Data Set (MDS) 3.0, dated 2/14/24, noted Resident #35 received scheduled medication for pain and hospice services. The comprehensive care plan, dated 2/21/24, included the following interventions under Hospice: Assess location, quality and intensity of pain. Administer pain medication as prescribed. Monitor and document effectiveness of regimen and update as needed. Current physician orders for Resident #35 include acetaminophen 325 mg (milligrams) two tablets orally 3 times daily. A review of Resident #35's MAR and TAR (Treatment Administration Record) lacked evidence of screening for pain, or follow-up of medication effectiveness. On 3/13/24 at 12:00 p.m., in an interview with a surveyor, the Director of Nursing and the Quality Improvement Specialist confirmed there was no evidence of pain assessment in Resident #35's record, and that that a pain scale should be included on the MAR/TAR for residents receiving scheduled pain medication.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	**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 686	Continued From page 20	F 686		

demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review, and interviews, the facility failed to follow its own policy for completing pressure ulcer wound assessment documentation for 2 of 2 residents reviewed with pressure ulcers (Resident #2 and Resident #5).

Findings:

On 3/13/24 at 11:00 a.m. a surveyor reviewed the facility policy titled: Skin Management Program Policy, last reviewed 8/2023, which stated "Daily documentation of:
a. the site
b. dressing status and/or surrounding skin areas if the site is covered
c. weekly wound measurements by a registered nurse."

On 03/13/24 at 10:09 AM a surveyor reviewed the Electronic Medical Record (EMR) for Resident #5 and located the following wound care orders: Wound #3 - Change dressing twice a day beginning 2/29/24 for 30 days. Wound #4 -change dressing every shift and as needed. A surveyor reviewed the wound assessment documentation in the EMR for Resident #5 and found only one entry documenting the condition of the wound since 2/29/24.

On 3/13/24 at 10:18 a.m., a surveyor reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 686	Continued From page 21 the EMR for Resident #2 and located a wound care order, dated 2/4/2024, that stated "change dressing two times a day". A surveyor reviewed the nursing wound documentation in the EMR and was unable to find twice daily wound documentation for any day following the 2/4/2024 order. On 3/13/24 at 10:45 a.m., a surveyor interviewed the Director of Nursing about the missing wound documentation and confirmed wound documentation wasn't being done. On 3/13/24 at 10:50 a.m.. a surveyor interviewed the Quality Improvement Specialist and learned that the expectation was "the wound condition should be documented every day, even if they are just noting the dressing is clean-dry-intact." On 3/13/24 at 11:30 a.m., a surveyor brought the above findings to the attention of the Administrator.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that the resident's environment was free of accident hazards relating to a patient	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 689	Continued From page 22 lift for 1 of 1 facility tours, for 1 of 4 days of survey. (3/11/24) Findings: On 3/11/24 at 9:45 a.m., a surveyor observed a Hoyer HPL500 patient lift on the A Unit that was missing 1 of 4 springs on the sling bar safety clips that would prevent the sling strap from potentially coming off during a lift/transfer. On 3/11/24 at 9:50 a.m., in an interview, Registered Nurse #2 confirmed the patient lift was missing 1 of 4 springs on the sling bar safety clips and it was an accident hazard. On 3/11/24 at 9:55 a.m., in an interview, the Quality Improvement Specialist confirmed the patient lift was missing 1 of 4 springs on the sling bar safety clips and it was an accident hazard. The patient lift was immediately removed from the floor.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 761	Continued From page 23	F 761		

temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations and interviews, facility failed to adequately date and properly dispose of open medications according to manufacturer specifications and failed to ensure expired medications were removed from the supply available for use in 2 of 2 medications rooms and 2 of 2 medications carts observed. (A wing and B/C wing carts)

Findings:

1. On 3/11/24 at 9:57 a.m., observation of the medication room with the Licensed Practical Nurse (LPN) #1, the surveyor noted a bottle of Tuberculin Purified Protein unlabeled without an opened date with manufactures instructions, "once entered vial should be discarded after 30 days".

2. On 3/12/24 at 8:58 a.m., observation of A wing medication cart with Certified Medication Technician (CNA-M) #1 the following was observed: one opened bottle of milk of magnesium with expiration date of 2/24, an opened bottle of nasal moisturizing spray not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 761	Continued From page 24 labeled with the resident's name of whom it belonged. At this time, a review of the medication storage containing over the counter medications revealed 2 additional bottles of milk of magnesium with the expiration date of 2/24. 3. On 3/12/24 at 9:04 a.m., observation of B/C wing medication cart with CNA-M #2 the following was observed: one opened bottle of Bisacodyl 5 milligram (mg) tabs with expiration date of 2/24, one opened bottle of Vitamin B-6 50mg with expiration date of 2/24 and one opened bottle of Geri Dryl allergy relief 25mg with expiration date of 2/24. On 3/12/24 at 1:11 p.m., During an interview with the Quality Improvement Specialists, the above was discussed.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 812	Continued From page 25	F 812		

serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and the facility's Daily Cleaning Schedule, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner, failed to ensure dishes were stored in a sanitary manner, failed to ensure foods were dated and labeled for 2 of 2 kitchen tours on 2 of 4 days of survey (3/11/24 and 3/12/24), and failed to remove dented cans from use for 1 of 2 days observed (3/11/24). This has the potential to affect all residents.

Findings:

Review of the facilities Daily Cleaning Schedule states, "Dish room floor/Walls" and "Air Conditioning Units" should be cleaned daily.

1. On 3/11/24 at 9:20 a.m., during initial tour of the kitchen two surveyors observed:

- The dry storage area contained two dented #10 cans of pumpkin, a large plastic bin 1/3 full and label as "quick oats" with no date and a bag of pasta wrapped in plastic wrap undated.

- The kitchen contained a shelving unit with a tray of bowls stored upright, an air conditioner above the prep sink coated with dust on top, two light fixtures with fluorescent light bulbs with no protection, multiple stained/dirty ceiling tiles and the countertop mixer arm had chipped and missing paint.

- The dish room contained an air conditioner unit coated with dust on top, one light fixture with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 812	Continued From page 26 fluorescent light bulbs with no protected, the on/off food disposal box with chipped and missing paint, the grease trap box/cover with chipped/missing paint and areas of rust, the top right corner of the wall had visible black/brown spotted growth extending approx. 4 feet down. On 3/12/24 at 3:39 p.m., two surveyors discussed the kitchen observations and concerns with the Administrator, Director of Nursing, Quality Improvement Specialists, and the Food Service Director (FSD). 2. On 3/12/24 at 8:15 a.m., during an additional tour of the kitchen two surveyors and the FSD observed, confirming the following: - The kitchen entrance ceiling vent was coated with thick dust with areas of hanging dust. At this time the FSD stated he had noticed it yesterday. The shelving unit still had a tray of bowls stored upright, now there was only one loaf of bread and the bag with bagel with no date or label, the top right corner of the wall still has black/brown spotted growth extending approx. 4 feet down. At this time, the FSD stated he had painted it but it must have come through, and "I'm assuming it's black mold" as he tried to rub it off. - Dry storage room still contained the large bin of quick oats without a date.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 842	Continued From page 27	F 842		

resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 842	Continued From page 28	F 842		

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure that the clinical records contained accurate documentation for 2 of 8 residents reviewed for Activities of Daily Living (ADLs) (#5 and #148).

Findings:

1. On 6/9/23 at 1:15 p.m., the state agency received a complaint which included a concern of lack of care for an extended period of time after admission for a Resident #148.

On 3/13/24 at 11:30 a.m., a review of the clinical record for Resident #148 showed an admission to the facility on 3/7/23 and discharge on 3/31/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 842	Continued From page 29	F 842		

The surveyor could not locate documentation for ADL care from 3/7/23 to 3/22/23.

On 3/13/24 at 12:20 p.m., in an interview, the Director of Nursing(DON) and the Quality Improvement Specialist reviewed Resident #148's clinical record with a surveyor and confirmed that Resident #148's clinical records contained no documentation for ADLs from 3/7/23 to 3/22/23.

2. On 3/12/24 at 10:55 a.m.. a surveyor observed the treatment nurse for the entirety of the wound care for Resident #5. Measuring of the wound was not performed. A surveyor asked the treatment nurse when wounds are typically measured in the facility and the treatment nurse responded, the wound care center does that.

On 3/13/24, a surveyor reviewed the Electronic Medical Record for Resident #5 and reviewed the documentation for the wound care observed on 3/12/24. Wound measurements were noted in the documentation dated 3/12/24 at 2:38 p.m. by the treatment nurse, but wound measuring was not observed during the wound care provided on 3/12/24.

On 3/13/24 at 10:30 a.m., surveyor interviewed the treatment nurse and confirmed that the wound documentation being reviewed was from the wound care observed on 3/12/24 for Resident #5. A surveyor asked the treatment nurse how those measurements were determined when the surveyor didn't observe the wound being measured. The treatment nurse said "I thought I measured. I'll fix it."

On 3/13/24 at 10:55 a.m., a surveyor brought the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	**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 842	Continued From page 30 above findings to the attention of the Administrator.	F 842		
F 880 SS=E	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 reported;	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 31 (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 maintain an Infection Control Program designed to help prevent cross contamination and/or development of infection by maintaining a safe and sanitary environment related to linen handling for 2 of 4 days of survey (3/11/24 and 3/13/24) on 1 of 3 units (A Unit), and for catheter	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 32	F 880		

care for 1 of 1 residents observed with an indwelling urinary catheter (#7).

Findings:

1. On 3/11/24 at 10:00 a.m., a surveyor observed laundry worker #1 delivering clean laundry on an uncovered cart to resident rooms on the A Unit. At this time, laundry worker #1 confirmed she was delivering clean laundry to resident rooms and stated she did not know clean laundry had to be covered when delivered.

2. On 3/11/24 at 10:50 a.m., a surveyor observed on A Unit CNA #5 carrying an large ball of visibly soiled linen, unbagged, against his body down the hallway to the spa room where the soiled linen hamper was. The surveyor discussed the finding with CNA #5 and he denied the ball of visibly soiled unbagged linen was soiled and that he was carrying it in his arms and against his body.

On 3/11/24 at 11:24 a.m.,, in an interview, the surveyor discussed the finding with the Director of Nursing and the Quality Improvement Specialist.

3. On 3/13/24 at 10:00 a.m., a surveyor observed laundry worker #2 transporting ripped open bags of soiled linens in an uncovered cart. Laundry worker #2 confirmed the finding at this time.

On 3/13/24 at 10:05 a.m., in an interview, the surveyor discussed the finding with the Director of Nursing and the Quality Improvement Specialist.

4. On 3/11/24 at 10:40 a.m., a surveyor observed Resident #7 seated in a wheelchair with other residents in a common area. The tubing from Resident #7's urinary catheter was observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 33 draining cloudy, brown-colored urine with sediment, and the tubing was dragging on the floor. The surveyor reported the observation to CNA #4, who stated "I don't know what I'm supposed to do about it." The surveyor explained this was not safe and the CNA removed the resident from the area to secure the catheter. On 3/11/24 at 10:55 a.m., the finding was discussed with the facility's Quality Improvement Specialist.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 883	Continued From page 34	F 883		

immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on immunization record review, review of the facility's immunization policy and interview, the facility failed to implement its own immunization policy for 2 of 5 residents whose immunization records were reviewed for influenza and pneumococcal vaccinations. (Resident #2 and Resident #248).

Finding:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 883	Continued From page 35 On 3/12/24 at 10:30 a.m. a surveyor reviewed Resident #2's Electronic Medical Record (EMR) under Immunizations and found no record of Resident #2 receiving an influenza or pneumococcal vaccination. Resident #2 was admitted to the facility on 12/19/23. A Review of the Paper Medical Record found documentation that an influenza vaccination was given on 3/8/24. This was not documented in the EMR under Immunizations. No documentation was found that Resident #2 received educational materials for the influenza vaccination. No documentation was found of the pneumococcal vaccination being offered, or educational materials provided. On 3/12/24 at 10:40 a.m. a surveyor reviewed Resident #248's EMR under immunizations and found no record of an influenza or pneumococcal vaccination. Resident #248 was admitted to the facility on 2/22/24. A surveyor reviewed the paper medical record and was unable to locate any documentation that an Influenza or pneumococcal vaccination had been offered. A surveyor reviewed the Facility Policy Titled - Infection Control Immunizations - Influenza, Pneumococcal Policy, last revised 3/2022, which stated: "The resident's medical record will include the following documentation: A. Signature of the person receiving the educational material, designating receipt and understanding of the material. Verbal Consent may also be obtained if communication is done via a telephone conversation. B. Proof the resident either received the Influenza and/or Pneumococcal vaccine, the vaccines(s) was contraindicated for medical reasons, or the resident refused the vaccine(s).	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 883	Continued From page 36 "Each resident will be offered an Influenza Vaccine October 1 through March 31 annually unless the immunization is medically contraindicated, or the resident has already been immunized during this time period." "Each resident will be offered a Pneumococcal Vaccine, upon admission unless the immunization is medically contraindicated, or the resident has already been immunized. " On 3/12/24 at 11:40 a.m. a surveyor brought the above findings to the attention of the Administrator.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 887	Continued From page 37 additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on immunization record review, review of the facility's immunization policy and interview, the facility failed to implement its "Immunization Policy" for 1 of 5 residents whose immunization records were reviewed for COVID -19 vaccination	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205052	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSSELL PARK REHABILITATION & LIVING CENTER	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 887	Continued From page 38 (#248). Finding: During a review of sampled residents for Immunizations, the surveyor noted that Resident #248 had not received a COVID-19 vaccine. The medical record also lacked documentation of a refusal or education provided for the COVID-19 vaccination. Facility Policy Titled - COVID-19 (SARS-CoV-2) Vaccine Policy, dated 5/2/23, says: "It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications of COVID-19 by offering residents and employee(s) COVID-19 vaccines." And, "If a resident and/or resident representatives' does not consent to the vaccine, the facility will document a clinical note in the resident's medical record and include date, time, and the name of the individual they spoke with." On 3/12/24 at 11:40 a.m., the above finding was brought to the attention of the Administrator.	F 887		