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 ______	05/21/2025

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 5/19/25 through 5/21/25, on-site visits were conducted at Russell Park Rehabilitation & Living Center for the purpose of a Recertification Survey and investigating complaints #ME00047265, #ME00047760, #ME00048554, and #ME00050623. It was determined that Russell Park Rehabilitation & Living Center was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
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	See attached POC 6/2/25 [signature]	6/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Administrator
TITLE
(X6) DATE: 6/2/2025

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.

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F 584	Continued From page 1 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 maintain maintenance and housekeeping services necessary to maintain the facility in good repair and sanitary condition for 1 of 1 environmental tour (5/21/25). Findings: On 5/21/25 from 8:20 a.m. to 8:45 a.m., an Environmental Services tour was conducted with the Environmental Services Director and the Administrator, in which the following findings were observed: A Unit - Shower/Spa room - The caulking around the base of the toilet was stained and dirty. The four shower curtains were stained and/or ripped. The heater unit had chipped/missing paint and the entrance metal door and door frame had chipped/missing paint creating uncleanable surfaces.	F 584	See attached POC 6/2/25 JRMS	6/27/2025

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F 584	Continued From page 2 - Resident Room 3 - The privacy curtain was missing hooks, hanging down and in disrepair. - Resident Room 4 - The wall across from the sink had chipped/missing paint and was marred with black marks creating an uncleanable surface. There was a wash basin sitting on the floor under the sink. - Resident Room 6 - The caulking around the base of the toilet was stained and dirty. The flooring around the toilet was stained and discolored. - Resident Room 12 - The wall across from the sink had chipped/missing paint and was marred with black marks creating an uncleanable surface. - Resident Room 14 - The caulking around the base of the toilet was stained and dirty. - Resident Room 16 - The caulking around the base of the toilet was stained and dirty. The bathroom exhaust fan was dusty/dirty. - Resident room 17 - The room entrance wooden door had chipped/gouged and missing laminate. B Unit - Resident Room 2 - The caulking and floor around the base of the toilet was stained and dirty. There were two pieces of grey duct tape, approximately eight inches long, stuck onto the middle of the bathroom floor that had started peeling up creating uncleanable surfaces. - Resident Room 3 - The baseboard heater had metal parts that had separated and unhooked from brackets. The caulking around the base of the toilet was stained and dirty. - Resident Room 5 - Resident #17's electric wheelchair was dirty/dusty around the controller and the foot base area had food crumbs and debris in it. - Resident Room 7 - The caulking around the	F 584	See attached POC 6/12/25 JBMDA	6/27/2025

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F 584	Continued From page 3 base of the toilet was stained and dirty. C Unit - Resident Room 6 - The room entrance wooden door had chipped/gouged and missing laminate. On 5/21/25 at 8:45 a.m., during an interview, the Environmental Services Director and the Administrator confirmed the findings.	F 584		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is	F 605	See attached POC 6/12/25 JHMCA	6/27/25

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F 605	Continued From page 4 indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of documentation to justify the continued use of a psychotropic medication and failed to ensure an as needed (PRN) psychotropic medication met the required 14-day limit for 2 of 6 residents reviewed for unnecessary medications. (#33, #11) Finding: 1. A review of the clinical record revealed Resident #33 was admitted in September, 2024. On 12/9/25, the pharmacist consultant submitted the following recommendation to the physician: "(Resident #33) recently experienced a fall on 11/29. A review of the medical record was conducted, identifying the following medications which may contribute to falls: Risperidone, Lorazepam, Fluoxetine, Trazodone. Recommendation: Please evaluate these medications as possibly causing or contributing to this fall and consider decreasing the dose of one of these medications, possibly Risperidone. If this therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that the medication is not believed to be contributing to falls in this individual, and b) the facility interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences." The Physician's response, dated 12/17/24, was "Thank you. No change."	F 605	see attached POC 6/12/25 JLB MCA	6/27/2025

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F 605	Continued From page 5 On 5/20/25 at 3:50 p.m., in an interview with the Director of Nursing Services (DNS), the surveyor discussed the physician had not provided an adequate indication for continued use of the medications, specifically the antipsychotic Risperidone. At this time, the DNS took the consultant pharmacist's report back to discuss with the physician, and returned with the physician's response on the form: "Please review record, actively titrated for dementia, meds for safety/dignity." 2. Resident #11's medical record contained a provider order, dated 4/4/25, for Lorazepam 0.5 mg (milligram) tablet orally PRN every 4 hours for anxiety disorder, with no stop date. As of 5/20/25, the medical record lacked evidence of clinical rational to continue the medication longer than 14 days. On 5/20/25 at 3:45 p.m., the above was confirmed with the Director of Nursing Services.	F 605		6/27/2025
F 656 SS=E	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	F 656	See attached POC 6/12/25 JPMX	

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F 656	Continued From page 6 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 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 reviews and interviews, the facility failed to implement a resident's care plan in the area of indwelling urinary catheters for 2 of 2 residents reviewed. (Resident #150, #35)	F 656	See attached for 6/2/25 JRun	6/27/2025

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F 656	Continued From page 7 Findings: 1. A review of the clinical record revealed Resident #150 was admitted in May, 2024, and had diagnoses which included obstructive uropathy and neuromuscular dysfunction of the bladder. Resident #150 required an indwelling catheter for urinary elimination. A review of Resident #150's care plan included a problem area of Alteration in Elimination related to obstructive uropathy with urinary retention as evidenced by insertion of indwelling catheter. Interventions included "record amount, color and characteristics of urine," and "monitor output." 2. A review of the clinical record revealed Resident #35 was admitted in September, 2024, and had diagnoses which included neurogenic bladder and a history of urinary tract infections. Resident #35 required an indwelling catheter for urinary elimination. A review of Resident #35's care plan included a problem area of Alteration in Elimination related to neuropathic bladder with urinary retention and need for a foley catheter. Interventions included "record amount, color, and characteristics of urine. Document output each shift." A review of CNA (Certified Nurse Assistant) and Nurse Treatment Administration Record (TAR) documentation lacked evidence that staff consistently monitored and documented urinary output for either Resident #150 or #35. On 5/21/25 at 9:30 a.m., in an interview with a surveyor, the Administrator stated residents with indwelling catheters do not have urinary output	F 656	See attached for 6/12/25 JP 6/27/25	

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F 656	Continued From page 8 documented unless there is a physician's order. On 5/27/25 at 11:30 a.m., in a telephone interview with the Director of Nursing Services (DNS), a surveyor discussed that although there were no provider orders to monitor and record urinary output for Residents #150 and #35, their care plans indicated that staff would monitor and record the amount of urinary output. The DNS confirmed that this had not been done as written in the care plan.	F 656		
F 684 SS=D	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 clinical record review and interviews, the facility failed to follow physician orders for 1 of 25 residents reviewed. (Resident #41). Findings: Review of Resident #41's clinical record noted the following doctor's order dated 1/4/25 for Aspart insulin 100 unit/ml (milliliter), 7 units subcutaneously 3 times daily. A nursing progress note dated 3/19/25 at 6:35 p.m., stated, "nurse on duty completed 1600 hs	F 684	See attached POC 6/12/25 JLM	6/27/2025

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F 684	Continued From page 9	F 684		

(evening) blood glucose check upon resident arrival from dialysis. Nurse on duty informed charge nurse of the resident blood glucose level which was 91. Nurse on duty informed charged nurse that resident did have a sliding scale parameter for 1600. Nurse on duty stated she had already given resident insulin but was unable to verify the amount to the nurse on duty or the resident. Resident stated to nurse on duty that charge nurse had informed [him/her] that the wrong amount was given and was unable to specify the specific number that was administered to [him/her]. Charge nurse also informed the resident that she was going to administer [him/her] some orange juice and to report and s/s of any reactions the resident may feel regarding a reaction. Charge nurse did inform nurse on duty that she administered orange juice to resident and told the resident to report any s/s of adverse reactions. Resident asked nurse on duty how many units were administered to [him/her] in the abdomen. Nurse on duty was unable to provide an accurate answer. Nurse on duty informed NOC (night) charge nurse of the situation. Resident will continue to be monitored for any and all adverse reactions or responses. Safety precautions are in place and resident states [he/she] feels anxious at this present time and is requesting [his/her] blood glucose to be rechecked at this time. Resident states [he/she] is upset at the situation and informed nurse on duty that [he/she] did call [his/her] sister to inform her of the incident. Nurse on duty will recheck resident blood glucose at this time."

On 5/19/25 at 3:32 p.m., during an interview, the Director of Nursing Services (DNS) confirmed that the resident had an order for 7 units of Aspart

See attached POC 6/2/25

6/27/2025

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F 684	Continued From page 10 insulin but was given 12 units of Humalog insulin instead on 3/19/25 at 1600 and confirmed that the doctor's order was not followed.	F 684		
F 689 SS=E	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 observations, interviews, record reviews, and the smoking policy, the facility failed to ensure a smoking assessment of resident capabilities and deficits to determine resident safety was completed for 2 of 2 resident reviewed for smoking. (#302 and #22) Findings: 1. On 5/19/25 at 9:12 a.m., during an interview, Resident #302 stated he/she has been smoking cigarettes since admission, approx. 2 weeks and the facility has a smoking area outside that is fenced in. He/she confirmed that on several occasions a staff member, called a "helper" has gone out with him/her. On the bedside table was a pack of cigarettes with a lighter. Review of Resident #302's medical record lacked evidence of a smoking assessment upon admission or upon the facilities knowledge of him/her smoking and lacked a smoking contract.	F 689	See attached POC 6/12/25	6/27/2025

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F 689	Continued From page 11	F 689		

On 5/20/25 at 1:52 p.m., during an interview, the Director of Nursing Services (DNS) confirmed a smoking assessment was not completed upon admission or upon the facility knowledge of the resident smoking until 5/20/25.

2. On 5/19/25 at 8:58 a.m., during an interview with Resident #22, it was determined that he/she is a smoker. At this time a surveyor observed 3 boxes of cigarettes in his/her room. One in his/her shirt pocket and two on the windowsill.

On 5/19/25 at 9:00 a.m., during an interview, the Licensed Practical Nurse #1 (LPN) stated Resident #22 goes out alone to smoke.

Review of Resident #22 clinical record indicated that he/she was admitted in February of 2025, furthermore the record lacked evidence of a completed smoking assessment.

On 5/20/25 at 9:05 a.m., during an interview with the DNS, it was confirmed that a smoking assessment was never completed on Resident #22. The DNS then discussed that the smoking assessment is what triggers the decision if residents are able to keep their cigarettes and lighter at bedside or if they need to be in a secured place within the facility.

The facilities "Resident Smoking Policy" last revised on 8/22 states, "For Residents who wish to smoke, the Resident Smoking Assessment will be completed upon admission, or once they begin smoking, and then quarterly for the remainder of their stay. If assessed as safe to smoke independently, residents, who smoke, will be required to sign a smoking contract and to abide

See attached for
6/12/25 DRNs

6/27/2025

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F 689	Continued From page 12 by this policy at all times. Not all residents are permitted to have lighters for safety reasons. If a resident is deemed capable and safe to maintain a lighter, it should be with them, or appropriately secured and not shared with others."	F 689		
F 695 SS=E	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, record reviews, interviews and the facility policy, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 5 of 5 residents reviewed for respiratory care. (Residents #2, #29, #11, #40, and #302) Findings: 1. On 5/19/25 at 8:45 a.m., and on 5/20/25 at 9:00 a.m., Resident #2 was observed receiving oxygen at 3 Liters Per Minute (LPM) via nasal cannula. The tubing was dated 5/6/25. A review of the clinical record revealed a diagnosis of Acute and Chronic Respiratory Failure with Hypoxia and Congestive Heart Failure requiring use of oxygen supplementation. Physician orders, dated 3/25/25, included oxygen 1-3 Liters via nasal	F 695	See attached POC 6/12/25 JS 6/27/2025	

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	205052	A. BUILDING _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 13	F 695		

cannula to maintain oxygen saturation greater than 88% or more, and change the oxygen tubing one time weekly. Review of the Treatment Administration Record (TAR) for May of 2025 indicated the O2 nasal cannula tubing is changed weekly. Documentation on the TAR revealed staff last changed the oxygen tubing on 5/13/25.

2. On 5/19/25 at 9:30 a.m., and on 5/20/25 at 9:00 a.m., Resident #29 was observed receiving oxygen at 2.5 Liters Per Minute (LPM) via nasal cannula. The tubing was dated 5/6/25. A review of the clinical record revealed a diagnosis of Acute Respiratory Failure with Hypoxia requiring use of oxygen supplementation. Physician orders, dated 4/18/25, included oxygen 3 Liters via nasal cannula and change the oxygen tubing one time weekly. Review of the TAR for May of 2025 indicated the O2 nasal cannula tubing is changed weekly. Documentation on the TAR revealed staff last changed the oxygen tubing on 5/13/25.

On 5/20/25 at approximately 9:10 a.m., the findings were confirmed by the Charge Nurse, who stated the oxygen tubing is usually changed every 2 weeks.

On 5/20/25 at 9:30 a.m., the surveyor discussed the findings with the Director of Nursing Services (DNS).

3. On 5/19/25 at 8:29 a.m., and at 3:36 p.m., Resident #11 was observed receiving oxygen at 4 LPM via nasal cannula with the tubing dated 5/6/25. On the bedside dresser was a nebulizer pipe stored on top. A review of the clinical record revealed a diagnosis of COPD (chronic obstructive pulmonary disease), metastatic lung

See attached POC 6/12/25 JMA

6/27/2025

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F 695	Continued From page 14	F 695		

cancer and end stage emphysema requiring use of oxygen supplementation. Physician orders dated 4/2/25 included oxygen 3-4 Liters via nasal cannula and change the oxygen tubing one time weekly. The care plan initiated on 4/11/25 for Impaired Respiratory Status had an intervention of "Change oxygen tubing weekly; label and date". Review of the TAR for May 2025 indicated the oxygen nasal cannula tubing is changed weekly. Documentation on the TAR revealed staff last changed the oxygen tubing on 5/13/25.

4. On 5/19/25 at 11:23 a.m., observation of Resident #40's nebulizer mask with tubing, unlabeled and stored on the dresser. At this time, Resident #40 stated he/she has not used the nebulizer for probably 2 or more months when he/she had pneumonia. Further review, a Physician order for the nebulizer was discontinued on 1/16/25.

On 5/19/25 at 4:19 p.m., during an interview, the DNS stated oxygen tubing and Nebulizer kits are changed every 2 weeks per the policy, but some residents have orders for weekly changes. At this time both the DNS and the surveyor observed the above and discussed resident #11's oxygen tubing dated 5/6 with the documentation on the TAR as the tubing being changed on 5/13/25.

On 5/20/25 at 7:01 a.m., after the discussion with the DNS the day prior, the surveyor again observed resident #11 utilizing the oxygen tubing dated 5/6.

5. On 5/19/25 at 9:12 a.m., observation of Resident #302 to have an oxygen cylinder stored in the room with the nasal cannula tubing wrapped around the caddy handle. At this time,

All attached POC
6/12/25

6/27/2025

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F 695	Continued From page 15 Resident #302 stated he/she uses the oxygen tank while working with therapy. On 5/20/25 at 2:22 p.m., both the surveyor and the Quality Improvement Specialists observed Resident #302's nasal cannula tubing wrapped around the cylinder caddy handle. A review of the facility's "Oxygen Use and Storage Policy," with a revision date of 4/2025, stated under "Section V. Respiratory Care - a. Nasal cannulas will be discarded and changed every 2 weeks... When the nasal cannula is not in use, on both the concentrator and portable tanks, the cannula will be stored in a plastic bag to avoid the risk of it becoming contaminated. b. Nebulizer parts should be rinsed after each use, allowed to dry while being covered with a paper towel and placed in respiratory setup bag once dried. d. Staff changing the tubing should document on the Treatment Administration Record (TAR) when the tubing has been changed following this policy."	F 695		6/27/2025
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on the review of annual evaluations and interviews, the facility failed to complete an annual performance evaluation for Certified	F 730	See attached POC 6/12/25 gfh	

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F 730	Continued From page 16 Nursing Assistants (CNA) at least every 12 months, for 5 of 5 CNA's reviewed with employment greater than 1 year. (CNA#1, CNA#2, CNA#3, CNA#4, and CNA#5) Findings: 1. CNA #1 was hired on 11/28/2012. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 2. CNA #2 was hired on 4/28/2016. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 3. CNA #3 was hired on 11/6/2002. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 4. CNA #4 was hired on 4/26/21. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 5. CNA #5 was hired on 9/8/23. The employee record lacked evidence of an annual performance evaluation being completed for 2024. On 5/20/25 at 11:10 a.m., during an interview, the Director of Nursing Services stated and confirmed that the 5 CNAs did not receive their annual performance evaluations for 2024.	F 730	See attached POC 6/12/25	6/27/2025
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		

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F 755	Continued From page 17	F 755		

them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations and interviews the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and failed to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for multiple

See attached POC
6/12/25 JHA

6/27/2025

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F 755	Continued From page 18 shifts, on 3 of 3 medication carts reviewed (Cart A, Cart B & C and the Nurse Treatment cart). Findings: On 5/20/25 during medication storage observation the following was reviewed: 1. Cart A Controlled Substance Book and Shift Counts were reviewed, which indicated the facility counts at the change of each shift, approx. 3 times a day. The person authorized to administer medications coming on duty and/or the person authorized to administer medications going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 2/3/25, 2/11/25, 2/12/25, 2/15/25, 2/18/25, 2/26/25, 2/28/25, 3/5/25, 3/7/25, 3/12/25, 3/18/25, 3/19/25, 3/21/25, 3/28/25, 3/29/25, 4/1/25, 4/3/25, 4/4/25, 4/7/25, 4/12/25, 4/16/25, 4/17/25, 4/18/25, 4/21/25, 4/22/25, 4/23/25, 4/25/25, 4/28/25, 5/2/25, 5/3/25, 5/5/25, 5/6/25, 5/7/25, 5/8/25, 5/9/25, 5/10/25, 5/16/25 and 5/17/25. 2. Cart B &C Controlled Substance Book and Shift Counts were reviewed, which indicated the facility counts at the change of each shift, approx. 3 times a day. The person authorized to administer medications coming on duty and/or the person authorized to administer medications going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 3/5/25, 3/19/25, 3/31/25, 4/8/25, 4/11/25, 4/13/25, 4/16/25, 4/22/25, 4/26/25, 5/2/25, 5/6/25, 5/11/25, 5/16/25,	F 755	See attached POC 6/12/25 dfb	6/27/2025

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F 755	Continued From page 19 3. Nurse Treatment Cart Controlled Substance Book and Shift Counts were reviewed, which indicated the facility counts at the change of each shift, approx. 3 times a day. The person authorized to administer medications coming on duty and/or the person authorized to administer medications going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 7/9/24, 7/12/24, 7/13/24, 7/14/24, 7/15/24, 7/16/24, 7/20/24, 7/21/24, 7/27/24, 7/28/24, 7/29/24, 7/30/24, 7/31/24, 8/2/24, 8/4/24, 9/1/24, 9/2/24, 9/3/24, 9/4/24, 9/7/24, 9/8/24, 9/10/24, 9/11/24, 9/14/24, 9/15/24, 9/16/24, 9/17/24, 5/15/25, 5/16/25, 5/17/25 and 5/18/25. On 5/20/25 at 9:02 a.m., during an interview, the Director of Nursing Services confirmed the above stating she had looked through all the narcotic books and they are missing quite a bit. A review of the facility's "Inventory Control of Controlled Substances" policy and procedure dated 8/1/24 states: "Facilities should ensure the incoming and outgoing nurses count all Schedule 2 controlled substances and other medications with a risk of abuse or diversion at the change of shift ... and document the results on a "Controlled Substance Count Verification/Shift Count Sheet.	F 755	See attached for 6/12/25	6/27/2025
F 761 SS=D	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	F 761		

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F 761	Continued From page 20 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 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 observation and interview, the facility failed to adequately date and properly dispose of open biologicals according to manufacturer specifications in 1 of 3 medication carts observed for medication storage. Finding: On 5/20/25 at 7:33 a.m., observation of the Nurse Treatment cart with the Licensed Practical Nurse (LPN) the following was observed; one opened and unlabeled Basaglar (insulin) Kwik Pen with the manufacturer's instructions of, "after first use ...discard after 28 days" and a Epinephrine injection with manufactures exp date of 4/2025. At this time, the LPN confirmed they were either	F 761	All attached POC 6/12/25 JS 6/27/2025	

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F 761	Continued From page 21 undated and/or expired. On 5/20/25 at 7:48 a.m., the above was discussed with the Director of Nursing Services	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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and facility policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for 1 of 1 kitchen tour. Furthermore, the facility failed to ensure staff were wearing proper beard restraints for 1 of 3 days of survey (5/20/25). Findings: 1. On 5/19/25 a surveyor toured the kitchen and	F 812	See attached POC 6/6/25 JH 6/27/2025	

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F 812	Continued From page 22 observed the following: > The kitchen floor was dirty with food debris and trash around the entire floor, under the equipment, and shelving. > Dirt and debris observed in the hood system, in the fan in the walk-in refrigerator, and in the Genus Fli fly zapper. > The reach in refrigerator was noted to have dirt, debris, and spillage. > The walk-in refrigerator and walk-in freezer had dirt, debris, and spillage on the floors. > The plastic coverings on the racks containing clean dishes are in despair and were soiled with dry liquid residue. On 5/19/25 at 8:30 p.m., during an interview with 2 surveyors, the above information was confirmed with the Food Service Director. 2. On 5/20/25 at 12:25 p.m., observation of a Dietary Aid, with facial hiar, not wearing a beard restraint while in the kitchen. Upon surveyor intervention the Dietary Aid applied a beard restraint. On 5/20/25 at 12:30 p.m., the above information was discussed with the Food Service Director. The Facility policy "Employee Sanitary Practices" under procedure, states all employees shall "wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food."	F 812	See attached Plan 6/2/25	6/7/2025

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F 814	Continued From page 23	F 814		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the garbage storage area in a sanitary condition to prevent the harborage and feeding of pests for 1 of 3 days of survey. (5/19/25) Findings: On 5/19/25 at 8:30 a.m., 2 surveyors and the Food Service Director (FSD) observed a heavily soiled garbage storage area containing 3 trash dumpsters, in which food and trash debris were noted behind all 3 trash dumpsters. At this time the above information was confirmed.	F 814	See attached POC 6/12/25 JH	6/27/2025
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may	F 947		

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RUSSELL PARK REHABILITATION & LIVING CENTER	158 RUSSELL ST LEWISTON, ME 04240

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F 947	Continued From page 24 address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to monitor and ensure that the CNAs received the required 12 hours of annual in-service education training including Dementia, Resident Rights and Abuse/ Neglect training for 5 of 5 CNAs employed greater than 1 year. (CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5). Findings: On 5/20/25 a surveyor reviewed the following employee files: 1. CNA #1 was hired on 11/28/2012. A review of CNA #1's education records lacked evidence that she had received the required 12 hours of education/in-service training including Dementia, Resident Rights and Abuse/ Neglect in 2024. 2. CNA #2 was hired on 4/28/2016. A review of CNA #2's education records lacked evidence that she had received the required 12 hours of education/in-service training including Dementia, Resident Rights and Abuse/ Neglect in 2024. 3. CNA #3 was hired on 11/6/2002. A review of CNA #3's education records lacked evidence that she had received the required 12 hours of education/in-service training including Dementia, Resident Rights and Abuse/ Neglect in 2024.	F 947	See attached POC 6/12/25 JSR 6/27/2025	

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 _____	05/21/2025

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 947	Continued From page 25 4. CNA #4 was hired on 4/26/21. A review of CNA #4's education records lacked evidence that she had received the required 12 hours of education/in-service training including Dementia, Resident Rights and Abuse/ Neglect in 2024. 5. CNA #5 was hired on 9/8/23. A review of CNA #5's education records lacked evidence that she had received the required 12 hours of education/in-service training including Dementia, Resident Rights and Abuse/ Neglect in 2024. On 5/20/25 at 10:45 a.m., in an interview, the Business Office Manager confirmed that the 5 CNAs did not have documentation to show they received 12 hours of education including Dementia, Resident Rights and Abuse/ Neglect in 2024. On 5/20/25 at 11:10 a.m., in an interview, the Director of Nursing Services confirmed that that the 5 CNAs did not have documentation to show they received 12 hours of education including Dementia, Resident Rights and Abuse/ Neglect in 2024.	F 947	see attached POC 6/12/25 JoAn	6/27/2025

Russell Park Rehabilitation & Living Center Annual Long Term Care Survey Process & Complaint Investigations #ME00047265, #ME00047760, #ME00048554, and #ME00050623: 5/19/25-5/21/25

RUSSELL PARK REHABILITATION & LIVING CENTER
ANNUAL LONG TERM CARE SURVEY PROCESS
FEDERAL RECERTIFICATION & COMPLAINT INVESTIGATIONS
PLAN OF CORRECTION
June 12, 2025

Please note the filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The facility is filing this plan of correction in accordance with applicable law.

F584 - 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment

Finding #'s 1-13 (Shower Room, A, B, and C Units)

1) Shower/Spa room - The caulking around the base of the toilet was repaired. The four shower curtains are being replaced, and will be installed, as soon as possible, once they arrive from the vendor. The heater unit, the entrance metal door, and door frame will be repainted creating a more cleanable surface.
2) Resident Room A3 - The hooks were reattached to the privacy curtain.
3) Resident Room A4 - The wall across from the sink was repaired and repainted, as indicated creating a more cleanable surface. The wash basin was removed from under the sink.
4) Resident Room A6 - The caulking around the base of the toilet was repaired. Staff will attempt to clear the stain from the flooring around the toilet-in the event the stain cannot be removed, a quote will be obtained to replace the flooring, and the work will be completed, as soon as able.
5) Resident Room A12 - The wall across from the sink was repaired and repainted, as indicated creating a more cleanable surface.
6) Resident Room A14 - The caulking around the base of the toilet was repaired.
7) Resident Room A16 - The caulking around the base of the toilet was repaired. The bathroom exhaust fan was cleaned of dust/debris.
8) Resident room A17 - The room entrance wooden door has been repaired.
9) Resident Room B2 - The caulking around the base of the toilet was repaired. The two pieces of grey duct tape were removed from the floor making a more cleanable surface.
10) Resident Room B3 - The baseboard heater was reconnected and hooked back on the brackets. The caulking around the base of the toilet was repaired.
11) Resident Room B5 - Resident #17's electric wheelchair controller and foot base was immediately cleaned of the dust/dirt/crumbs and debris as soon as staff were notified of the issue(s).
12) Resident Room B7 - The caulking around the base of the toilet was repaired.
13) Resident Room C6 - The room entrance wooden door was repaired.

- No residents were affected by these findings; residents have the potential to be minimally affected. Other resident care areas/rooms have the potential to be affected by these findings.
- Repairs will continue, as promptly as able. Education has been provided to housekeeping, maintenance, and nursing staff regarding these findings, as indicated.
- The Environmental Services Director, or designee, will conduct routine and random audits of these issues x 3 months to ensure the plan of correction improves the area(s) of concern and sustains compliant practice(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

Pomelow, Lori [Russell Park]
Lori Pomelow, HCA
6/12/2025

Russell Park Rehabilitation & Living Center Annual Long Term Care Survey Process & Complaint Investigations #ME00047265, #ME00047760, #ME00048554, and #ME00050623: 5/19/25-5/21/25

F605 - 483.10 (e)(1), 483.12(a)(2) Right to be Free From Chemical Restraints

Findings #1-2

1) Resident #33's clinical record will be updated to include a risk versus benefit notation for the continued use of Risperidone.

2) Resident #11's medical record will be updated to include the medical rationale for the continued use of Ativan longer than 14 days.

- Neither resident was negatively affected by these findings; other residents have the potential to be minimally affected by the same or similar issue(s).
- Clinical records of residents who are prescribed psychotropic medications have been reviewed by the facility's consultant pharmacist, and a pharmacy recommendation has been generated for the medical provider to review and document the risk versus benefit of continued use of psychotropic medication(s). Other recommendations have been generated to document the medical rationale for continued use beyond 14 days on newer psychotropic medication orders, as indicated. Licensed staff have been educated on these finding(s).
- The Director of Nursing Services, or designee, will conduct routine and random audits of these issues x 3 months to ensure the plan of correction improves the areas of concern and sustains compliant practice(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

F656 – 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plans

Findings #1-2

1) Resident #150's care plan cannot be updated as the resident has since discharged from the facility.
2) Resident # 35's care plan has been updated. The resident does not have an order to monitor catheter output, therefore the need does not exist to do so.

- Neither resident was negatively affected by this finding; other residents have the potential to be minimally affected by the same or similar issue.
- The facility's Urinary Catheter Policy does not require staff to record the amount, color and characteristics of urine. The care plans of residents who have indwelling catheters have been updated to remove these interventions, as they are not deemed necessary in the absence of an order to monitor output. Nursing staff have been educated on these care plan changes, as indicated.
- The Director of Nursing Services, or designee, will conduct routine and random audits of the resident care plans for those with indwelling catheters for this finding x 3 months to ensure the plan of correction improves the areas of concern and sustains compliant practice(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

Pomelow, Lori [Russell Park]

Lori Pomelow, HCA
6/12/25

Russell Park Rehabilitation & Living Center Annual Long Term Care Survey Process & Complaint Investigations #ME00047265, #ME00047760, #ME00048554, and #ME00050623: 5/19/25-5/21/25

F684 - 483.25 Quality of Care

Finding #1

1) A medication error was made on Resident #41, and appropriately documented. The resident received close monitoring after the error was made to ensure there were no negative effects from this incident.

- Other residents have the potential to be affected by a medication error.
- Licensed Staff who have medication administration responsibilities will be educated on following the proper steps for safe medication administration specific to insulin orders/injections.
- The Director of Nursing Services, or designee, will conduct routine and random audits x 3 months to ensure the plan of correction improves the areas of concern and sustains compliant practice(s), in regards to following physician orders for insulin administration. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

F689 - 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices

Finding(s) #1-2

1) A smoking assessment has been completed for resident #302 and the clinical record contains a signed smoking contract.

2) A smoking assessment has been completed for resident #22.

- No residents were affected by these findings; other residents have a minimal risk of being affected by this finding.
- Staff Education has been provided regarding completing smoking assessments/smoking contracts per facility policy, with residents who are actively smoking.
- The Director of Nursing Services, or designee, will conduct routine and random audits of smoking assessments and smoking contracts for residents who smoke, x 3 months to ensure the plan of correction improves the areas of concern and sustains compliant practice(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

F695 - 483.25(i) Respiratory/Tracheostomy Care and Suctioning

Finding(s) 1-5

(1-4) Resident #2, Resident #29, Resident #11, Resident #302's oxygen tubing was changed in accordance with current physician order(s)

5) Resident #40's nebulizer treatments were discontinued; therefore the equipment was discarded.

- None of the residents were negatively affected by these findings; other residents have the potential to be affected by the same or similar issue.
- The facility's Policy and Procedure, "Oxygen Use and Storage Policy" states, "Nasal cannulas will be discarded and changed every 2 weeks." Resident oxygen tubing orders have been changed to match the policy. Staff Education has been provided regarding this issue.
- Director of Nursing, and/or designee(s), will conduct routine/random audits to ensure oxygen tubing/cannulas, and nebulizer masks/mouthpieces are being appropriately changed and discarded, as indicated. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

Pomelow, Lori [Russell Park]

Lori Pomelow, MSA

6/12/25

Russell Park Rehabilitation & Living Center Annual Long Term Care Survey Process & Complaint Investigations #ME00047265, #ME00047760, #ME00048554, and #ME00050623: 5/19/25-5/21/25

F730 - 483.35 (d)(7) Nurse Aide Perform Review – 12 hr./yr. In-Service
Finding #'s 1-5

(1-5) Current evaluations for C.N.A's #1-5, will be completed.

- Personnel files for C.N.A staff will be reviewed to identify dates evaluations are due. (Out of date evaluations will be completed, as soon as able.)
- The facility implemented a monitoring system to ensure performance reviews are up to date, and evaluations will be completed as timely as able, going forward.
- The Business Office Manager/DNS, and/or designee(s) will complete routine audits of C.N.A personnel files for timely completion of performance evaluations. The results of the audits will be reported to the facility's Quality Assurance Committee x 3 months, as indicated.
- **Date of Completion: June 27, 2025**

F755 - 483.45 (g)(h)(1)(2) Label/Store Drugs and Biologicals
Finding #'s 1-3

(1-2) Carts A and B/C Shift Count pages in the controlled substances book are being completed appropriately (any omissions from this time forward, if noted, are being addressed as soon as able, as indicated.)

3) There are no longer any medications in the treatment cart requiring the controlled substances log to be completed.

- No residents were affected by these findings; other residents have a minimal risk of being affected by these findings.
- Staff Education is being provided regarding properly signing off the controlled substance books at the change of shift(s).
- The Director of Nursing Services, and/or designee(s), will conduct routine and random audits to ensure the plan of correction improves the areas of concern and sustains compliant practice(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

F761 - 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals
Findings #1-2

1) The opened and unlabeled Basaglar (insulin) Kwik Pen was removed and replaced promptly.

2)The expired Epinephrine injection with a conflict in the expiration dates was removed/discarded, and replaced promptly; the pharmacy was made aware of this finding due to the conflicting expiration dates.

- No residents were affected by this finding; other residents could be minimally affected.
- Staff Education is being provided regarding labeling insulin pens and checking expiration dates on Epinephrine.
- The Director of Nursing Services, and/or designee(s), will conduct routine and random audits to ensure the plan of correction improves the areas of concern and sustains compliant practice(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

Pomelow, Lori [Russell Park]

6/12/25

Russell Park Rehabilitation & Living Center Annual Long Term Care Survey Process & Complaint Investigations #ME00047265, #ME00047760, #ME00048554, and #ME00050623: 5/19/25-5/21/25

F812 - 483.60(i)(1)(2) Food Procurement, Store/Prepare/Serve-Sanitary
Finding #'s 1-6

1) The kitchen floor was cleaned of the food debris and trash visible around the floor, under the equipment, and shelving.
2) The dirt and debris was cleaned from the hood system, from the fan in the walk-in refrigerator, and from the Genus Fli fly zapper.
3) The dirt, debris, and spillage was cleaned from within the reach-in refrigerator.
4) The dirt, debris, and spillage on the floors was cleaned from the walk-in refrigerator and the walk-in freezer.
5) The splatter of dry (liquid) residue was cleaned immediately from the plastic covering on the rack containing clean dishes.
6) The dietary aide washing the pots and pans immediately put a beard restraint on.

- No residents were affected by these findings; other residents could be minimally affected.
- Staff Education will be provided regarding these findings.
- The Food Service Director, and/or designee(s), will conduct routine and random audits to ensure the plan of correction improves the areas of concern and sustains compliant practice(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

F814 - 483.60(i)(4) Dispose Garbage and Refuse Properly
Finding # 1

1) The garbage storage area behind the 3 trash dumpsters was cleaned of food and trash debris.

- No residents were affected by this finding; other residents could be minimally affected.
- Staff Education has been provided regarding this finding.
- The Environmental Services and Food Service Director(s), and/or designee(s), will conduct routine and random audits to ensure the plan of correction improves the areas of concern and sustains compliant practice(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

Pomelow, Lori [Russell Park]
Lori Pomelow, HK 6/12/25

Russell Park Rehabilitation & Living Center Annual Long Term Care Survey Process & Complaint Investigations #ME00047265, #ME00047760, #ME00048554, and #ME00050623: 5/19/25-5/21/25

F947 – 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides

Findings #1-5

(1-5) C.N.A #'s 1-5 cannot complete the required Abuse Prevention/Resident Rights and Dementia training for calendar year 2024, as time has already lapsed. These C.N.A's will be provided with the required in-service education during the remainder of this calendar year. Each C.N.A will be provided with a minimum of the Abuse Prevention/Resident Rights training prior to the completion date of this POC and will have the opportunity to complete other training (to include the Dementia training) to meet the requirement of 12 hours for the year.

- No residents were affected by this finding; other residents could be minimally affected.
- An in-service education tracking system has been implemented. Several in-service dates and times have been scheduled to assist nurse aides in acquiring the required in-service training hours of 12 hours per year; including Abuse Prevention/Resident Rights, and Dementia training.
- The Staff Development Coordinator, and/or designee(s) will conduct routine and random audits to ensure the plan of correction improves the areas of concern and sustains compliant practice(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: June 27, 2025**

Pomelow, Lori [Russell Park]

Lori Pomelow, HCA

6/12/25