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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. - Resident room [ROOM NUMBER] - The privacy curtain was missing hooks, hanging down and in disrepair. - Resident room [ROOM NUMBER] - 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 [ROOM NUMBER] - The caulking around the base of the toilet was stained and dirty. The flooring around the toilet was stained and discolored. - Resident room [ROOM NUMBER] - The wall across from the sink had chipped/missing paint and was marred with black marks creating an uncleanable surface. - Resident room [ROOM NUMBER] - The caulking around the base of the toilet was stained and dirty. - Resident room [ROOM NUMBER] - The caulking around the base of the toilet was stained and dirty. The bathroom exhaust fan was dusty/dirty. - Resident room [ROOM NUMBER] - The room entrance wooden door had chipped/gouged and missing laminate. B Unit - Resident room [ROOM NUMBER] - 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 [ROOM NUMBER] - 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 [ROOM NUMBER] - 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 [ROOM NUMBER] - The caulking around the base of the toilet was stained and dirty. C Unit - Resident room [ROOM NUMBER] - The room entrance wooden door had chipped/gouged and missing laminate. (continued on next page)

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.

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
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/25 at 8:45 a.m., during an interview, the Environmental Services Director and the Administrator confirmed the findings.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 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. 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 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) 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 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 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 (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 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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. 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 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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 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 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 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, 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.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on the review of annual evaluations and interviews, the facility failed to complete an annual performance evaluation for Certified 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.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 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 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, 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 undated and/or expired. On [DATE] at 7:48 a.m., the above was discussed with the Director of Nursing Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [NAME] 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interviews, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification dated 5/21/25, was effective. The Federal citation F695 was cited again during the re-visit to the annual Long Term Care Recertification Survey, dated 7/15/25.During the follow-up survey on 7/15/25, it was determined that F695 for failure to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care. (see F695). On 7/15/25 at 3:45 p.m., during an interview, the above was confirmed with the Administrator and the Director of Nursing.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 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. 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.