



MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES LICENSING AND CERTIFICATION ASSISTED HOUSING

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION License Renewal Survey		Date Completed: 3/18/25
Name of Facility: Lark Administrator: Misty Marston Residential Care Facility. Census: 3 Total Capacity: 4 License Number: RCC319021	Address: 3 Lark St Westbrook Maine	
Summary Statement of Deficiencies	Plan of Correction	Completion Date

<p>Lark, a Level III Residential Care Facility is not compliance with the Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level III Residential Care Facilities, Part of 10-144, Chapter 113 and Infection Prevention and Control.</p> <p>The following requirements were not met:</p> <p>3.25.2 Signing a contract. Each provider and each resident, or someone authorized to act on the resident’s behalf, shall sign a standard contract issued by the department, attached as Appendix A, at the time of any modification of an existing contract and with all new admissions. The resident and/or resident’s legal representative shall be given an original of the signed contract and the provider shall keep a duplicate in the resident’s file. No one other than the resident shall incur any responsibility for the resident’s obligations by signing the contract for admission of the resident. Financial responsibility for the resident’s expenses can only be assumed according to Section 3.25.3.7.</p> <p>Based on a review of two resident records and an interview with staff, the facility failed to provide evidence of a signed admission contract.</p> <p>Finding: On 3/18/25 the record was reviewed for Resident #1 and Resident #2. No evidence of a standard admission contract was found in the record. On 3/18/25 at approximately 1pm Employee # 1 was</p>	
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<p>interviewed, who was unable to locate a standard admission contract in the record for Resident #1.</p> <p>3.26 Information to residents. The licensee must provide an information packet that includes the following information to the resident and/or resident's legal representative at the time of admission or within sixty (60) calendar days of the effective date of these regulations for all current residents who have not already been given this information:</p> <p>3.26.1 Advance Directives information;</p> <p>3.26.2 Information regarding the type of facility and the licensing status;</p> <p>3.26.3 The Maine Long Term Care Ombudsman Program brochure;</p> <p>3.26.4 The department's toll-free telephone numbers for the Office of Advocacy, Adult Protective Services, and the Division of Licensing and Regulatory Services, Community Services Programs;</p> <p>3.26.5 The process and criteria for placement in, or transfer or discharge from, the program; and</p> <p>3.26.6 The program's staff qualifications.</p> <p>Based on a review of resident records the facility failed to provide proof that an informational packet with the required information was provided to the resident and/or resident's legal representative.</p> <p>Finding:</p>		



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<p>On 3/18/25 the record was reviewed for Resident #1 and Resident #2. No evidence of evidence of the required information or proof that the resident or resident representative received the required information was located in the record. The information was not posted or located in the facility ensuring the residents had access to important and emergency information including the department's toll-free telephone numbers for the Office of Advocacy, Adult Protective Services, and the Division of Licensing and Regulatory Services, Community Services Programs. On 3/18/25 at approximately 1pm Employee #1 was interviewed and was not able to locate the information or documentation.</p> <p>5.12 Right to confidentiality. Residents' records and information pertaining to their personal, medical and mental health status is confidential. Residents and their legal representatives shall have access to all records pertaining to the resident at reasonable times, in the presence of the provider or his/her representative, within one (1) business day of the request. Residents and their legal representatives are entitled to have copies made of their record within one (1) business day of the request. The licensee and employees shall have access to confidential information about each resident only to the extent needed to carry out the requirements of the licensing regulations or as authorized by any other applicable state or federal law. The written consent of the resident or his/her legal representative shall be required for release of information to any other person except authorized representatives of the Department or the Long-Term Care Ombudsman Program. The Department shall have access to these records for determining compliance with these regulations. Records shall not be removed from the facility, except as may be necessary to carry out these regulations. Upon admission, each resident shall sign, and date a written consent which lists individuals, groups, or categories of individuals with whom the program may share information (e.g., sons, daughters, family members or duly authorized licensed</p>		



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<p>practitioners, etc.). A written consent to release of information shall be renewed and time dated every thirty (30) months, pursuant to 22 M.R.S.A. §1711-C (4). Consent may be withdrawn at any time. [Class IV]</p> <p>Based on a review of two resident records and an interview with staff, the facility failed to provide evidence of current written consent to release of information.</p> <p>Finding: On 3/18/25 the record was reviewed for Resident #1 and Resident #2. No evidence of evidence of current written consent to release of information found in the record. On 3/18/25 at approximately 1pm Employee # 1 was interviewed, who was unable to locate evidence of current written consent to release of information.</p> <p>5.23 Notification of Residents Rights. The provider shall inform each resident and legal representative of these rights prior to or at admission and shall provide them with a copy of these rights. In addition, the provider shall inform each resident and legal representative, within thirty (30) calendar days of any changes to Section 5 and shall provide them with a copy of the changes. The provider must accommodate for any communication barriers that may exist, to ensure that each resident is fully informed of his/her rights. [Class IV]</p> <p>Based on a review of two resident records and an interview with staff, the facility failed to provide evidence of the notification of resident rights to the resident and/or their representative.</p> <p>Finding: On 3/17/25 the record was reviewed for Resident #1 and Resident #2. No evidence of residents and/or their representative being notified of their resident rights was found in the record. On 3/17/25 at</p>		



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<p>approximately 1pm Employee # 1 was interviewed, who was unable to locate evidence of residents being informed or a copy of resident rights in the resident record.</p> <p>11.2.1 Assessments. Each resident shall be assessed within thirty (30) calendar days of admission. Reassessments must be completed annually or more frequently if there is a significant change in his/her condition. The assessments/reassessments are to determine each resident's abilities and need for services. Residents shall have an opportunity to receive individualized services that help them function in the facility and in the community and that help restore them to an optimal state of health, or for constructive activity, as needed. The facility will assure, to a practicable extent, that residents' needs will be accommodated regarding individual choices and preferences. This shall be evidenced in the assessment, in the development and implementation of individual service plans and in regular progress notes. The areas identified below are to be assessed. The resident and resident's guardian or other legal representative, as well as staff or other persons approved by the resident or resident's guardian who are knowledgeable about the resident, shall participate in or be consulted concerning the assessment. The listing of these areas is not meant to exclude assessment of any other obvious needs that residents may exhibit. The facility shall use the state approved resident assessment instrument (RAI) or other assessment or assessment process as required by the agency providing the MaineCare funds to determine their abilities and need for services. The most current assessment shall be kept in the resident's record. Previous assessments shall be kept with the residents active record.</p> <p>11.2.1.1 Ability and need regarding psychological services, as indicated by the ability to adjust to the facility, ability to make a social and emotional transition to the facility, such as communicating/relating with others, behaving appropriately, acting</p>		



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<p>compatibly with other residents or adapting/controlling personal habits;</p> <p>11.2.1.2 Ability and need to maintain or develop family and community ties;</p> <p>11.2.1.3 Need for educational, religious or community vocational services;</p> <p>11.2.1.4 Ability and need for assistance with legal or financial problems;</p> <p>11.2.1.5 Ability and need for assistance with personal care, or ADLs;</p> <p>11.2.1.6 Ability to manage own personal affairs, use a telephone, handle own finances, read/write correspondence, express likes/dislikes, register to vote;</p> <p>11.2.1.7 Ability and need regarding social, recreational and leisure time activities, specifying likes and dislikes;</p> <p>11.2.1.8 Abilities and needs regarding hearing, vision, speech, communication, mobility and memory impairments and use of related adaptive equipment;</p> <p>11.2.1.9 Ability and need for assistance with securing necessary health care, including medical, nursing, dental, day treatment, psychological or mental health services, qualified sign language interpreters and other communication assistance;</p> <p>11.2.1.10 Ability and need for arranging transportation to meet medical, social and business needs;</p>		



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<p>11.2.1.11 Ability and need for assistance to be independent in the community;</p> <p>11.2.1.12 Ability and need for assistance regarding administration of medications; and</p> <p>11.2.1.13 Need for discharge planning.</p> <p>Based on record review the facility failed to provide evidence of an assessment being completed within 30 days of admission and annually thereafter.</p> <p>Finding: On 3/18/25 the record was reviewed for Resident #1 and Resident #2. No assessment was found in the record. Information regarding resident current or progress on physical and mental condition, behavior, mood, activities of daily living, independent living skills and other required information was found. On 3/18/25 at approximately 1pm Employee # 1 was interviewed and was not able to locate documentation of an assessment in the resident records.</p> <p>11.2.2 Service plan. A service plan shall be developed and implemented within thirty (30) calendar days of admission for each resident based upon the findings of the assessment. The plan shall address those areas in which the resident needs encouragement, assistance or an intervention strategy. The resident, his/her legal representative (if applicable) and others chosen by the resident shall be actively involved in the development of the service plan, unless he/she is unable or unwilling to participate. There shall be documentation in the resident's record identifying who participated in the development of the service plan. The plan shall describe strategies and approaches to meet the resident's needs, names of who will arrange and/or deliver services, when and how often</p>		



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<p>services will be provided and goals to improve or maintain the resident's level of functioning. Residents shall be encouraged to be as independent as possible in their functioning, including ADLs and normal household tasks if they choose, unless contraindicated by the resident's duly authorized licensed practitioner. The service plan shall be modified, as necessary, based upon identified changes. Residents shall never be required to perform activities specified in the residential service plan or any other activities and cannot be used to replace paid staff.</p> <p>Based on resident record review the facility failed to provide evidence of an active service plan completed by the residence based on a current assessment of skills and needs.</p> <p>Finding: On 3/18/25 the record was reviewed for Residents #1 and #2. No current facility service plan was located in the record to drive supports and services. On 3/18/25 at approximately 1pm Employee # 1 was interviewed. Employee #1 stated that the services provided to each resident in the facility were based on and directed by the current person-centered plan however was not able to locate a copy of this plan in the resident record.</p> <p>11.2.3 Progress notes. The facility shall maintain ongoing signed and dated progress notes at least monthly, on implementation of the service plan and for any significant changes in the resident's life including any increases or declines in the resident's physical and mental functioning that should be considered at the time of reassessment or adjustment in the service plan. Progress notes shall begin within twenty-four (24) hours of admission and shall include an initial summary of basic care needs, circumstances of resident's placement and resident's adjustment to the facility.</p>		



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<p>Based on a review of two resident records and interview with staff the facility failed to document progress on the current resident goals as stated in their individual Person-Centered Plan.</p> <p>Finding: On 3/17/25 the records were reviewed for Resident #1 and Resident #2. Progress notes were found in the records however they noted no documentation of progress related to current resident goals as stated in each individuals Person Centered Plan. Facility documentation included documentation related to past and outdated goals and skill levels. On 3/17/25 at approximately 1PM Employee #1 was interviewed. Employee confirmed that there was no documentation related to current goals and that the facility has been documenting based on outdated information.</p> <p>Based on a review of two resident records and interview with staff the facility failed to ensure that progress notes were signed and dated by the provided and/or documenting resident care and progress.</p> <p>Finding: On 3/17/25 the records for Resident #1 and Resident #2 were reviewed. Progress notes were found to cover a 24-hour period of service provision. Notes were signed and dated by the individual who set up the notes. However, this was not the individual providing service, observing progress or completing the documentation within the progress note. By reviewing the progress notes it is not able to determine who completed the documentation, who provided the services or who made observations during the period of time noted on the progress notes. On 3/17/25 at approximately 1PM Employee #1 was interviewed. Employee stated that the overnight staff set up and sign the progress notes for the following day. Employee then stated that the expectation was that staff on shift complete the progress note on the overnight staff's signed documentation.</p>		



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<p>13.1 Summary sheets. There shall be a summary sheet maintained for each resident that includes applicable information, including the resident's name, birth date, date of admission, duly authorized licensed practitioner's name, address and telephone number, nearest relative or friend's name, address and telephone number, person to be notified in an emergency, their name, address and telephone number, day program name, telephone number, address and contact person, date of discharge or death and significant medical/social issues.</p> <p>Based on a review of resident records the facility failed to ensure all required information was included on the resident summery sheet.</p> <p>Finding: On 3/18/25 the record was reviewed for Resident #1 and Resident #2. No information regarding: date of admission, duly authorized licensed practitioner's name, address and telephone number, nearest relative or friend's name, address and telephone number, or significant medical/social issues was found on the resident summery sheet. On 3/18/25 at approximately 1PM Employee # 1 was interviewed and confirmed this finding.</p> <p>13.2 Resident records. There shall be a record maintained for each resident that contains applicable information on physical and mental condition, behavior, mood, eating habits, incidents or accidents, documented proof of guardianship, conservatorship, representative payee, power of attorney or other legal</p>		



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<p>representative, and the dates of medical examinations, other medical and dental treatment and drugs prescribed.</p> <p>Based on a review of two resident records and an interview with staff, the facility failed to provide documented proof of guardianship, conservatorship, representative payee, power of attorney or other legal representative.</p> <p>Finding: On 3/18/25 the record was reviewed for Resident #1 and Resident #2. No evidence of proof of guardianship, conservatorship, representative payee, power of attorney or other legal representative. On 3/18/25 at approximately 1PM Employee # 1 was interviewed and was not able to locate documentation of proof of guardianship, conservatorship, representative payee, power of attorney or other legal representative.</p> <p>All findings were reviewed during the exit conference. Exit conference form was signed by surveyor and representative facility staff member.</p>		