

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/31/2023
NAME OF PROVIDER OR SUPPLIER LAKEWOOD A CONTINUING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 KENNEDY MEMORIAL DR WATERVILLE, ME 04901		
(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	F 000			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that portable oxygen was available for 1 of 1 resident (Resident #1 [R1]) to leave their room for activities and to eat in the dining room for breakfast, lunch and supper for 4 of 6 meals served (8/27/23 supper, 8/28/23 breakfast, 8/28/23 lunch, and 8/28/23 supper). Findings: On 8/28/23 at 1:07 p.m. in an interview with a surveyor, R1 stated he/she did not receive lunch and that he/she goes to the dining room to eat, but there were no portable oxygen tanks in storage or available, so was told by staff he/she could not go to the dining room and has to eat in his/her room, and could not attend activities. He/she had to eat in room, where there is an	F 558			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Lucia Ortega

Interim Administrator

9-22-23

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.