

Department of Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1964	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2024
NAME OF PROVIDER OR SUPPLIER CUMMINGS HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 367 HOWLAND, ME 04448		
(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) COMPLETE DATE
P 000	Initial Comments On 7/16/24, an unannounced visit was conducted at Cummings Health Care Facility (Residential Care Level IV) for the purpose of investigating complaint #ME00048146. It was determined that Cummings Health Care Facility (Residential Care Level IV) was in substantial compliance with 10/144, Chapter 113- Regulations Governing the Licensing and Functioning of Assistive Housing Programs-Level IV, Private Non-Medical Institutions.	P 000		

Department of Health and Human Services

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

TITLE

(X6) DATE