STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1964	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS HEALTH CARE FACILITY	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 10/14/25 and 10/15/25 an unannounced onsite visit was conducted at Cummings Health Care Facility (Residential Care) for the purpose of completing the State Re-licensure survey. It was determined that Cummings Health Care Facility (Residential Care) was not in compliance with 10/144, Chapter 113- Regulations Governing the Licensing and Functioning of Assistive Housing Programs-Level IV, Private Non-Medical Institutions.	P 000		
P 219	5.22 Resident Rights Right to information regarding deficiencies. Residents have the right to be fully informed of findings of the most recent survey conducted by the Department. The provider shall inform residents or their legal representatives that the survey results are public information and are available in a common area of the facility. Residents and their legal representatives shall be notified by the provider, in writing, of any actions proposed or taken against the license of the facility/program by the Department, including but not limited to, decisions to issue a Directed Plan of Correction, decisions to issue a Conditional license, refusal to renew a license, appointment of a receiver or decisions to impose fines or other sanctions. This notification shall take place within fifteen (15) working days from receipt of notice of action. [Class IV] This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the results of the most recent survey were available in a common area of the facility.	P 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1964	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS HEALTH CARE FACILITY	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 219	Continued From page 1 Finding: On 10/14/25 at 1:20 p.m., a surveyor observed the common areas and was unable to find the results of the most recent survey. On 10/14/25 at 1:20 p.m., the surveyor asked the Residential Care Director where the most recent survey results were located. She stated that the results of the most recent survey were located in a binder in her office. She also confirmed that a copy of the survey results was not located in a common area within the facility. This provision has changed in the rule effective 9/18/25. See new provisions of the rule Section 4(Y)(1).	P 219		
P 306	7.1.4 Medications and Treatments Unlicensed assistive personnel must be trained by a registered professional nurse in regard to the management of persons with diabetes. The registered professional nurse must provide in-service training and documentation to include: [Class III] This STANDARD is not met as evidenced by: Based on employee personnel file reviews and interview, the facility failed to provide documented evidence that 1 of 3 Certified Residential	P 306		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1964	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS HEALTH CARE FACILITY	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 306	Continued From page 2 Medication Aide's (CRMA's) received annual diabetes management training (CRMA2), Finding: On 10/15/25 during the review of CRMA2's employee personnel file, there is no evidence that they received their annual diabetes management training. On 10/15/25 at 10:30 a.m., during an interview with the Administrator, the surveyor confirmed that CRMA2 has not had their annual diabetes training. This provision has changed in the rule effective 9/18/25. See new provisions of the rule Section 9(A)(6)(v).	P 306		
P 344	7.6 Medications and Treatments Improperly labeled medications. For medications administered by the assisted living program, residential care facility, or private non-medical institution, all pharmaceutical containers having soiled, damaged, incomplete, incorrect, illegible or makeshift labels shall be returned to the original dispensing pharmacy for relabeling within two (2) working days or shall be disposed of in accordance with the requirements contained in Section 7.9. [Class III] This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to remove an unlabeled medication from use in 1 of 1 medicaiton cart.	P 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1964	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS HEALTH CARE FACILITY	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 344	Continued From page 3 Finding: On 10/14/25 between 11:20 a.m. and 11:58 a.m. a Certified Residential Medication Aide #1 (CRMA1) and a surveyor observed a bottle with orange tablets in the bottle, with no label. The bottle does not have the name of the product, open date, or expiration date on the bottle. The above finding in the medication cart was confirmed with the CRMA1 at the time of the observation. This provision has not changed in the new rule effective 9/18/25. See the provisions of the new rule Section 5. Medications and Treatments, H. Improperly labeled medications.	P 344		
P 345	7.7 Medications and Treatments Expired and discontinued medications. For medications administered by the assisted living program, residential care facility, or private non-medical institution, medications shall be removed from use and properly destroyed after the expiration date and when discontinued, according to procedures contained in Section 7.9. They shall be taken out of service and locked separately from other medications until reordered or destroyed. [III] This STANDARD is not met as evidenced by: Based on observations and interviews, the facility	P 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1964	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS HEALTH CARE FACILITY	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 345	Continued From page 4	P 345		

failed to ensure a medication was labeled with an open date, an expired medication was removed from use/available, a medication was removed from use after the resident had completed the medication, and a medication was removed from use when a resident was admitted to another facility in 1 of 1 medication cart reviewed.

Findings:

On 10/14/25 between 11:20 a.m. and 11:58 a.m., a Certified Residential Medication Aide #1 (CRMA1) and a surveyor observed the following in the medication cart:

- An opened insulin glargine (Lantus) pen for Resident #6 with no open date. Manufacturer recommendations indicated that once opened, insulin glargine (Lantus) should be used within 28 days;

- An opened bottle of ear wax removal drops for Resident #5 with an expiration date of 7/25 (July 2025);

- An antibiotic eye drop bottle for Resident #1 "Cipro 0.3% eye drops instill right eye 1-2 drops every 4 hours times 5 days, diagnosis, conjunctivitis" was in the medication cart, available for use after the completion of medication order. In an interview with a surveyor, the CRMA1 stated that the prescription is complete and R1 is not receiving this medicaiton any longer.

- a bottle of Visine dry eye relief for Resident #7 that was discharged from the facility;

A surveyor observed a bottle of Visine dry eye relief medication labeled for Resident #7 in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1964	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS HEALTH CARE FACILITY	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 345	Continued From page 5 medication cart. During an interview with a surveyor, CRMA1 stated that Resident #7 was no longer at the facility, was admitted to the Long Term Care facility. Per regulation 7.1.7.1, if a resident is admitted to another facility all existing orders are no longer in effect and all medications must be removed from service and placed in a locked area. The above findings in the medication cart were confirmed at the time of the observations and interviews. This provision has not changed in the new rule effective 9/18/25. See the provisions of the new rule Section 5.I, 5.A.9.e, and 5.A.9.g.	P 345		
P 359	7.12.4 Medications and Treatments Administration of medications ordered as needed (PRN) shall be documented and shall include date, time given, medication and dosage, route, reason given, results or response and initials or signature of administering individual. Treatments ordered PRN shall be documented in the same manner. This STANDARD is not met as evidenced by: Based on medication administration records (MAR)s and interview, the facility failed to document the results or responses of as needed (prn) medications/treatments on the MAR or in the progress notes for 1 of 3 residents reviewed (Resident #3). Finding: Resident #3 had a physician's order dated 11/6/24 for oxygen via nasal cannula at 2 liters	P 359		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1964	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS HEALTH CARE FACILITY	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 359	Continued From page 6 per minute (LPM) to keep oxygen saturation (O2 Sat) above 90% prn. On the October 2025 MAR, the resident was documented as having a O2 Sat of 88%. There is no documentation in the resident record of the results for the use of this prn treatment of oxygen. On 10/14/25 at 1:00 p.m. during interviews with the Residential Care Director and the Certified Residential Medication Aide, the surveyor confirmed that the use of prn oxygen for September and October were not documented and did not have any results documented in the residents record. This provision has changed in the rule effective 9/18/25. See new provisions of the rule Section 5(N)(1)(d).	P 359		
P 449	11.1.1.16 Administrative and Resident Records Name, address and telephone number of the person to be notified and the procedures to be followed in an emergency to cover the immediate care of the resident and disposition of the body at the time of death. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure that resident records contained procedures to be followed in an emergency to cover the immediate care of the resident and the disposition of the body at the time of death for 2 of 2 residents (Resident #3, and Resident #4). Findings:	P 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1964	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS HEALTH CARE FACILITY	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 449	Continued From page 7 1. Resident #3 was admitted to the facility in July 2019. As of 10/14/25, the resident's record lacked procedures to be followed in an emergency to cover the immediate care of the resident and the disposition of the body at the time of death. 2. Resident #4 was admitted to the facility in February 2023. As of 10/14/25, the resident's record lacked procedures to be followed in an emergency to cover the immediate care of the resident and the disposition of the body at the time of death. On 10/14/25 at 1:00 p.m., during an interview with a surveyor, the Residential Care Director stated that the policy/procedure was kept in a policy binder in the office and not in any clinical records, the surveyor confirmed this finding at this time. This provision has changed in the rule effective 9/18/25. See new provisions of the rule Section 8(A)(1)(o).	P 449		