

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

PRINTED: 08/11/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |  |                                                                                                  |                                                                                                                          |                                                                    |                            |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>205134</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                             |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>08/10/2023</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST JOSEPH'S REHABILITATION AND RESIDENCE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1133 WASHINGTON AVE</b><br><b>PORTLAND, ME 04103</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |  | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| F 000                                                                               | <b>INITIAL COMMENTS</b><br><br>On August 10, 2023, an unannounced on-site visit was conducted at St. Joseph's Rehabilitation and Residence for the purpose of an investigation of complaints #ME00039536, #ME00039587, and #ME00040099 and to determine if the facility was in compliance with the Medicare and Medicaid Federal Conditions of Participation requirements for nursing homes. There were no regulatory deficiencies identified as a result of the August 10, 2023 investigation. |                                                                            |  | F 000                                                                                            |                                                                                                                          |                                                                    |                            |

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

TITLE

(X6) DATE

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.