STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205062	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brewer Center for Health & Rehabilitation, LLC	74 Parkway South Brewer, ME 04412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, facility investigation and interview, the facility failed to ensure that a resident's care plan was followed for transfer assist for 1 of 1 sampled resident (Resident #1 [R1]).On 2/19/26, R1's clinical record was reviewed. Documentation indicate that in the past year, R1 suffered a stroke and his/her left side is affected. R1's left arm is flaccid and R1 is unable to move the left arm. Documentation in a nurse note, dated 2/10/26, indicated CNA1 was transferring R1 from his/her wheelchair to the bed. The transfer failed and CNA1 lowered R1 to the floor. The charge nurse assessed the resident and no visible injuries were identified.A review of R1's care plan for the problem deficit in functional mobility, dated 7/28/25, indicated two staff are needed for transfers.A review of the facility investigation and CNA1's written statement regarding the incident was completed. CNA1 wrote that she did not follow the care plan which instructed that two staff are needed for R1's transfers.On 2/19/26 at 9:10 a.m., in an interview with the surveyor, the Administrator confirmed that CNA1 did not follow the care plan which required R1 to be transferred with two staff.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE