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	04/30/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record reviews and interviews, the facility failed to ensure physician orders were followed for 4 of 6 resident's reviewed for medications (Resident #45 [R45], R103, R125, and R74). Findings: 1. On 4/29/26, a review of R45's clinical record was completed. Documentation in the physician orders indicated that an order was written on 4/23/26 for Ceftriaxone Sodium (antibiotic) injection solution, reconstitute 1 gram (Ceftriaxone Sodium), inject 1 gram intramuscularly one time a day for a urinary tract infection for 5 days. A review of R45's Treatment Administration Record (TAR) indicated that the antibiotic was administered on 4/23/26, 4/24/26, 4/26/26 and 4/27/26. There was no evidence that the resident received the antibiotic on 4/25/26. On 4/29/26 at 11:58 a.m., in an interview with the surveyor, the Director of Nursing confirmed that the antibiotic Ceftriaxone had not been administered on 4/25/26. 2. On 4/28/26 at 12:53 p.m., during an interview with a surveyor, R103 stated he/she has had trouble with constipation and diarrhea since admission to the facility. On 4/29/26, R103's clinical record was reviewed and indicated the following: An active order for Loperamide [Hydrochloride (HCl)] Capsule 2 [milligrams (MG)] Give 1 capsule by mouth as needed for diarrhea after loose stool, may repeat [one time (x1)], with a start date of 11/2/25. An active order for Sennosides Tablet 8.6 MG Give 2 tablets by mouth two times a day for constipation Hold for loose stools in the last 24 hours, with a start date of 4/27/26. Review of the Bowel Elimination History indicated that on 4/3/26, R103 did not have a bowel movement. Review of the Medication Administration Record (MAR) indicated R103 received a dose of Loperamide. The Loperamide was not given as ordered. Review of the Bowel Elimination History indicated that R103 had a Loose/Diarrhea bowel movement on 4/4/26. Review of the MAR indicated Loperamide was not given after a loose stool as ordered. Review of the Bowel Elimination History indicated that on 4/6/26, R103 did not have a bowel movement. Review of the Medication Administration Record (MAR) indicated R103 received a dose of Loperamide. The Loperamide was not given as ordered. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Bowel Elimination History indicated that on 4/7/26, R103 did not have a bowel movement and on 4/8/26 R103 had a normal bowel movement. Review of the Medication Administration Record (MAR) indicated R103 received 2 doses of Loperamide on 4/8/26. The Loperamide was not given as ordered. Review of the Bowel Elimination History indicated that on 4/9/26, R103 had 2 normal bowel movements. Review of the Medication Administration Record (MAR) indicated R103 received a dose of Loperamide. The Loperamide was not given as ordered. Review of the Bowel Elimination History indicated that R103 had Loose/Diarrhea bowel movements on 4/10/26 and 4/11/26. Review of the MAR indicated Loperamide was not given after loose stools as ordered. Review of the Bowel Elimination History indicated that on 4/16/26, R103 did not have a bowel movement. Review of the Medication Administration Record (MAR) indicated R103 received a dose of Loperamide. The Loperamide was not given as ordered. Review of the Bowel Elimination History indicated that on 4/21/26, R103 did not have a bowel movement. Review of the Medication Administration Record (MAR) indicated R103 received a dose of Loperamide. The Loperamide was not given as ordered. Review of the Bowel Elimination History indicated that on 4/23/26, R103 had a normal bowel movement. Review of the Medication Administration Record (MAR) indicated R103 received a dose of Loperamide. The Loperamide was not given as ordered. Review of the Bowel Elimination History indicated that R103 had 2 Loose/Diarrhea bowel movements on 4/24/26. Review of the MAR indicated Loperamide was not given after loose stools as ordered. Review of the Bowel Elimination History indicated that R103 had a Loose/Diarrhea bowel movement on 4/26/26. Review of the MAR indicated that a dose of Sennosides was given on 4/27/26b within 24 hours of a loose stool. The Sennosides order was not followed. Review of the Bowel Elimination History indicated that R103 had a Loose/Diarrhea bowel movement on 4/28/26. Review of the MAR indicated Loperamide was not given after a loose stool as ordered, and R103 was given Sennosides on 4/29/26 within 24 hours of a loose stool. The Sennosides order was not followed. 04/29/2026 11:44 PM during an interview, a surveyor and the Regional Director of Clinical Operations reviewed R103's clinical record and confirmed that the physician orders for Loperamide and Sennosides were not followed. 3. On 4/28/26 at 12:53 p.m., during an interview with a surveyor, R103 stated he/she had an appointment with a Urologist who ordered an antibiotic. R103 stated the prescription was filled and in the facility, but the staff refused to provide it for weeks. On 4/29/26, R103's clinical record was reviewed and indicated: On 3/6/26, a provider request form indicated that R103 experienced dysuria and hematuria and R103 made an appointment with the Urologist for 3/18/26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/21/26, a provider request form indicated a request for orders to administer the antibiotic received from the pharmacy. On 4/1/26, a faxed order was sent to the facility stating R103 was seen in the office on 3/18/26 and was ordered an antibiotic to be taken every 8 hours for 7 days. Review of the Medication Administration Record indicated R103 received the first dose of antibiotic on 4/1/26 (12 days after receiving the antibiotic from the pharmacy). On 4/29/26 at 12:51 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated the Urologist did not have a discharge note prepared after R103's visit for the Certified Nursing Assistant or R103 to return with. The DON stated that multiple staff attempted to follow up but were unable to reach the Urologist. At this time the surveyor confirmed the clinical record lacks evidence that staff followed up with the Urologist regarding the antibiotic and/or for a progress note to be maintained in the medical record resulting in the delay of treatment (12 days). 4. On 4/28/2026 during a clinical record review the surveyor noted that Resident #125 had a provider request dated 1/2/26 identifying R125 was having complaints of shortness of breath (SOB), the nurse asked for nebulizer treatments. The provider's response was that R125 already has an order for as needed (PRN) nebulizer ordered which was dated 12/30/25. During review of R125's electronic medication administration record for January 2026 there is no evidence that R125 received any PRN nebulizer treatments as ordered on 1/2/26 when he/she was experiencing SOB. On 4/28/26 at 3:28 p.m. during an interview and a record review for R125 with the Director of Nursing the surveyor confirmed that there was no evidence that R125 received a nebulizer treatment for SOB as ordered on 1/2/26. 5. On 4/29/26 at 8:54 a.m. during a medication administration observation a surveyor observed Certified Nursing Assistant – Medications (CNA-M) administer medications to R74. R74 was seated at a table in the dining room with a Speech Therapist sitting next to him/her. The CNA-M handed R74 a medication cup that contained 14 pills and R74 brought the medication cup to his/her mouth and emptied all 14 pills into his/her mouth and then took a drink of the water provided by the CNA-M to swallow the pills. The Speech Therapist asked the CNA-M if she usually gives R74 his/her medications this way. The CNA-M stated that she usually gives them one at a time. She stated, she sets the medication cup on the table and R74 takes the medication one at a time. The Speech Therapist reminded the CNA-M to give the medications to R74 one at a time. On 4/30/26, a review of R74's clinical record was completed. Documentation in the physician orders indicated an order written on 4/9/26 for Dietary orders Meds whole with water one at a time and upright position. On 4/30/26 at 8:55 a.m. in an interview with the CNA-M, a surveyor confirmed that R74 received his/her medications all at once and not one at a time as ordered by the provider.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by not storing dishes and food in a sanitary manner. In addition, the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 2 of 4 days of survey (4/27/26 and 4/29/26).Findings:On 4/27/26 at 10:48 a.m., during the initial tour of the kitchen, a surveyor, the Food Service Director (FSD) and the Maintenance Director observed and confirmed that the ice machine had 3 draining pipelines, one drain pipeline extended several inches into the receiving vessel, and one was less than 1 inch from the receiving vessel, in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm).On 4/27/26 at 11:50 a.m., a surveyor and the FSD observed and confirmed that the interior of the plate warmer machine was soiled with food debris in all three storage chambers. The FSD stated she was unsure how the machine is cleaned as it does not appear to come apart.On 4/29/26 at 9:30 a.m., during an interview, a surveyor and the FSD observed and confirmed that 1 of the 3 drains for the ice machine in the kitchen did not have the minimum 1 air gap to prevent backflow of water.On 4/29/26 at 9:55 a.m., during an interview, a surveyor and the Maintenance Director observed and confirmed the ice machine drain on A-unit did not have the minimum 1 air gap.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview the facility failed to promote care to residents in a manner that maintains each resident's dignity for 1 of 2 units observed for dining services (Unit A).Finding: On 4/27/26 at 12:50 p.m., a surveyor observed a Certified Nursing Assistant (CNA) serve lunch to 2 residents at a table of 3. Resident #98 (R98) was not served at that time. On 4/27/26 at12:54 p.m., a surveyor observed the CNA serve another table of 3 residents. R98 was still waiting to be served. R98 began calling out to staff in the room stating, is that mine? and gesturing toward a meal tray sitting at the other end of the room. On 4/27/26 at 12:58 p.m., a staff member stopped assisting a resident to eat in response to R98's request for food. The meal tray at the end of the dining room did not belong to R98. The staff member requested a meal tray from the kitchen for R98. On 4/27/2026 at 1:00 p.m., R98 was served their meal (10 minutes after his/her table mates). On 4/27/26 at 1:03 p.m., during an interview with a surveyor, the CNA stated that usually there are 4 staff assisting in the dining room, but they only had 3 today and 2 needed to help residents with feeding assistance. R98 was listed to eat in their room so his/her meal went to the wrong place. At this time, the surveyor confirmed that R98 was not served with dignity when meals were not served to all residents at a table at the same time, and another table was served before R98.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interviews and clinical record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours of admission that included the instructions needed to provide the minimum healthcare information necessary to properly care for 1 of 5 sampled residents (Resident #122 [R122]). Finding: On 4/27/26 at 11:42 a.m., in an interview with a surveyor, R122 stated he/she was admitted to the facility recently and the facility has not discussed his/her plan of care and thinks that it will be done today or tomorrow. R122's clinical record was reviewed and the clinical record lacks evidence that R122's baseline care plan was implemented or developed to provide the instructions needed to provide minimum healthcare necessary to properly care for R122 within 48 hours of admission. On 4/29/26 at 11:51 a.m., during an interview with the Regional Director of Clinical Operations, a surveyor confirmed that R122's baseline care plan was not developed within 48 hours of admission.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observations, interviews, and record review, the facility failed to ensure bed mattresses were compatible with bed frames and identify areas of possible entrapment for 3 of 102 residents observed on survey [Resident #78 (R78, R47, and R45].Findings:1. On 4/28/26 at 8:56 a.m., a surveyor observed R78 lying in bed. The bed frame was observed to be larger than the mattress with several inches exposed at the foot end of the bed creating a potential area for entrapment of body parts. During an interview with the surveyor, R78 stated his/her foot has gotten caught in the gap more than once over the past several months when he/she attempted to get up to the bathroom at night.On 4/28/26 at 2:32 p.m., during an interview, a surveyor and the Maintenance Director observed and confirmed that R78 was lying in bed; the mattress did not fit the bed frame leaving a 5-inch gap at the foot of the bed creating the potential for entrapment of body parts.2. On 4/28/26 at 9:40 a.m., a surveyor observed R47 lying in bed. The bed mattress did not fit the bed frame with a 7-inch gap between the mattress and side rail at the head of the bed creating a potential space for entrapment of body parts. R47 stated that he/she has used this mattress and bed frame for the past month and has not rolled off the side of the mattress onto the exposed bedframe and is able to independently reposition in bed.On 4/28/26 at 2:34 p.m., during an interview, a surveyor and the Maintenance Director observed and confirmed that R47 was lying in bed; the mattress did not fit the bed frame leaving a 7 inch gap at the head of the bed between the top of the mattress and the head board, and a 7 inch gap between the side of the mattress and the siderail, creating potential spaces for entrapment of body parts.3. On 4/28/26 at 9:50 a.m., a surveyor observed R45 lying in bed. The bed frame was observed to be larger than the mattress with several inches exposed at the foot end of the bed creating a potential area for entrapment of body parts.On 4/28/26 at 2:30 p.m., during an interview, a surveyor and the Maintenance Director observed and confirmed that R45 was lying in bed; the mattress did not fit the bed frame leaving a 5-inch gap at the foot of the bed creating the potential for entrapment of body parts.On 4/28/26 at 2:36 p.m., during an interview, a surveyor and the Maintenance Director reviewed the bed assessments. At this time, the surveyor confirmed the bed assessments lack evidence that the foot-end of the beds were assessed for the potential entrapment of body parts.