STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205079	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Center for Health & Rehabilitation, LLC	370 Portland Street Yarmouth, ME 04096

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 - Some	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 and interviews, the facility failed to ensure that a care plan was developed for 2 of 3 sampled residents reviewed for wound care (Resident #2 and #3).Findings:1. Review of Resident #2 clinical record revealed he/she has a chronic abscess to his/her right lateral thigh requiring wound care. On 8/31/25 a nursing note stated, resident returned from ER at 10:30 with 2 new orders of abx (antibiotics) for cellulitis, packing is to stay in place for 48-72 hours. As of 10/20/25 the clinical record lacked evidence of a care plan in place for his/her wound including goals and interventions.2. Review of Resident #3 clinical record revealed on 6/24/25 a wound on his/her left foot, second toe and on 7/19/25 an unstageable pressure ulcer on his/her right foot, both requiring wound care. As of 10/20/25 the clinical record lacked evidence of a care plan in place for his/her wound including goals and interventions.On 10/20/25 at 12:35 p.m., the above information was confirmed with the Director of Nursing and the Director of Clinical Operations.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205079	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Center for Health & Rehabilitation, LLC	370 Portland Street Yarmouth, ME 04096

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 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 record review and interviews, the facility failed to obtain physician orders for wound care, for 2 of 3 residents reviewed for wound care (Resident #1 and #2). Findings: 1. Review of Resident #2 clinical record indicated he/she has a chronic abscess to his/her right lateral thigh. On 8/30/25 a nursing progress note stated Resident #2 has a right thigh abscess that was previously healed on 8/19/25. The nurse was called to the resident's room and found that his/her right lateral thigh appeared swollen and now having drainage resulting in Resident #2 being sent to the emergency room (ER). On 8/31/25 a nursing note stated, resident returned from ER at 10:30 with 2 new orders of abx (antibiotics) for cellulitis, packing is to stay in place for 48-72 hours, additional instructions left in binder for [RN #1 Unit Manager]. Resident #2's clinical record lacked evidence of the emergency room discharge instructions and provider's order for this wound care or any wound care orders for the right lateral thigh from 8/31/25 until 9/11/25. Documentation in the skin and wound section revealed on 9/5/25 the right lateral thigh was assessed and measured by RN#1. On 10/20/25 at 2:18 p.m., during an interview, RN#2 stated, resident #2 has a chronic right lateral hip wound and remembers when he/she returned from the ER. The discharge summary said there was a dressing on his/her hip and it's supposed to be packed, leave it in place with the dressing on it for about 3 or 4 days, then take it off and have the wound Dr. take a look and they're supposed to do new orders. At this time, RN#2 stated she has not provided any wound care on that wound until 9/11/25 when the doctor wrote orders. RN#2 reviewed Resident #2's orders, including current, discontinued and completed orders and could not locate any wound care orders for the right lateral hip from 8/31/25 until 9/11/25 and confirmed she physically had the emergency room discharge summary in her hand and is now unable to find it in the hard chart or the electronic medical record. On 10/20/25 at 2:37 p.m., during an interview with 2 surveyors and the Director of Nursing, RN #1 Unit Manager stated that on 9/5/25 he had unpacked, assessed and repacked the wound. He reached out to the on-call provider to obtain wound care orders. The provider asked him to take a photo of the wound and pack it until a provider could assess it in person. RN #1 was unable to provide orders or documentation of this encounter. The surveyor asked if wound care was provided and physician orders were obtained from 8/31/25 through 9/11/25 when the wound was reviewed by the provider. He stated he was unable to find any information that wound care was provided with the exception of his assessment on 9/5/25. 2. Review of Resident #1's medical record contained a nursing note dated 10/9/25 which stated, Called to patient room for questions regarding NPWT (negative pressure wound therapy). On assessment, wound vac appears to not be functioning correctly r/t dressing malfunction. Supplies due to be delivered tomorrow, wound packed with VASHE soaked gauze per provider in lieu of new NPWT dressing. Review of provider orders lacked evidence of any orders for VASHE soaked gauze. On 10/20/25 at 11:32 a.m., during an interview, the above was confirmed with the Director of Nursing who stated RN#1 had called the provider and got verbal orders for the VASHE dressing but failed to write the order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205079	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Center for Health & Rehabilitation, LLC	370 Portland Street Yarmouth, ME 04096

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record reviews, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 3 residents reviewed for wound care (Resident #1 and #3).Findings: 1. On 10/20/25 review of resident #1's Treatment Administration Record (TAR) contained the following: An order dated 9/12/25 for change wound vac dressing every day shift, every Tues and Fri. On 9/17/25 the TAR lacked evidence that the wound vac dressing was changed. An order dated 9/25/25 for, change wound vac Mon-Wed-Fri and prn every day shift (when necessary). On 10/1/25 the TAR lacked evidence that the wound vac dressing was changed. 2. On 10/20/25 review of Resident #3's TAR contained the following: An order dated 7/23/25 for Wound Care: Right heel, Unstageable- Clean with wound cleanser. Pat dry. Skin prep and cover with foam dressing every day shift. On 10/2/25, 10/5/25, 10/12/25, and 10/15/25 the TAR lacked evidence that the wound care was completed. An order dated 8/31/25 for Wound Care: left foot, second toe, dorsal aspect- 1. Clean with wound cleaner. Pat dry. 2. Apply calcium alginate, and wrap with kerlix gauze. 3. Change ever day shift and as needed. On 10/2/25, 10/5/25, 10/12/25, and 10/15/25 the TAR lacked evidence that the wound care was completed. On 10/20/25 at 12:35 p.m., the above was discussed with the Director of Nursing and the Director of Clinical Operations.