STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205138	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood A Continuing Care Center	220 Kennedy Memorial Dr Waterville, ME 04901

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews, the facility failed to develop a Comprehensive Care Plan that addressed the physical needs of 4 of 22 sampled residents (Resident #9 [R9], R2, R60 and R7).1. R9 was admitted in June 2024 with diagnoses to include chronic pain and bilateral hand and knee contractures. A review of R9's care plan, most recently revised on 10/22/25 states, The resident is (SPECIFY High, Moderate, Low) risk for falls r/t [related to] Gait/balance problems. and lacked evidence that the care plan was accurately revised to reflect R9's current fall risk status. Further review of the care plan indicated a focus of .acute on chronic pain as it relates to my fibromyalgia, contractures, and functional deficits. and interventions included, .Identify, record, and treat the resident's existing conditions which may increase pain.(SPECIFY: arthritis, neuropathies, cancer, osteoporosis, fractures, shingles, peripheral vascular disease, ulcers, contractures, parathesia [paresthesia] r/t stroke). Review of R9's clinical record lacked evidence that R9 has or has had the diagnoses, other than contractures, indicated in the intervention on the care plan. On 12/10/25 at 1:43 p.m. a surveyor discussed the above finding during an interview with the Director of Nursing (DON) and the MDS Coordinator. At this time, the DON and MDS Coordinator reviewed R9's care plan and clinical record and confirmed the care plan was not revised to reflect R9's current needs. 2. R2 was admitted in February 2025 and has diagnoses to include recent left femur fracture, retention of urine, and indwelling urinary catheter. On 12/8/25 at 11:02 a.m., a surveyor observed R2 lying in his/her recliner, with indwelling urinary catheter tubing extending to a urinary drainage bag hanging on R2's bed frame. A review of R2's clinical record revealed that he/she was hospitalized in September 2025 and underwent surgical repair of a left hip fracture. Further record review indicated R2 was again hospitalized in October 2025 and returned to the facility with the indwelling urinary catheter. Further review of R2's clinical record revealed an active physician order for May perform voiding trial once resident is ambulatory. A review of R2's December 2025 Treatment Administration (TAR) record indicated the voiding trial had not been performed because R2 is not ambulatory. R2's care plan, most recently revised 10/29/25 includes the following: (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- - .resident has an ADL [activities of daily living] self-care deficit.recent fall with fx [fracture], recent UTI/Infection.TOILET USE: The resident is able to independently toilet self as desired and requires assistance as requested. - - .resident has had an actual fall with major injury.and functional decline. - - .resident has bladder incontinence r/t Dementia.Ensure the resident has unobstructed path to the bathroom. - - .resident has Indwelling Catheter. On 12/10/25 at 1:50 p.m. a surveyor discussed the above finding with the DON and the MDS Coordinator. At this time, the DON and the MDS Coordinator confirmed that R2's care plan was not accurately revised to reflect his/her current ADL and toileting needs. 3. On 12/9/25, review of R60's clinical record indicated R60 had a fall on 11/20/25 which resulted in a hip fracture and a compression fracture in his/her back. Upon returning from the hospital on [DATE] after having hip surgery the Care Plan identified the focus area as, Impaired physical mobility, The listed interventions were determine level of needed assistance based on Activities of daily living (ADLs) evaluation Educate Resident/Representative on exercise and safe transfer techniques to evaluate post operative ADLs On 12/9/25 at 2:14 p.m., during an interview with the Director of Nursing (DON), R60's clinical record and Care Plan were reviewed. At this time the surveyor confirmed with the DON that R60's care plan was not complete by not addressing recent hip fracture and compression fracture in his/her back and that the care plan was not person centered to address R60's needs. 4. On 12/9/25, review of R7's clinical record indicated R7 needed physical and occupational therapy for a left femur fracture. The Care Plan identified the focus, The resident has limited physical mobility [related to (r/t)] left femur fracture. The associated interventions stated, AMBULATION: The resident requires (SPECIFY: assistance) by (X) staff to walk (SPECIFY FREQ) and as necessary. LOCOMOTION: The resident requires (SPECIFY assistance) by (X) staff for locomotion using (SPECIFY). On 12/9/25 at 3:40 p.m., during an interview with a surveyor and the Unit Manager, R7's clinical record and Care Plan was reviewed. The Unit Manager was unable to determined what requirements should have been specified for assistance, number of staff, and/or frequency needed. At this time the surveyor confirmed the Care Plan was not updated and/or resident centered to address the resident's physical needs related to a femur fracture.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were offered pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations for 2 of 5 residents reviewed for immunizations (Resident #7 [R7] and R8).On 12/9/25, the Facility's Policy Pneumococcal Vaccine, revised 03/2025, was reviewed. The policy stated, 1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility . 2. Assessments of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission.On 12/10/25, from 9:20 - 10:00 a.m., during an interview with a surveyor and the Infection Preventionist (IP), the following was reviewed and confirmed:R7 was admitted on [DATE]. R7's paper chart contained a Prevnar20 Consent Form that was signed by the resident on 10/29/25, the consent form was blank and did not indicate if the resident consented or declined the vaccination. The clinical record lacked evidence that R7 had received, been offered, or refused the pneumococcal series vaccination.R8 was admitted on [DATE]. The clinical record lacked evidence that R8 had received, been offered, or refused the pneumococcal series vaccination.