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 _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWER CENTER FOR HEALTH & REHABILITATION, LLC	**74 PARKWAY SOUTH BREWER, ME 04412**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/18/23, an unannounced visit was conducted at Brewer Center for Health and Rehabilitation for the purpose of investigating facility reported incident #ME00045158. It was determined that Brewer Center for Health and Rehabilitation was not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		

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
	205062	A. BUILDING _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWER CENTER FOR HEALTH & REHABILITATION, LLC	**74 PARKWAY SOUTH BREWER, ME 04412**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 1 assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise and implement an individualized person-centered care plan to render trauma informed care to a resident with a personal history of trauma related to verbal abuse and bullying for 1 of 1 residents reviewed (Resident #1). Finding: On 10/18/23, Resident #1"s clinical record was reviewed indicating the resident was originally admitted to the facility on 4/18/23 with multiple mental health diagnoses as well as Post Traumatic Stress Disorder (PTSD). The Minimum Data Set (MDS) Quartely 3.0, dated 8/15/23, indicated, under "Active Diagnosis" Section I6100, that the resident had PTSD. On 10/18/23 at 10:30 a.m., during an interview with a surveyor, the Bayview Social Worker (BSW) stated that Social Services was responsible to complete the trauma screen on admission and to complete the care plan. The surveyor explained that she was unable to determine what Resident #1's triggers might be based on this screen and review of the careplan. At 11:00 a.m., the BSW provided what information she had. The information provided was included on the Level II Preadmission Screening and Resident Review (PASRR) dated 6/29/22. BSW also stated that the facility's Social History Evaluation, dated 5/12/23, asked questions about if the resident experienced	F 657		

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 _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWER CENTER FOR HEALTH & REHABILITATION, LLC	**74 PARKWAY SOUTH BREWER, ME 04412**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 2 trauma or certain events that were answered with a yes or no response. but it did not ask the resident about what type of event may be a trigger to the past trauma. BSW stated she was unaware that this needed to be included in the evaluation and/or careplan but was able to discuss some of Resident #1's trust issues and feeling no one liked him/her which may have been related to the history of bullying. Upon review of the PASRR, there was some information about what symptoms, events, or behaviors may be triggers or exhibited by the resident. The BSW and surveyor reviewed Resident #1's care plan, and the surveyor confirmed that it was not revised to include trigger-specific interventions to decrease Resident #1's exposure to triggers which may re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. The interventions were not created related what information the facility was able to obtain and was not individualized for Resident #1.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on facility reported incident and investigation, record review, facility policy review,	F 689	Past noncompliance: no plan of correction required.	

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 _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWER CENTER FOR HEALTH & REHABILITATION, LLC	**74 PARKWAY SOUTH BREWER, ME 04412**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

and interviews, the facility failed to supervise a resident safety and complete a new elopement risk evaluation/assessment after a resident received a new power wheelchair and expressed the desire to leave the facility and go to the store. This failure enabled the resident to leave the facility's grounds without staff knowledge or supervision and cross a 3 lane street for 1 of 1 incidents reviewed (10/5/23).

Findings:

Review of the facility's incident report sent to the State Agency on 10/6/23 indicated that Resident #1 was seen by staff across the street on 10/5/23 at 2:13 p.m. after being let outside by a staff member at 1:54 p.m. Staff immediately went to get the resident when he/she was noticed and the resident was returned to the facility with no injuries. The facility's investigation was completed on 10/11/23 and included written statements from staff. Certified Nursing Assistant - Medication (CNA-M) completed a written statement on 10/5/23 that indicated he had seen Resident #1 outside before in his/her old wheelchair and he was the one that let Resident #1 outside. He was unaware that Resident #1 could not go outside unsupervised. Another statement completed by Physical Therapy Assistant (PTA) on 10/7/23, indicated that on 9/29/23, Resident #1 was released from therapy with the new power wheelchair and that Resident #1 asked her about going across the street to the store with the new chair. PTA wrote that she educated Resident #1 that he/she could not leave the premises unsupervised in the power wheelchair.

On 10/18/23 at 9:15 a.m., during an interview with

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 _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWER CENTER FOR HEALTH & REHABILITATION, LLC	**74 PARKWAY SOUTH BREWER, ME 04412**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

a surveyor, the Director of Nursing stated that PTA had not shared with nursing that Resident #1 had asked about leaving the premises with the new power wheelchair. Nursing was not aware that Resident #1 was keeping this power wheelchair either. It was confirmed that a new elopement risk assessment should have been completed on 9/29/23, after the statement of the desire to leave the grounds with the new power wheelchair which would have made Resident #1 an elopement risk.

On 10/18/23 at 9:40 a.m., during an interview with a surveyor, PTA stated that she did not tell anyone about Resident's #1 statement about wanting to leave the facility grounds (with the power wheel chair) but stated that she did educate the resident that he/she could not leave unsupervised. PTA did state that there was a Certified Nursing Assistant in the room when Resident #1 asked about going to the store with the power wheelchair.

On 10/18/23 at 10:30 a.m., during an interview with a surveyor, Resident #1 stated that he/she is now reminded every day that he/she cannot leave the grounds with the power wheelchair. Resident #1 stated that a couple of cars and a bus stopped so he/she could get across the street. Once across the street, Resident #1 stated he/she changed his/her mind and was coming back to the facility.

The facility's policy, "Elopement", revised 2/23, indicated that "Residents will be accounted for at all times" and that "a risk evaluation will be done on new admissions and with a change of resident's condition."

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 _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWER CENTER FOR HEALTH & REHABILITATION, LLC	**74 PARKWAY SOUTH BREWER, ME 04412**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 As a result of this isolated incident, the following corrective actions were initiated with a completion date of 10/16/23: - A new elopement risk assessment was completed on 10/5/23. A wander guard/secure care was placed on Resident #1's power wheelchair. - Resident #1's photo was added to the elopement book that is kept at the front desk of the lobby. - Increased communication between therapy and nursing - educated Therapy Manager about need to communicate to nursing when there is an upgrade of equipment. - Education to nursing that a new elopement risk assessment was to be completed when there is a change of mobility for a resident. - Complete a new elopement risk assessment when a resident receives a new piece of equipment (used for mobility). - During daily morning meetings ask if a resident has received a new piece of equipment. - The facility will continue to conduct elopement drills.	F 689		