STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085034	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breakwater Village	301 Ocean View Blvd Lewes, DE 19958

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44706 Based on record review and interview, it was determined that for one (R255) out of three residents reviewed for abuse, the facility failed to report a bruise of unknown origin. Findings include: 9/26/23 - An admission MDS assessment documented R255 had a BIMS score of 3 (severe cognitive impairment). 10/10/23 6:20 AM - A skin and wound note documented, resident noted with left upper arm bruise of unknown origin while care was being provided. 10/10/23 - A facility incident report documented that R255 had a bruise to the left upper arm. No measurements or description was documented in R255's clinical record. R255 was unable to explain what happened. 10/11/23 12:10 AM - An order note documented, monitor left upper arm bruise until resolved every shift. 10/12/24 2:07 AM - An order note documented, monitor right upper arm and chest bruise until resolved every shift for monitoring. The facility lacked evidence that a bruise of unknown origin was reported to the state agency within the required eight-hour time frame. 3/20/24 12:34 PM - During an interview, E2 (DON) confirmed that the family was not notified. Additionally, E12 confirmed that the incident was not reported to the State Agency. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46988 Based on interviews and review of the clinical record, it was determined that for one (R309) out of two residents reviewed for admission, the facility failed to ensure that R309 had physician orders for the resident's immediate care. Findings include: 1 a. Review of R309's clinical record revealed: 3/6/24 - R309 was admitted to the facility. 3/6/24 6:30 PM - An admission assessment was completed for R309 indicating an indwelling urinary catheter in place. 3/6/24 - A care plan was initiated for indwelling urinary catheter. 3/9/24 - An admission MDS indicated R309 had an indwelling urinary catheter. 3/11/24 11:02 AM - An observation of R309 revealed an indwelling catheter in place and bag in a privacy bag. An interview with R309 confirmed use of indwelling urinary catheter related to neurogenic bladder (retention of urine). 3/12/24 9:32 AM - A physician's order revealed R309 use of indwelling urinary catheter related to neurogenic bladder. 3/13/24 2:22 PM - An interview with E19 (CNA) confirmed R309 was admitted with an indwelling urinary catheter and care was being completed. 3/14/24 1:08 PM - An interview with E15 (UM) confirmed the admission process is completed by the admitting nurse. The admitting nurse is responsible for admission assessments and inputting of physician orders. 3/14/24 1:30 PM - An interview with E18 (RN) confirmed that R309 was admitted on [DATE] and E18 completed the admission assessments and orders. E18 stated R309 was admitted with an indwelling urinary catheter, and she forgot to obtain the batch orders (set of orders) related to the catheter from the provider. b. Review of R309's clinical record revealed: 3/6/24 - A care plan was initiated for diabetes management for R309. 3/6/24 6:30 PM - An admission assessment was completed for R309 and did not indicate that R309 was diabetic. 3/6/24 7:00 PM - A physician's order was written for Levemir (Insulin) and glipizide (oral diabetic) medications. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/12/24 1:05 PM - A physician's order for R309 was written for blood glucose monitoring before meals and at bedtime. Additionally, an order was written for sliding scale insulin coverage with blood glucose results. 3/14/24 1:08 PM - An interview with E15 (UM) confirmed the admission process is completed by the admitting nurse. The admitting nurse is responsible for admission assessments and inputting physician orders. 3/14/24 1:30 PM - An interview with E18 (RN) confirmed that R309 was admitted on [DATE] and E18 completed the admission assessments and orders. E18 stated R309 was diabetic, and she forgot to obtain the batch orders (set of orders) related to the diabetic management from the provider. The facility failed to ensure physician's orders needed for immediate care were present on admission. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46988 Based on interview and record review it was determined that for one (R313) out of one residents reviewed for bowel and bladder incontinence care, the facility failed to ensure that R313 received treatment and care in accordance with professional standards of practice and physician orders. Findings include: 1. Review of R313's clinical record revealed: 6/19/23 - The EMR diagnosis page documented that R313 was admitted to the facility with a diagnosis of chronic idiopathic constipation. 6/19/23 Review of the physician's orders included medications for constipation: - Milk of magnesia (MOM)- give 30 ml by mouth every 24 hours as needed for constipation If no BM x 9 shifts. -Bisacodyl suppository- insert 1 suppository rectally every 24 hours as needed for constipation. Administer if MOM is ineffective or NO bowel movement x 10 shifts. -Bisacodyl oral tablets- give 10 mg by mouth every 24 hours as needed for Constipation. -Senna s tablets- give 2 tablets by mouth in the evening every other day for constipation. -Miralax powder- give 17 grams by mouth one time a day every other day for constipation Administer with 8 oz of fluids. 7/1/23 through 9/30/23 - The CNA documentation of R313's BM activity revealed that the facility failed to ensure that physician's orders were implemented when R313 failed to have bowel movements for nine (9) shifts on the following dates: -Ending on evening shift 7/14/23 - total 20 shifts -Ending on evening shift 9/2/23 - total 22 shifts -Ending on night shift 9/7/23 - total 15 shifts 7/1/23 through 9/30/23 - A review of the MAR's for R313 revealed that the facility lacked evidence of monitoring and initiating bowel protocol for any of the above dates. 7/1/23 through 9/30/23 - A review of the progress notes for R313 lacked evidence that the facility monitored or completed bowel assessments related to above dates. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/20/24 9:19 AM - An interview with E16 (RN) confirmed the bowel protocol occurs after no bowel movement for nine shifts and the nurse would administer MOM. Nurses should be completing a bowel assessment and monitor for bowel movements. If one does not occur, then the next step of bisacodyl oral or suppository is administered. E16 confirmed that R313 did not receive the bowel protocol during the above dates. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47142 Based on observation and interview it was determined that for one (R14) out of one residents reviewed for food the facility failed to prepare food in a form designed to meet the individuals needs. Findings include: Review of R14's clinical record revealed: 6/19/18 - R14 was admitted to the facility. 2/28/24 - A physician's order stated that R14 was on a regular diet with ground meats/mechanical soft texture, regular/thin consistency liquids. (mechanical soft texture are foods that are moist, soft texture, and easily swallowed. Meats are ground or finely cut to equal size no bigger than 1/4 inch). 3/8/24 - A swallow study completed by an outside provider revealed R14 required ground solids and regular liquids. 3/11/24 approximately 12:30 PM - An observation of lunch with R14 revealed whole cauliflower florets. R14's meal ticket stated, 1/2 cup - Ground Parslied Cauliflower. R14 attempted to eat the cauliflower and spit out the stem and stated, I can't eat this, it's too hard. R14 does not use his dentures and has no other natural teeth. 3/11/24 1:10 PM - During an interview, E16 (RN) confirmed that R14 had whole cauliflower florets and the meal ticket stated it was ground cauliflower. 3/14/24 12:19 PM - During an interview, E22 (Food Service Director) was shown the picture of R14's lunch from 3/11/24 and confirmed the cauliflower was not ground. E22 stated that if the vegetable is soft enough, it is acceptable to be given to residents. E22 was informed R14 was unable to consume the cauliflower due to the texture being too hard. E22 stated it was tough to determine which consistency to use (meaning ground or mechanically soft). 3/14/24 12:30 PM - An interview with E23 (Dietician) confirmed that R14 was on a ground diet and he failed his swallow study. E23 confirmed the cauliflower on 3/11/24 was not ground. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.