

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2024
NAME OF PROVIDER OR SUPPLIER Breakwater Commons		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Commons Drive Rockland, ME 04841	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33639</p> <p>Based on record review and interview, the facility failed to notify the physician and the resident representative of significant changes in the resident's condition in a timely manner for 1 of 1 sampled residents. (1#)</p> <p>Finding:</p> <p>On 3/13/24, a review of Resident #1's clinical record was completed. Resident #1's clinical record indicates he/she was hospitalized on [DATE] and diagnosed with a Hemorrhagic stroke.</p> <p>A Physician/Nurse Communication Tool dated 2/19/24 at 10:08 a.m. indicates Resident #1 had left sided weakness, slurring speech and drooping on the right side of his/her face. The blood sugar was noted to be 65 and Blood Pressure 196/90.</p> <p>Nursing progress notes on 2/19/24 at 10:57 a.m. indicate that Resident #1 had a low blood sugar of 65 before breakfast and was given juice, also noticed left sided weakness, slurry speech and facial drooping as well as incontinence of bladder, leaning to the left side, lethargy and confusion noted. Resident #1's blood pressure was noted to be 196/90. Resident #1 was given the medication Hydralazine and a recheck of the blood pressure was 130/65. Resident #1 is still symptomatic. The physician assessed Resident #1 and ordered to send the resident to the emergency department for an evaluation and treatment. Emergency transport came and transported Resident #1 to the emergency department.</p> <p>On 3/13/24 at 1:10 p.m. during an interview with Registered Nurse #1 (RN), he/she stated that Resident #1's blood sugar was taken between 7:30 a.m. and 8:00 a.m. and at that time the resident looked funny. Resident #1 was given the medication Hydralazine for a high blood pressure.</p> <p>On 3/13/24 at 1:00 p.m. during an interview with the physician, he stated that he believed he was notified of Resident #1's change in condition about 9:00 a.m. but feels he should have received a call sooner.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/14/24 at 1:16 p.m., certified Nurses Aid #1 (CNA) stated that he/she was asked by RN #1 and RN #2 to assist Resident #1 with repositioning at approximately 8:10 a.m. CNA #1 states that he/she observed Resident #1 leaning to one side, facial drooping, left sided weakness, garbled speech and not making sense. At that time, CNA #1 expressed concern that Resident #1 may be having a stroke. CNA #1 states that he/she was told that Resident #1's symptoms were due to a low blood sugar and Resident #1 was just drooling. CNA #1 states that he/she entered the room of Resident #1 again at 9:00 a.m. to retrieve his/her breakfast tray. Resident #1 was found alone with facial drooping, left sided weakness and garbled speech. CNA #1 expressed concern again to RN #1 and RN #2 that Resident #1 may be having a stroke. CNA #1 recalls being told that Resident #1's vital signs and blood sugar were normal.</p> <p>Emergency Medical Services (EMS) documentation indicates that the call from the facility to transfer the resident to the emergency department was 10:21 a.m. EMS arrival time to the facility was 10:29 a.m.</p> <p>Additionally, the clinical record lacked documentation that the physician and resident representative were notified of a significant change in Resident #1's medical condition in a timely manner.</p> <p>On 3/13/24 at 2:30 p.m., a surveyor discussed the finding that the physician and resident representative were not notified of a significant change in Resident #1' medical condition in a timely manner.</p>		