STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breakwater Commons	100 Commons Drive Rockland, ME 04841

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on interviews, the facility failed to maintain a comfortable homelike environment for 1 of 2 units reviewed during a complaint investigation (Memory). Findings: On 9/11/24 at 8:00 a.m., the Department of Licensing received an anonymous compliant indicating on 9/8/24 at 10:30 a.m., indicating on multiple times when [family member] has visited her mother/father in the morning, his/her room has been very cold. Resident #1 was admitted on [DATE] and has diagnoses to include dementia, anxiety, depression, and is receiving Hospice services for end of life care and resided on the Memory Care unit. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident 1 had a Brief Interview for Mental Status (BIMS) of 0 of 15 indicating he/she is not cognitively intact. During an interview with 2 surveyors on 9/26/24 at 10:30 a.m., Memory Care Unit Manager (UM) indicated a couple of weeks ago he/she came to work in the am and observed a resident coming out of his/ her room and they looked cold, UM went over to see if he/she wanted a sweater and brought resident back into their room and noted it was very cold. UM looked at the thermostat and the air conditioning (AC) was on and set to 68F. UM turned the heat on and went around to check other rooms and found that there were multiple other rooms that also had their AC on at 68F as well. During a confidential interview with 2 surveyors on 9/26/24 at 10:45 a.m. a SM #2 indicated that some CNA's on the overnight shift have been turning the AC on in the Memory Unit at night to try to keep the residents in bed, so they don't wander. Has come in multiple times to AC on in rooms, very cold. (most recently 2-3 days ago [9/23/24]). not comfortable giving names, but it continues to happen. During an interview with 2 surveyors on 9/26/24 at 2:26 p.m., Director of Nursing confirmed she was aware that staff were turning ac on at night and addressed it in a CNA meeting on 9/17/24 and is not sure if it is still happening or not.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42531 Based on policy review, record reviews, and interviews the facility failed to establish/implement their own grievance policy reviewed for 1 of 4 records reviewed during a complaint investigation (Resident #3). Findings: On 7/29/24 at 9:24 a.m., the Department of Licensing received a complaint indicating they filed a grievance on behalf of their family member (Resident #3) on 7/25/24 and did not receive a response for 30 days, even though [complainant] kept inquiring. Complainant further indicated [he/she] was informed the Grievance Officer was the Director of Nursing (DON) and the facility provided [him/her] with 2 different grievance policies, one policy states a response will be received in 15 days, and the other says they will respond in a reasonable amount of time, but they never told [him/her] what a reasonable amount of time was. Review of facility provided Grievance Policy dated 10/18 states The facility will ensure prompt resolution to all grievances, keeping the resident and resident representative informed through the investigation and resolution process. The facility grievance process will be overseen by a Grievance Official who will be responsible for receiving and tracking grievances through their conclusion . Resident and Resident Representative Notification: The notice shall include. Reasonable time frame for completing the review of a complaint . Upon receipt of a grievance or concerns, the Grievance Official will initiate the appropriate notification and investigation processes per indicial and facility policies. Resolution: The facility will strive for a prompt resolution outcome for grievances or complaints rendered. A reasonable time frame will be agreed upon with involved parties. Review of Resident Admission Packet revealed Notice of Resident Grievance Procedure undated, states . The Administrator will respond to a written grievance within 15 days. The response will include actions taken . Review of facility provided Grievance packet dated 7/29/24 states: Care being provide by [cna] [staff member], UTI concern, decline and hospice needing to do a sternal rub; getting out of bed; drinks. Further review of Grievance packet revealed response was dated 8/26/24. During an interview with 2 surveyors on 9/25/24 at 1:16 p.m., Social Worker (SW) indicated she used to be the Grievance Officer, but the responsibility was transferred to the Director of Nursing in April (2024). SW indicated she does encourage residents and families to try to settle things without a grievance, but when that's not possible they are encouraged to file a grievance with the Director of Nursing and the facility has 15 days to get back to the person that filed it. At this time SW confirmed Resident #3's family member filed the grievance on 7/25/24. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/24 at 2:26 p.m., DON indicated that the SW was the Grievance Officer, but it was the responsibility of whatever department to investigate the grievance. When asked how long it takes to respond to a grievance, the DON replied 30 days and that she felt that was a reasonable time frame. At this time DON confirmed she received complainants' grievance on 7/25/24 but DON didn't file it until the 26 because she had a few questions she needed answered first.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record reviews and interviews, the facility failed to ensure that an injury of unknown origin was reported to the State Agency after a resident was found on the floor and bleeding from a head laceration for 1 of 4 complaint investigations reviewed (Resident #1). Findings: On 9/11/24 at 8:00 a.m., the Department of Licensing received a compliant indicating on 9/8/24 at 10:30 a.m. , Resident #1, who is a high fall risk was left in his/her room unattended in a Broda chair and was found face down on the floor, sustaining head and right hand laceration requiring transfer to and acute care hospital for evaluation and treatment. Resident #1 has diagnoses to include dementia, anxiety, depression, is dependent on staff for all Activities of Daily Living (ADL)'s and is receiving Hospice services for end of life care. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident 1 had a Brief Interview for Mental Status (BIMS) of 0 of 15 indicating he/she is not cognitively intact. Review of facility Resident Incident Reporting Form dated 9/7/23 states .This nurse was notified that resident was on the floor in [his/her] room and the broad chair was lying on its side . Upon entering residents' room this nurse noted resident lying face down but more on [his/her] right side . noticed there was blood on the floor by [his/her] head. Upon checking resident over[he/she] had a laceration to [his/her] outer eye at the end of her eyebrow . During an interview on 9/26/24 at 7:52 a.m., Administrator confirmed the facility did not report this injury of unknown origin to the state. In front of 2 surveyors.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record reviews and interviews, the facility failed to investigate an injury of unknown origin after a resident was found on the floor, bleeding from a head laceration for 1 of 4 complaint investigations reviewed (Resident #1). Findings: On 9/11/24 at 8:00 a.m., the Department of Licensing received a compliant indicating on 9/8/24 at 10:30 a.m. , Resident #1 who is a high fall risk was left in his/her room unattended in a Broda chair and was found face down on the floor, sustaining head and right hand laceration requiring transfer to and acute care hospital for evaluation and treatment. Resident #1 has diagnoses to include dementia, anxiety, depression, and is receiving Hospice services for end of life care. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident 1 had a Brief Interview for Mental Status (BIMS) of 0 of 15 indicating he/she is not cognitively intact. Review of Resident 1's clinical record revealed that he/she is dependent on staff for Activities of Daily Living (ADL)'s and has had multiple falls since admission. Review of facility Resident Incident Reporting Form dated 9/7/23 states .This nurse was notified that resident was on the floor in [his/her] room and the broad chair was lying on its side . Upon entering residents' room this nurse noted resident lying face down but more on [his/her] right side . noticed there was blood on the floor by [his/her] head. Upon checking resident over[he/she] had a laceration to [his/her] outer eye at the end of her eyebrow . Further review of Resident 1's clinical record lacked evidence that an investigation was conducted after this incident. During an interview with 2 surveyors on 9/26/24 at 7:52 a.m., Administrator confirmed the facility did not investigate this injury of unknown origin.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review, interviews, observations, and facility policy, the facility failed to update and include goals and interventions on the resident's current comprehensive care plan for the areas of falls for 1 of 3 residents reviewed (Resident #2), incontinent care for 1 of 3 residents (Resident #3), and psychotropic medication use for 3 of 3 residents reviewed during a complaint investigation. Findings: Review of facility policy Psychoactive Medication Use Policy dated 9/18 states Psychoactive medications will only be used in conjunction with the Individual Care Plan . 1. Resident #1 has diagnoses to include hypertension (HTN), kidney disease, dementia, anxiety, and depression and is receiving Hospice for end of life care. Review of active medication orders dated September 2024 revealed Resident #1 was taking anti-anxiety medications Ativan and Lorazepam, antidepressant Sertraline, and antipsychotic Risperdal. Review of Resident #1 Care plan most recently reviewed on 9/24/24 revealed Mood: I have Depression, Anxiety and Dementia. I use psychoactive medications for management of symptoms of striking out physically, paranoid thoughts, depression, trying to stand on my own. I will have no adverse drug reactions from psychotropic medications over the next 90 days. Monitor, report, and document changes in mentation: Anti- anxiety: sedation, drowsiness, ataxia, dizziness, nausea, vomiting, confusion, headache, blurred vision, skin rash . Further review of Resident #1's clinical record lacked documented evidence that he/she was being monitored for the above medication side effects. During an interview with 2 surveyors on 9/26/24 at 3:09 p.m., the Director of Nursing reviewed the entire clinical record and confirmed Resident #1 was not being monitored for side effects of the above medications. 2. Resident #2 was admitted on [DATE] and has diagnoses to include heart failure, Alzheimer's disease, anxiety, depression and is receiving Hospice for end of life care. Review of active orders dated September 2024 revealed Resident #2 was taking antidepressant medication Sertraline, and Lorazepam for anxiety. Observations of Resident #2 on 9/25/24 at 2:38 p.m., and 9/26/24 at 1:02 p.m., revealed Resident #2 in bed, bed was located against the wall, with fall mat at bedside. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's care plan, most recently reviewed 8/5/24 revealed: FALL: I have a potential for falls r/t poor safety awareness. I will not have any falls over the next 90 days. anticipate and meet needs. keep personal space clutter free. Unable to use call bell due to cognitive impairment. Mobility: extensive assistance required with mobility; Hoyer lift for transferring; COGNITION: Cognition: [Resident #2] has an alteration in mood state related to Alzheimer's dementia with anxiety: Goal: Medications and treatments per physician orders. Monitor for side effects and effectiveness, Medications and treatments per physician orders. Monitor for side effects and effectiveness. Further review of Resident #2's clinical record lacked documented evidence he/she was being monitored for side effects of psychotropic medication use. Further review of Resident #2's care plan lacked evidence of goals and interventions for locating the bed against the wall or fall mat use. In addition, Resident #2's clinical record laced documented evidence he/she was being monitored for side effects of psychotropic medication use. During an interview with 2 surveyors on 9/26/24 at 3:10 p.m., Director of Nursing (DON) reviewed Resident #2's entire clinical record and confirmed it lacked evidence Resident #2 was being monitored for signs and symptoms for psychotropic medication use, and the care plan was not updated with goals and interventions to have the bed against the wall or fall mat use. 3. Resident #3 was originally admitted on [DATE] and has diagnoses to include neurogenic bladder, arthritis, heart failure, dementia, anxiety, depression and is receiving Hospice services for end of life care. Review of Resident #3 Care plan initiated on 6/18/24 revealed Urinary Continence: I am incontinent of urine. I require your total assist for incontinence care.Check for incontinence at times such as before or after meals, HS, and prn; change if wet/soiled [minimum of 6 times daily]; Mood and Behavior: .I take medication for my moods/behaviors . will have no adverse drug reactions from psychotropic medications over the next 90 days. Monitor Anti- anxiety: sedation, drowsiness, ataxia, dizziness, nausea, vomiting, confusion, headache, blurred vision, skin rash. Antidepressant: sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity, excessive weight gain. Antipsychotics: sedation, drowsiness, dry mouth, constipation, blurred vision, EPS, weight gain, edema, postural hypotension, seizures, glaucoma, jaundice. Hypnotic/Sedative: Sedation, drowsiness, ataxia . Review of entire clinical record laced evidence lacked documented evidence Resident #3 received/refused incontinent care per care plan and lacked evidence he/she was being monitored for side effects of psychotropic medication use. During an interview with 2 surveyors on 9/26/24 at 2:50 p.m., the Director of Nursing reviewed the entire clinical record and confirmed Resident #3 is not being monitored for side effects of psychotropic medication, and was not receiving incontinent care per care plan interventions.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 sampled residents reviewed for incontinent care (Resident #1). Findings: Resident #3 was originally admitted on [DATE] and has diagnoses to include neurogenic bladder. Review of Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had a Brief Interview for Mental Status (BIMS) of 0 of 15 indicating he/she is not cognitively intact. Further review of MDS revealed he/she is dependent on staff for all Activities of Daily Living (ADL). Review of Resident #3 Care plan initiated on 6/18/24 revealed Urinary Continence: I am incontinent of urine. I require your total assist for incontinence care.Check for incontinence at times such as before or after meals, HS, and prn; change if wet/soiled [minimum of 6 times daily]. Review of ADL Verification Worksheet dated July 2024 revealed Resident #3 received incontinent 1 (one) time on 7/10/24, 7/18/24, 7/24/24, 7/25/24, 7/26/24, 7/27/24, 7/28/24, and 7/31/24. 2 (two) times on 7/1/24, 7/2/24, 7/3/24, 7/4/24, 7/8/24, 7/9/24, 7/12/24, 7/15/24, 7/16/24, 7/17/24, 7/19/24, 7/20/24, 7/22/24, 7/23/24, and 7/30/24, and 3 (three times) on 7/5/24, 7/6/24, 7/7/24, 7/11/24, 7/13/24, 7/14/24, and 7/29/24. During a review of Resident #3's clinical record with 2 surveyors on 9/26/24 at 2:55 p.m., the Director of Nursing (DON) indicated that at the time of documents reviewed, residents should have been toileted/changed at each meal time, first thing in the morning, before bed and any other time necessary in between. At this time DON confirmed above findings.