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	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breakwater Commons	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 37015 Based on interviews and review of the facility internal investigation reports, the facility failed to ensure that 2 of 5 residents reviewed were treated with dignity and respect (#1, #4) . Findings: 1. On 10/21/24, the Division of Licensing and Certification received a facility reported incident. The report noted that a Resident #1 complained to his/her family member that there was a bar under him/her. The family member moved the bed linens and saw that a bedpan had been left underneath the resident. A review of the clinical record for Resident #1 revealed diagnoses that included Alzheimer's Disease and recent fractures of the left hip and humerus. A review of the Minimum Data Set (MDS) 3.0, Admission Assessment, dated 10/17/24, noted in Section C0500, Cognitive Patterns, a BIMS (Brief Interview of Mental Status) score of 3, indicating severe cognitive impairment. Section GG0130, Self Care, Resident #1 was dependent on staff for toileting, lying to sitting, and sitting to standing for bed mobility. A review of the facility's internal investigation noted staff had failed to effectively communicate that Resident #1 was placed on a bedpan resulting in Resident #1 being left on the bedpan for approximately one and one half hours. Written statements obtained from the CNA (Certified Nursing Assistant) who had placed Resident #1 on the bedpan noted he/she assumed that others had removed the bedpan. On 11/12/24 at 10:30 a.m., in an interview with a surveyor, the Director of Nursing (DON) confirmed that on 10/21/24, Resident #1 had been placed on the bedpan between 6:15-6:30 a.m. The family member reported finding Resident #1 on the bedpan at 7:50 a.m., and stated staff immediately removed the bedpan and assessed the resident's skin. The DON stated on 10/21/24 at 8:18 a.m., she assessed Resident #1 and noted a red line on the skin where the bedpan had been. In follow-up, the facility terminated the contract with the agency CNA. 2. On 10/31/24, the Division of Licensing and Certification received a facility reported incident. The report noted that a licensed nurse heard a CNA state to Resident #4, Stop being an asshole. You always make up stuff to hit your call light. (continued on next page)

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #4's clinical record noted diagnoses including spinal stenosis with bilateral foot drop, osteoarthritis, osteoporosis, diabetes mellitus with polyneuropathy and chronic pain. No recent BIMS assessment was located in the record. A nursing progress note, dated 10/30/24 at 5:18 p.m., stated Resident #4's daughter was called regarding an allegation of verbal abuse and that it was being reported and investigated. On 11/12/24 at 12:40 p.m., in an interview with a surveyor, the DON discussed the facility's investigation. She stated when Resident #4 was interviewed, he/she did not remember being called a name. The CNA, who was employed by a travel staffing agency, denied the allegations. The CNA's agency contract had ended and the facility notified the agency of the allegations. On 11/12/24 at 4:00 p.m., in the exit interview with the facility's Administrator and DON, the surveyor discussed that residents had not been treated with dignity and respect when CNA staff left Resident #1 on the bedpan for an hour and a half, and when swearing at Resident #4. On 11/21/24 at 8:58 a.m., in a telephone interview with a surveyor, the licensed nurse stated I was sitting at my desk and (Resident #4's) room is right by the nurses station. I can hear just about anything. I heard her (CNA) say 'you're acting like an asshole. Why do you keep ringing? You're being an asshole. The nurse stated I walked in and talked to (Resident #4) and apologized for the way the CNA acted.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37015 Based on observation and interviews, the facility failed to serve food in accordance with professional standards for food service safety by not delivering food in a sanitary manner for 1 of 1 units observed during the noon meal service. (East unit) Finding: On 11/12/24 at 12:10 p.m., a surveyor observed the noon meal service on the East unit. A CNA (Certified Nursing Assistant) was observed carrying a tray with an uncovered plate of pot pie and an uncovered dessert down a hallway to a resident's room. The CNA returned to the serving line with the tray and stated the resident wanted a salad instead. The surveyor asked if meals were always delivered to residents in their rooms in this manner. The dietary aide stated meals were always delivered on trays this way. At this time, the surveyor observed several CNAs were present at the serving line. The surveyor asked if they knew the correct way the trays should be delivered. One CNA picked up a plate cover and placed it over the next meal tray's plate. The CNA who had delivered the uncovered tray asked the surveyor if all items were supposed to always be covered. The surveyor confirmed that food items should be covered. On 11/12/24 at 12:30 p.m., the surveyor discussed the observation with the Administrator, who acknowledged the concerns with delivering uncovered meals down the hallways.