

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 05/28/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on record review and interview, the facility failed to obtain a physician order to change an indwelling urinary catheter (Foley catheter) for 1 of 3 residents reviewed for indwelling urinary catheters (Resident #1).</p> <p>Finding:</p> <p>Resident #1 has diagnoses to include benign prostatic hyperplasia (enlarged prostate), retention of urine, urinary tract infection, and Foley catheter.</p> <p>Review of Resident #1's clinical record revealed a nursing progress note, dated 4/29/25, stating, Resident complained of pain with [his/her] foley catheter. Foley was not flowing. This nurse flushed foley with no relief. Foley catheter 16 french was changed out. Balloon filled with 10 cc [cubic centimeters]. Resident stated relief from pain. No issues with the foley change. Resident tolerated well. 750 urine output.</p> <p>Further review of Resident #1's clinical record lacked evidence of a provider order for an as-needed (PRN) Foley catheter change.</p> <p>On 5/28/25 at 1:51 p.m., during an interview, Nurse Practitioner (NP) #1 stated she was unaware of the above Foley catheter change on 4/29/25.</p> <p>On 5/28/25 at 4:28 p.m. during a telephone interview, NP #2 stated a nurse should have an order to change a foley catheter and that he was not made aware of the above concerns with Resident #1's Foley catheter, did not give an order for a PRN Foley catheter change on 4/29/25, and was not contacted about it until the next day when the Director of Nursing called him.</p> <p>On 5/28/25 at 5:04 p.m. during a telephone interview, Licensed Practical Nurse (LPN) # 1 stated Resident #1's catheter slipped out and there was no liquid in the balloon, so she used a PRN order to change the Foley catheter and stated she did not check Resident #1's orders to ensure there was a PRN order prior to changing the Foley catheter.</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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents reviewed for indwelling urinary catheters (Resident #1).</p> <p>Findings:</p> <p>1. Resident #1 has diagnoses to include benign prostatic hyperplasia (enlarged prostate), retention of urine, urinary tract infection, and indwelling urinary catheter (Foley catheter).</p> <p>Review of Resident #1's active physician orders revealed an order with a start date of 1/13/25 for, Intake and Output (I & O) 2 Times Daily .</p> <p>Review of the April and May 2025 Treatment Administration Records (TAR) revealed I & O is scheduled daily at 5:00 a.m. and 6:00 p.m. Further review of the April 2025 and May 2025 TAR lacked documentation of intake and lacked evidence that output was recorded on the following dates:</p> <p>-4/1/25 at 5:00 a.m.</p> <p>-4/6/25 at 5:00 a.m.</p> <p>-4/8/25 at 5:00 a.m.</p> <p>-4/11/25 at 5:00 a.m.</p> <p>-4/27/25 at 6:00 p.m.</p> <p>-5/7/25 at 6:00 p.m.</p> <p>On 5/28/25 at 11:15 a.m., during an interview with 2 surveyors, the above finding was discussed with the Regional Quality Improvement Specialist. At this time, the Regional Quality Improvement Specialist stated I&O should be entered on the TAR by the nurse and should include any I&O documented by the Certified Nursing Assistant (CNA) because the provider reviews the TAR, not CNA documentation to determine urinary output.</p> <p>2. Review of Resident #1's clinical record revealed the following nursing progress note, dated 5/8/25 by the East Unit Manager ([NAME]):</p> <p>Resident advised this RN that [he/she] 'felt like [he/she] had to urinate.' This RN assessed resident's catheter bag to see if there was urine draining into the bag. Bag contained very little urine . Unable to flush tubing. This RN removed catheter .Following sterile procedure for insertion of catheter, this RN inserted a 16 Fr [French] into resident's bladder .Secured tubing to left leg .Urine flowing freely into catheter bag.</p> <p>Further review of the clinical record revealed the progress note did not specify a late entry and was not entered until 5/13/25 at 11:23 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/28/25 at 11:15 a.m., during an interview, the Regional Quality Improvement Specialist stated the above progress note was entered late because during the facility's investigation of an incident concerning Resident #1, the facility discovered the [NAME] had not documented the above concern on 5/8/25 when it occurred.</p> <p>On 5/28/25 at 1:47 p.m., during an interview, the [NAME] stated she had a really busy day and did not document the progress note until 5/13/25.</p> <p>3. Review of Resident #1's active physician orders revealed an order with a start date of 3/26/25 for, Insert indwelling catheter (16 french) Every Twenty-Eight Days starting 3/26/25 .</p> <p>Review of Resident #1's April 2025 TAR revealed his/her indwelling catheter was changed, according to the above order, on 4/23/25.</p> <p>Review of Resident #1's clinical record revealed a nursing progress note, by the East Unit Manager ([NAME]), dated 5/8/25 stating, Resident advised this RN that [he/she] 'felt like [he/she] had to urinate.' This RN assessed resident's catheter . Unable to flush tubing. This RN removed catheter . Following sterile procedure for insertion of catheter, this RN inserted a 16 Fr into resident's bladder .</p> <p>Further review of the clinical record lacked evidence of a provider order for the indwelling catheter insertion on 5/8/25.</p> <p>On 5/28/25 at 1:47 p.m., during an interview with 2 surveyors, and in the presence of the Regional Quality Improvement Specialist, the [NAME] stated she had received a verbal order from NP #1 for the catheter change and didn't enter the order and should have.</p>

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on record review and interview, the facility failed to implement its Quality Assurance and Performance Improvement (QAPI) program to ensure compliance with its Plan of Correction (POC) for F-842, related to intake and output (I & O) documentation resulting in inaccurate and incomplete documentation. During the revisit survey on 7/16/25, F-842 was recited related to incomplete intake and output (I & O) documentation. The facility POC indicated a date of correction date of 7/10/25 that included the following corrective actions: A house audit was performed by the unit managers of resident charts for residents with an order for I & O tracking. Educate nurse managers on documenting the facility order protocol inclusive of entering verbal provider orders into the clinical chart. Nurse managers/designee will conduct weekly audits for 60 days. Audit results will be reviewed in QAPI. On 7/16/25 a.m. at 2:00 pm during an interview with a surveyor, the above finding was confirmed with the Regional Quality Improvement Specialist.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2 Review of Center for Disease Control: Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) updated July 12, 2022 states Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves). For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. Make PPE, including gowns and gloves, available immediately outside of the resident room. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.</p> <p>Review of facility provided Foley Catheter list revealed Residents #1, #2, #3, #4, #5, #6, #7, #8 and #9 had indwelling foley catheters.</p> <p>During an observation of above resident rooms on 5/28/25 between 12:00 and 12:20 p.m., with two surveyors and Quality Improvement Specialist (QIP) revealed the following:</p> <p>East Wing</p> <ul style="list-style-type: none"> -room [ROOM NUMBER]B, belonging to Resident #2, lacked signage at the door, no PPE available for use. -room [ROOM NUMBER]A, belonging to Resident # 3, lacked signage at the door, no PPE available for use. -room [ROOM NUMBER]-1, belonging to Resident #1, lacked signage at the door, no PPE available for use. -room [ROOM NUMBER] belonging to Resident #6, lacked signage at the door, no PPE available for use. <p>room [ROOM NUMBER] belonging to Resident #8 revealed a sign on the footboard of the bed stating Enhanced Barrier Precautions. There is no signage at the door and no PPE available for use.</p> <p>South Wing</p> <ul style="list-style-type: none"> -room [ROOM NUMBER]-A belonging to Resident #5 revealed a sign attached to footboard stating Enhanced Barrier Precautions. There is no signage at the door and a bag hanging over the back of the door that is empty. There is no PPE available for use. -room [ROOM NUMBER]-1 belonging to Resident #4 revealed an Enhanced Barrier Sign face down on the floor behind the door. There is no PPE available for use. -room [ROOM NUMBER] belonging to Resident #9 revealed no sign on door, and no PPE available for use. <p>At this time QIP confirmed above findings.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/28/25 at 11:28 a.m., QIP stated facility follows Lipincott for Enhanced Barrier Precautions. At this time provided surveyor with Clinical & Nursing Services Policy (Not otherwise Specified) dated 10/18 states The Lippincott Manual of Nursing Practice will be utilizes as a reference guide for standard clinical information and procedures. The Lippincott Manual of Nursing will be updated annually or when new additions are published. North Country Associates will utilize the Maine CDC website for infection control issues .</p> <p>During in interview on 5/28/25 at 1:30 p.m., The Director of Nursing (DON) was asked to the facilities Lippincott Manual. At the time DON stated that she did not know where it was as the had been looking for it the other day.</p> <p>Based on record review, observations, interviews, facility policy, and Center for Disease Control (CDC) guidance the facility failed to maintain and implement an infection control program to help prevent the development and transmission of infectious disease for 9 of 9 residents reviewed for foley catheters. (Residents #1, #2, and #3, #4, and #5, #6, #7, #8, and #9).</p> <p>Findings:</p> <p>Review of facility policy Infection Control: Multi-Resistant Organism (MDROs) Policy dated 4/18/24 states Enhanced Barrier Protection (EBP): Gowns and gloves are worn during high-contact resident care activity. Examples of high-contact activity are: Providing device care Device care would include, . Catheters . Residents being treated for an active MDRO infection will be placed on Contact Precautions. EBP is indicated for anyone with chronic wounds and indwelling medical devices regardless of MDRO status</p> <p>1. Resident #1 has diagnoses to include urinary tract infection requiring an indwelling urinary catheter.</p> <p>Review of Resident #1's care plan, most recently updated on 5/13/25, revealed, .has an Infection related to Urinary tract infection .Contact precautions .</p> <p>Review of Resident #1's hospital Discharge summary, dated [DATE], revealed, Urine positive for klebsiella and e. Coli [Escherichia coli] .</p> <p>On 5/28/25 at approximately 12:00 p.m., an observation of Resident #1's room lacked signage/Personal protective equipment (PPE) for transmission-based precautions (TBP).</p> <p>On 5/28/25 at 11:55 a.m., during an interview, Registered Nurse #1 stated there are no residents on the East Wing on any precautions.</p> <p>On 5/28/25 at 1:43 p.m., during an interview, a surveyor discussed the above finding with the Regional Quality Improvement Specialist, and she stated Resident #1 should be on contact TBP.</p> <p>On 5/28/25 at 2:45 p.m. during an interview, the Infection Preventionist (IP) stated that the facility currently does not have any residents on TBP. At this time, a surveyor reviewed the above finding with the IP, and the IP stated Resident #1 should be on contact TBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/28/25 at 4:05 p.m., Certified Nursing Assistant (CNA)1 stated she was never made aware that Resident #1 was on contact precautions.</p>

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to implement and maintain an effective training program for nursing staff in the areas of urinary catheter care, as part of the facility's follow-up to their facility reported incident dated 5/12/25. Additionally, the facility failed to implement and maintain an effective training program for nursing staff contracted through a staffing agency, in the areas of urinary catheter care and infection prevention, for 2 of 2 staff reviewed during an investigation of a facility-reported incident (Licensed Practical Nurse [LPN] #2, #3).</p> <p>Findings:</p> <p>1. The facility's 5-day follow-up, submitted to the state agency on 5/19/25, states, .The clinical coordinator will educate licensed staff on foley catheter policies and procedures .</p> <p>Upon entrance to the facility, the survey team requested evidence of the above education. A folder, containing educational materials titled, Flushing Urinary Catheters, Catheter Care Competency, Urinary Catheter or Urinary Tract Infection Critical Element Pathway, and Urinary Catheter Care Education for RNs [Registered Nurses]; and facility Policy, Urinary Catheters Insertion and Maintenance, was provided by the Director of Nursing Services (DNS). Scheduled Friday 5/30 2pm was written on a Post-It note on the cover of the folder.</p> <p>On 5/28/25 at 9:52 a.m., during an interview, the East Unit Manager ([NAME]) stated she conducted a debriefing with her staff following the incident, but staff has not received any education and that the Educator is responsible for conducting education.</p> <p>On 5/28/25 at 10:18 a.m., during an interview, RN #2 stated that she has not received education following the incident and that the Educator is responsible for staff education.</p> <p>On 5/28/25 at 1:47 p.m., during an interview, the Regional Quality Specialist stated that skills checklists for nurses and Certified Nursing Assistants (CNA) were established but have not been implemented.</p> <p>On 5/28/25 at 3:43 p.m, during an interview, the DNS stated the Educator gathered information and gave it to the unit managers to provide education. At this time, the DNS confirmed education had not been implemented prior to the survey team entrance today.</p> <p>2. Review of Reportable Incident Form, dated 5/12/25, indicates LPN #1 was a witness to the incident dated 5/11/25.</p> <p>Review of LPN #1's Core Mandatory Clinical Assessment competency, completed 2/23/25 by the staffing agency lacked evidence of education on urinary catheter care.</p> <p>Review of LPN #2's Core Mandatory Clinical Assessment competency, completed 2/23/25 by the staffing agency lacked evidence of education on urinary catheter care.</p> <p>(continued on next page)</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/28/25 at 2:32 p.m., Nurse Educator stated at the time of the incident she was asked to find education for foley care, which she did. She made 4 folders that included all the education resources she gathered. She was never directed to start education, just to gather the information. Confirmed only facility staff receive new hire orientation.</p> <p>On 5/28/25 at 3:32 p.m. during an interview, the DNS and the IP stated agency staff do not receive an orientation or education, other than a handbook emailed to them, and the facility relies on competencies provided by the staffing agency.</p> <p>On 5/28/25 at 4:03 p.m., during a telephone interview, LPN #2 stated she has the option for education through her staffing agency but has not been offered any training by the facility.</p> <p>On 5/28/25 at 4:21 p.m., during a telephone interview, LPN #1 stated she was the dayshift nurse on the day the facility-reported incident occurred, and that she has not had any training on urinary catheter care, transmission-based precautions (TBP), or enhanced barrier precautions (EBP). LPN #1 then stated that she wears gloves to provide catheter care but does not wear a gown unless a resident is on TBP. When a surveyor asked what Enhanced Barrier Precautions require, LPN #1 stated she knows EBP are regarding skin tearing and skin health and means residents are at an increased risk of friction, shearing, and pressure ulcers, so staff need to keep an extra eye on the resident's bottom and provide good incontinence and perineal care.</p>