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	01/23/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on facility policy review, record reviews, and interviews, the facility failed to ensure that the resident and/or resident representative was provided with written information, concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive, or appoint a surrogate, was completed for 11 of 13 residents reviewed for advanced directives. (Resident #13, #79, #16, #84, #17, #83, #86, #54, #85, #37, #33). Findings: Review of facility policy Advanced Directives dated 10/18 states .The resident has the right and the facility will assist the resident to formulate an advanced directive at their option. Upon admission, the facility will inform and provide the resident and/or resident's representative with information about advance directives. Upon admission, identify if the resident has an advance directive and if not, determine if the resident wishes to formulate an advanced directive. a resident has the option to execute an advance directive but will not be required to do so. 1.Resident #13 was admitted on [DATE]. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 2. Resident #79 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 33639 3. Resident #16 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #84 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 37648 5. Resident #17 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 6. Resident #83 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 7. Resident #86 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 51331 8. Resident #54 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 9. Resident #85 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 51669 10. Resident #37 was admitted on [DATE]. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representative, or that the resident and/or resident representative were provided, written information concerning the right to formulate an advanced directive. 11. Resident #33 was admitted on [DATE]. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representative, or that the resident and/or resident representatives were provided, written information concerning the right to formulate an advanced directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/22/25 at 9:54 a.m., the Quality Improvement Specialist confirmed that the above residents and/or resident representatives were not offered/reviewed or provided with written information concerning the right to formulate an advanced directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on record review and interview, the facility failed to ensure that a medical provider and the resident's representative were notified of a significant change in medical condition for 1 of 2 residents reviewed for death (Resident #243). Finding: Upon review of Resident #243's clinical record, a hospice Discharge Summary dated [DATE] stated during a telephone call, the resident's representative reports anger with the facility that she was not notified of [Resident #243's] change in status from transitioning to active and was not given the opportunity to be present when [Resident #243] died . Review of all the Nursing notes from [DATE] through [DATE] included all of the following: Nursing note on [DATE] at 1:37 p.m. stated, Alert but not swallowing well and pocketing of food noted at lunch. [Doctor] notified. New orders received and noted to downgrade to puree texture diet. Notified [resident representative] of new order. Nursing note on [DATE] at 6:11 p.m. stated, Had eaten all of (his/her) mashed potatoes for lunch today, however at dinner resident has been holding puree food and fluids in (his/her) mouth and not swallowing. Lots of encouragement required for resident to swallow. Also groaning and yelling out during dinner, PRN morphine administered. Nursing note on [DATE] at 8:20 p.m. stated, HS meds held due to lethargy and not awake enough to swallow medications. Resident had difficulty swallowing at supper this evening and was holding (his/her) food and drinks in (his/her) mouth. Charge nurse notified. Hospice was in this evening and nurse notified her of the above and resident's difficulty swallowing. Nursing note on [DATE] at 10:27 a.m. stated, Writer was called to assess patient, upon exam death was noted to be at 1007 on [DATE]. Exam: upon auscultation there were no heart sounds and breath sounds were noted after 1 minute. Eyes were fixed and dilated without pupillary light reflex, no palpable central pulse was noted, no response to painful stimuli noted. Provider notified . Family notified by phone and is traveling here to see [Resident #243], staff was notified postmortem care was provided. Hospice was called . On [DATE] at 10:09 a.m., during an interview, Registered Nurse #3 (RN#3) stated she was working on a different unit the day Resident #243 passed. She was asked by the Licensed Practical Nurse to come over to pronounce the death. The surveyor asked if Resident #243 had family present. RN#3 stated, Nobody, I had to call the daughter myself to have her come. On [DATE] at 10:55 a.m. the lack of nursing documentation of the resident decline with medical provider and family representative being notified from [DATE] through [DATE] was discussed with the [NAME] President of Quality Improvement and Nursing Services.

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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** 37648 Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 2 of 3 units (East and South) for 3 of 3 days of survey. Findings: East Unit: 1. On 1/21/25 at 11:28 a.m., observations of room [ROOM NUMBER]'s, shared bathroom with 2 basins stored on the floor under the sink. One of the basins had a commode bucket stored in it. room [ROOM NUMBER]'s bathroom had a wash basin on the floor with commode bucket stored inside of it. 2. On 1/22/25 at 8:41 a.m., observations of room [ROOM NUMBER]'s bathroom had a commode bucket on the floor with the basin stored inside of it. room [ROOM NUMBER]'s bathroom had a commode bucket stored on the floor. 3. On 1/23/25 from 8:13 a.m. to 8:21 a.m., the Surveyor and the Director of Nursing discussed the above observations and observed both rooms [ROOM NUMBERS]'s bathrooms with commode buckets stored on the floor. 42531 South Unit: 4. On 1/21/25 at 9:23 a.m., and on 1/22/25 at 7:31 a.m., observations of room [ROOM NUMBER]'s bathroom with an uncovered bed pan stored on shelf in between 2 wash basins. 5. On 1/21/25 at 9:37 a.m., and on 1/22/25 at 7:35 a.m., observations of room [ROOM NUMBER]'s bathroom with an uncovered bed pan on shower shelf with 3 briefs stored inside it. On 1/23/25 at 9:20 a.m., during an interview with 4 surveyors, the Director of Nursing confirmed the bed pans were not stored properly.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 37648 Based on record review and interview, the facility failed to ensure that a Minimum Data Set, Version 3.0 (MDS) Significant Change in Status Assessment was completed within 14 days from the effective date of the Hospice election, for 1 of 2 sampled residents reviewed for hospice (Resident#243). Finding: The Resident Assessment Instrument (RAI) Version 3.0 Manual, Chapter 2, page 2-23 reads that a Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The Assessment Reference date (ARD) must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. Resident #243's clinical record indicated the resident was receiving hospice services, with the admitted into hospice as 6/19/24. Further review showed a Significant Change in Status Assessment completed on 9/17/24, 76 days later than required. On 1/23/25 at 10:55 a.m. the above was discussed with the [NAME] President of Quality Improvement and Nursing Services.

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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** 37648 Based on observation, record review and interview, the facility failed to ensure that a care plan was developed in the area of cardiac pacemaker (Resident #86, #83), hospice services (#243), respiratory needs (#54, #16) and psychoactive medications (#71) for 6 of 26 sampled residents reviewed for comprehensive care plans. Findings: 1. On 1/21/25 at 9:56 a.m., during an interview, Resident #86 stated he/she had a pacemaker placed about 1 year ago and is followed by cardiology. Review of Resident #86's medical record states he/she was admitted on [DATE] with a diagnosis of sick sinus syndrome, chronic atrial fibrillation and nonrheumatic aortic insufficiency with the presence of cardiac pacemaker. The medical record lacked evidence that a comprehensive care plan had been developed in the area of a cardiac pacemaker. On 1/22/25 at 11:32 a.m., during an interview, the [NAME] President of Quality Improvement and Nursing Services the care plan lacks pacemaker. 2. Resident #83 was admitted on [DATE] with diagnosis of Atrial fibrillation with the presence of cardiac pacemaker. The medical record lacked evidence that a comprehensive care plan had been developed in the area of a cardiac pacemaker. On 1/22/25 at 2:29 p.m., during an interview, the above was confirmed with the [NAME] President of Quality Improvement and Nursing Services and the Quality Improvement Specialists. 3. Resident #243 was admitted to Hospice services on 6/19/24 for primary diagnosis of senile degeneration of brain and passed away on 10/5/24. The medical record lacked evidence that a comprehensive care plan had been developed in the area of hospice/end of life care. On 1/23/25 at 10:00 a.m., the above was discussed with the Director of Nursing and the [NAME] President of Quality Improvement and Nursing Services. 51331 4. Resident #54 was admitted to the facility on [DATE]. Review of the residents physican orders indicates that he/she has been recieving oxygen since 11/20/24 with the diagnosis of Hypoxia. Further review of the his/her medical record lacks evidence of a care plan for oxygen usage. On 1/22/25 at 1:50 p.m., the above information was confirmed with the Quality Improvement Specialist. 33639 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #16's physician orders indicates that he/she has been recieving oxygen since 11/11/24 with the diagnosis of an Upper Respiratory Infection. Resident #16's medical record lacks evidence of a care plan for oxygen usage. On 1/23/25 at 9:30 a m., the above information was confirmed with the Director of Nursing. 6. Resident #71's Minimum Data Set (MDS) 3.0 Admission assessment dated [DATE], under Care Area Assessment Summary, noted Resident #71 would be care planned for Psychotropic Drug use. As of 1/23/25, Resident #71's medical record lacked evidence of a comprehensive care plan in the area of psychotropic drug use. On 1/23/25 at 1:45 p.m., in an interview, the [NAME] President of Quality Improvement and Nursing Services confirmed the above finding.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on interviews, record reviews, and facility policy, the facility failed to review and revise the care plan by an interdisciplinary team (IDT) meeting, which included the participation of the resident and resident's representative, after each Minimum Data Set (MDS) 3.0 assessments, for 10 of 26 residents whose care plans were reviewed (#73, #79, #90, #28, #51, #54, #67, #71, #37, #40). Findings: Review of policy Comprehensive Person Centered Care Planning. Dated 119 states The comprehensive person-centered care plan must be consistent with resident rights, developed with the resident/representative input; Include resident goals and desired discharge plans; The facility must develop and implement a comprehensive person centered care plan for each resident, which includes measurable objectives and time frames to meet a residence medical, nursing, and mental/ psychosocial needs identified in the comprehensive assessment/evaluation. A comprehensive care plan must be: Developed within seven days after completion of the comprehensive assessment . 1. Resident #73 was admitted on [DATE] and has diagnoses to include Parkinson's Disease. Review of Resident #73's clinical record revealed he/she had a Brief Interview for Mental Status of 15 of 15 indicating he/she is cognitively intact. Further review of Resident #73's clinical record revealed that an Interdisciplinary Team Meeting (IDT) was held on 1/20/2025. The clinical record lacked evidence that Resident #73 was invited to attend the IDT meeting. During an interview on 1/23/25 Resident #73 stated he/she was not invited to the IDT meeting but would have gone if invited. 2. Review of Resident #79 clinical record revealed quarterly MDS dated [DATE]. Further review of Resident #79's clinical record lacked evidence that an IDT meeting was held within 7 days of this assessment. During an interview on 1/23/25 at 1:35 p.m., [NAME] President of Quality Improvement and Nursing Services confirmed she reviewed clinical record and there was no evidence that and IDT meeting was held after MDS 11/28/24. During an interview on 1/23/25 at 12:00 p.m. Social Worker Trainee stated IDT meetings should be held withing 1 week of comprehensive assessments and residents and their representatives are supposed to be invited, and all invitations should be documented in the clinical record. At this time confirmed IDT meetings were not held on time, and residents have not been invited to attend. 37648 3. On 1/21/25 at 9:07 a.m., during an interview, Resident #90 stated he/she was not sure if he/she had an IDT meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #90 was admitted on [DATE] and had an Admission MDS completed on 1/1/25. The medical record lacks evidence that an IDT meeting, which included the participation of the resident and resident's representative, was held within 7 days of this assessment. On 1/21/25 at 2:29 p.m., during an interview, the [NAME] President of Quality Improvement and Nursing Services stated social services believes they had one on either the 7th or the 14th but they failed to have anyone sign for attendance or document their meeting. 51331 4. Review of Resident #28 medical record indicates that he/she was admitted to the facility on [DATE]. The quarterly MDS dated [DATE] with an IDT meeting taking place on 12/30/24, indicated the IDT meeting was not completed within 7 days of the MDS. On 1/23/25 at 12:00 p.m., the above information was confirmed with the Social Worker. 5. Review of Resident #51's medical record shows he/she was admitted to the facility on [DATE] with the diagnosis of Post Operative Left Femur Fracture. On 1/13/25 an Admission MDS revealed Resident had a BIMS of 13 of 15, indicating he/she is cognitively intact. During an interview on 1/21/25 at 9:16 a.m., the resident states he/she did not think his/her care plan meeting occurred. Further review of the resident's medical record showed a care plan meeting took place on 1/14/25 however, lacked evidence that the resident was invited and/or attended the care plan meetng. 6. Review of Resident #54's medical record indicates that he/she was admitted to the facility on [DATE] with the diagnosis of Chronic Respiratory Failure. On 1/7/25 Resident #54 had a BIMS of 15 of 15, indicating he/she is cognitively intact. Further review shows the resident had a MDS completed on 1/3/25 and an IDT meeting held on 1/24/25, indicating the IDT meeting was not completed within 7 days of the MDS. On 1/23/25 at 12:00 p.m., the above information was confirmed with the Social Worker. 7. Review of Resident #67's medical record shows he/she was admitted to the facility on [DATE] with the diagnosis of Dementia. On 1/7/25 Resident #67 had a BIMS of 13 of 15, indicating he/she is cognitively intact. During an interview on 1/21/25 at 1:00 p.m., the resident stated he/she is unsure if he/she was invited to the care plan meetings. Further review of the residents medical record shows that a care plan meeting took place on 1/7/25 however, lacked evidence that the resident was invited and/or attended the care plan meetng On 1/23/25 at 8:37 a.m., during an interview with 3 surveyors present, the Administrator stated, he was not sure if residents were being invited to their meetings but he created a form to make sure residents are being invited. 33639 8. Resident #71's medical record, surveyor noted two MDS Significant change assessments, dated 2/15/24 and 5/1/24 and two MDS Quarterly assessments dated 7/1/24 and 9/4/24. The clinical record lacked evidence that a care plan meeting was held by the IDT for the 2/15/24, 5/1/24, 7/1/24 and 9/4/24 assessments. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/25 at 1:41 p.m., the above finding was confirmed with the [NAME] President of Quality Improvement and Nursing Services 51669 9. Review of Resident #37's clinical record revealed a Minimum Data Set (MDS) Significant Change Assessment was completed on 7/26/24. Further review of the clinical record lacked evidence that an interdisciplinary team (IDT) meeting was held following the assessment. During an interview on 1/23/25 at 3:27 p.m., the [NAME] President of Clinical Services and Quality Assurance confirmed that she reviewed Resident #37's clinical record and that there was no evidence an IDT meeting was held after the 7/26/24 MDS assessment. 10. Review of Resident #40's clinical record revealed a Comprehensive MDS Assessment was completed on 8/23/24 and an MDS Quarterly Assessment was completed on 12/5/24. Further review of the clinical record lacked evidence that an IDT meeting was held within 7 days of the assessments. During an interview on 1/23/25 at 3:27 p.m., the [NAME] President of Clinical Services and Quality Assurance confirmed that she reviewed Resident #40's clinical record and that there was no evidence an IDT meeting was held after the 8/23/24 or 12/5/24 MDS assessments.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on observations, interviews, record reviews, facility policy, and manufacturer directions, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice in the area of nutrition for 1 of 2 residents reviewed (Resident #60) and in the area of falls for 2 of 3 residents reviewed (Residents #79, #37). Additionally, the facility failed to obtain physician orders for medications located at a resident's bedside, for 2 of 2 sampled residents (Residents #40, #70). Findings: 1. Review of manufacturer directions dated November 2024 states NovoLog(R) is a rapid-acting insulin that helps lower mealtime blood sugar spikes in adults . with diabetes .NovoLog(R) starts acting fast. Eat a meal within 5 to 10 minutes after taking it . Resident #60 was admitted on [DATE] and has diagnosis to Diabetes Mellitus II. Review of Resident #60 active orders dated January 2025 reveled order with state date of 11/30/24 for Novolog U-100 Insulin; Aspart 100 unit/mL subcutaneous solution Before Meals for Type II diabetes mellitus; Sliding Scale Insulin: Insulin Units <70 or > 400 Notify MD; MD; 151-200, 2Units; 201-250, 4Units; 251-300, 6Units; 301-350, 8Units; 351-400, 10Units; 401-450, 12 units. During a medication observation pass on 1/22/25 at 7:20 a.m., a surveyor observed Registered Nure #1 (RN#1) administering 4 units of Novolog to Resident #30 for blood sugar of 206, per provider order. Observation of breakfast meal on 1/22/25 revealed Resident #60 did not receive his/her breakfast tray until 8:45 a.m., which is 1 hour and 25 minutes after receiving Novolog. During an interview on 1/22/25 at 9:15 a.m., RN #1stated he administered sliding scale insulin to Resident #30 earlier this morning but could not specifically remember what time it was as he did not write it down. RN#1 further stated he did not know how to look back in the Electronic Medical Record to see what it was, but was aware that Resident #30 had not received his/her breakfast until 8:45 a.m. During an interview with 4 surveyors on 1/22/25 at 10:08 a.m., Quality Improvement Specialists stated that Residents that received short acting insulin before a meal should eat as soon as possible after insulin was administered. At this time a surveyor discussed the above findings. 2. Review of provided Side Rails/Grab Bars Policy dated 11/18 states .Whenever side rails or grab bars are considered .A physician's order will be obtained to include the reason for use.The nurse will provide and review A Guide to Bed Rail Safety for Patients with resident/resident representative; Informed consent for Use of Side Rails/Grab Bars will be obtained. Side rail and grab bar use will be screened quarterly and with any significant change in the resident's condition or behavior. Resident #79 was admitted on [DATE] and had diagnoses to include hemiplegia, dementia, and history of falls. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of Resident #79 on 1/22/25 at 7:15 a.m., he/she was observed lying in bed with bilateral side rails in use. Review of Resident #79's care plan updated 9/20/24 states enablers to promote independent bed mobility. Falls: I am at risk for falls r/t impaired mobility, poor safety awareness, impulse control, secondary to a stroke and dementia Fall without injury 8/12/24 . Review of Resident #79's clinical record revealed a Fall Risk Assessment completed 11/24/24, and Side Rail Screen dated 11/24/24. Further review of Resident #79's clinical record lacked evidence that side rail assessments/screens were conducted prior to 11/24/24. Review of Resident #79's clinical record lacked evidence that a provider order was obtained for bed rail use, that the resident/representative was presented with copy of A Guide to Bed Rail Safety for Patients, a signed consent for bed rail use was obtained and quarterly side rail screenings were completed. During an interview on 1/23/25 at 12:31 p.m. the Director of Nursing reviewed Resident #79's entire clinical record and confirmed the above findings. 51669 3. Resident #37 was admitted on [DATE] and has diagnoses to include dementia and repeated falls. On 1/21/25 at 10:51 a.m. and 1/22/25 at 11:04 a.m., Resident #37 was observed lying in bed, with bilateral side rails in use. Review of Resident #37's care plan, updated 11/4/24, revealed, ADL [Activities of Daily Living] .Side rails as enablers to promote independent bed mobility . and Falls: I am at risk for falls r/t [related to] impaired mobility . Review of Resident #37's clinical record revealed a Fall Risk Screen was completed on 10/21/24 and 1/20/25, and a Side Rail Screen was completed on 10/21/24. Further review of Resident #37's clinical record lacked evidence of a physician's order for side rail use and lacked evidence that informed consent for use of side rails was obtained. During an interview on 1/23/25 at 3:27 p.m., the [NAME] President of Clinical Services and Quality Assurance reviewed Resident #37's entire clinical record and confirmed the above finding. 4. Review of Facility Policy Self-Administration of Medications Policy, revealed, Procedure: A. If the resident has an order to keep a medication at bedside, the facility must complete a Self-Administration of medications screen. B. If outcome .indicates resident is able to self-administer his/her medications, obtain a physician order to self-administer . F. If the resident has an order to keep medications at bedside, the medication must be secured in a locked box, to maintain the safety of other residents . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations of room [ROOM NUMBER] on 01/21/25 at 10:41 a.m. and 1/22/25 at 8:58 a.m., a 0.38 ounce (72 sprays) Flonase 50mcg/spray nasal spray medication device and a 30-pad box of Ocu Soft Lid Scrub eyelid pads were observed on Resident #40's bedside table. Review of Resident #40's clinical record lacked evidence of a physician order for the Flonase and Ocu Soft Lid Scrub and lacked evidence of a physician order to self-administer. Further review of the clinical record lacked evidence of a Self-Administration screen. During an interview on 1/22/25, between 9:14 a.m. and 9:22 a.m., Registered Nurse (RN) #2 stated that if a resident or resident's family brings a medication in from home, there should be a physician order for the medication and an order that the resident may keep the medication at bedside. At this time, RN #2 reviewed Resident #40's clinical record and confirmed that there was no order for the Flonase, the Ocu Soft Lid Scrub, or for resident to keep medications at bedside. During an interview on 1/22/25 at 9:27 a.m., the South Unit Manager stated it was her expectation that if a resident had medication at the bedside, there would be a physician order for the medication(s) and the order must state it is ok for the medication to be at bedside and for the resident to self-administer. At this time, the above finding was reviewed with the South Unit Manager. On 1/22/25 at 11:10 a.m., the above finding was reviewed with the Quality Improvement Specialist. 51331 On 1/22/25 at 8:30 a.m. and on 1/23/25 at 9:15 a.m., observation of an Albuterol Sulfate HFA 90 mcg aerosol inhaler on the resident's bedside table. On 1/22/25 at 8:30 a.m., during an interview, Resident #70 states that he/she uses the inhaler often as needed. In an additional interview on 1/23/25 at 9:15 a.m., Resident #70 states that he/she and their power of attorney requested to keep the inhaler at bedside. During this interview resident proceeded to take 2 puffs of the inhaler for shortness of breath. Review of Resident #70 medical record shows the medication being Albuterol Sulfate HFA 90 mcg aerosol inhaler with instructions to use every 6 hours as needed. Further review of the resident's medical record lacks evidence of an order to keep the medication at bedside. Review of the Medication Administration Record lacks evidence that the resident has received/administered the medication for the month of January. On 1/22/25 at 9:25 a.m., during an interview with the [NAME] President of Clinical Services and Quality Improvement the above information was confirmed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51331 Based on observations and interviews, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to oxygen and nebulizer use for 5 of 6 residents reviewed for respiratory care. (Resident #54, #70, #17, #13 and #42) Findings: Review of provided Oxygen Use & Storage Policy dated 10/24 states: .when nebulizer parts are not in use; after being air dried, the mask and/or hand held devices should be stored in a plastic bag to the risk of it being contaminated. 1. On 1/21/25 at 8:40 a.m. and on 1/22/25 at 8:50 a.m., observation of Resident #54's oxygen nasal cannula tubing on the floor by his/her bed labeled with the date of 1/6/25. Review of Resident #54 medical record reveals a physician order to change oxygen weekly. Review of the Treatment Administration Record (TAR) stated the tubing was changed on 1/12/25 and on 1/19/25. 2. On 1/21/25 at 9:01 a.m. and on 1/22/25 at 8:30 a.m., observation of Resident #70's unlabeled nebulizer pipe and tubing stored on the nebulizer machine. 37648 3. On 1/21/25 at 9:15 a.m., 1/22/25 at 8:41 a.m., and on 1/23/25 at 8:21 a.m., observations of Resident #17's oxygen nasal cannula tubing dated 1/13 and an undated nebulizer pipe stored on the back of the nebulizer machine and the bedside dresser. Review of resident #17's medical record had providers orders dated 1/9/25 to Change Tubing 1 Time Weekly, Clean/Store oxygen tubing not in use 1 Time Weekly and provider orders dated 1/4/25 for ipratropium 0.5 mg (milligram)-albuterol 3 mg (2.5 mg base)/3 mL (milliliter) nebulization solution .Inhalation Three Times Daily. The most recent care plan for Impaired Respiratory secondary to Acute on Chronic Respiratory Failure, RLL (right lower lobe) Pneumonia, COPD AEB (chronic obstructive pulmonary disease acute exacerbation) need for hospitalization , respiratory medications/treatments and supplemental Oxygen with interventions of Change oxygen tubing weekly; label and date. Review of the January treatment administration records states the oxygen tubing was changed on the 12th and the 19th and lacked evidence of the nebulizer tubing being changed. On 1/23/25 from 8:13 a.m. to 8:21 a.m., both the surveyor and the Director of Nursing conducted a tour of the East unit and observed the above nebulizer tubing and pipe storage, the oxygen tubing dates and discussed the inaccurate documentation in the residents TAR relating to changing the tubing. 42531 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observations of room [ROOM NUMBER] on 1/21/25 at 9:18 a.m., 1/22/25 at 7:27 a.m., and 1/23/25 at 1:17 p.m., revealed nebulizer located on top of Resident #13's side table with tubing attached with/to facemask/reservoir which is resting/stored on top of the side table without a barrier between the nebulizer mask and the machine allowing potential cross contamination. During an interview with 4 surveyors on 1/23/25 at 9:20 a.m., the Director of Nursing confirmed Resident #13's nebulizer tubing was not stored appropriately when not in use. 51669 5. Resident #42 was admitted on [DATE] and has diagnoses to include obstructive sleep apnea. During an observation of room [ROOM NUMBER] on 1/21/25 at 10:44 a.m., Resident #42's unbagged nasal cannula and oxygen tubing, dated 1/17, was lying on the floor by Resident #42's bed and was connected to an oxygen concentrator, located next to the bed, with an empty black antimicrobial bag, dated 1/8/24, stored on top of the concentrator. During a follow-up observation of room [ROOM NUMBER] on 1/22/25 at 9:00 a.m., the oxygen tubing was observed in the black antimicrobial bag, dated 1/8/24, located on top of the oxygen concentrator. Review of Resident #42's care plan revealed, Respiratory .I use O2 [oxygen] at 2L [liters] HS [hour of sleep] r/t [related to] SOB [shortness of breath] .Change oxygen tubing and antimicrobial bag weekly; label and date . Review of Resident #42's active January Treatment Administration Record (TAR) revealed an order, with a start date of 10/9/24, to Change O2 tubing and antimicrobial bag Q [every] Sunday night and date both . Review of the TAR indicated the tubing and antimicrobial bag were changed on Wednesday, 1/15/24. During an interview on 1/23/25 at 8:53 a.m., in the presence of 5 surveyors, the above finding was reviewed with the Director of Nursing.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 51331 Based on the review of annual evaluations and interviews, the facility failed to complete a annual performance evaluation for Certified Nursing Assistants (CNA) at least every 12 months, for 1 of 5 CNA's reviewed with employment greater than 1 year. (CNA#4) Finding: CNA #4 was hired on 2/8/21. The employee lacked evidance of a annual preformance evaluaion being completed for 2024. On 1/23/25 at 11:32 a.m , during an interview, the [NAME] President of Clinical Services and Qaulity Improvement confirmed CNA #4 did not have a preformace evaluation on file for the year of 2024.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37648 Based on observations and interviews, the facility failed to ensure expired medications were removed from the supply available for use and failed to ensure that medications were stored properly as per manufacturers' recommendations for 3 of 5 medication/treatment carts reviewed for medication storage. Findings: 1. On 1/22/25 at 7:30 a.m., observation of the South unit nurse treatment cart #2 with the Registered Nurse #2 (RN#2), the cart contained an opened and undated vail of Tuberculin Purified Protein Derivative with manufactures instructions of Store between 36 degrees - 46 degrees F and Once entered vial should be discarded after 30 days. At this time, RN#2 confirmed the Tuberculin vial was not labeled or stored correctly and immediately wasted the vial. 2. On 1/22/25 at 7:36 a.m., observation of the South unit medication cart with the Certified Medication Technician #1 (CNA-M #1), the cart contained an opened bottle of Acidophilus w/Pectin with the manufactures instructions to refrigerate after opening, one opened bottle of Famotidine 10mg (milligram) with an expiration date of 12/24 and one opened bottle of Loratadine 10mg with an expiration date of 11/24. At this time, the CNA-M#1 removed the expired bottle and acidophilus. On 1/22/25 at 7:40 a.m., the above was discussed with the [NAME] President of Quality Improvement and Nursing Services. 3. On 1/22/25 at 9:57 a.m., observation of the [NAME] unit medication cart with the CNA-M #2, the cart contained an opened bottle of Acidophilus probiotic with the manufacturer's instructions of refrigerate after opening. At this time, the CNA-M#2 removed the acidophilus. On 1/22/25 at approx. 10:15 a.m., the above was discussed with the [NAME] President of Quality Improvement and Nursing Services.

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42531 Based on observations, interviews, and policy review the facility failed to ensure foods were dated and labeled in, stand up freezer, dry storage room and the walk in freezer. In addition, the facility failed to discard obvious freezer burned food on 1 of 3 survey days. Additionally, the facility failed to ensure a sanitary environment during 1of 2 dining observations of meal service on 1 of 3 units. Findings: Review of policy Food Storage undated states . All containers must be legible and accurately labeled and dated .Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days (4 days or 96 hours per Maine regs) or discarded. During an initial kitchen tour with 2 surveyors and the Dietary Manger on 1/21/25 between 8:22 a.m. and 8:45 a.m., the following was observed: -Dry storage area: A rolled up unlabeled clear bag containing unknown brown crumbly substance with open date of 11/12 available for use. -Stand up freezer: Small undated blue squeezable bag of chocolate icing opened with frosting coming out of it and 3 gallon size bags of bananas with obvious freezer burn. -Walk in refrigerator: Undated and unlabeled, unknown brown substance rolled up with plastic wrap, the Dietary Manger stated it was crumbled bacon, 1 large metal tray with multiple small metal containers containing green and red peppers, one containing pork chops, one containing a sandwich, 1 containing unidentifiable small round brown balls, and 2 small containers of unidentifiable substances, all undated and unlabeled. During an interview with 2 surveyors on 1/21/25 at 8:45 a.m., the Dietary Manger confirmed above findings. 51669 2. Facility policy, Director of Food and Nutrition Services Responsibilities, states, Procedure .6 .Staff will follow proper sanitation and food handling practices . and facility policy, Hazard Analysis Critical Control Points and Food Safety, states, Procedure: 1. Staff will be aware of the following sources of food borne organisms in food service: a. Humans (nose and throat, hands .clothing) .poor hand washing practices . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the lunch dining service for the South Kitchen on 1/22/25 between 12:06 p.m., and 12:25 p.m., Dietary Aide #1 walked up to refrigerator and placed his left hand on the freezer door handle and then opened the refrigerator door with right hand. Dietary Aide #1 then removed a container of chocolate milk from the refrigerator and using his right hand, poured chocolate milk into a cup, drank the chocolate milk, proceeded to put the cup into the trash can and then donned (put on) gloves. Dietary Aide #1 then removed the serving spoons from the container on the top of the food truck, removed the plastic wrap from the metal food trays in the food service area, and placed a serving spoon in each tray. Dietary Aide #1 then rested his right hand on the counter and placed his gloved left hand on his left hip and then doffed (took off) the gloves and proceeded to don a new pair of gloves. Dietary Aide then spooned pasta onto a plate and with his gloved right hand, picked up a piece of garlic bread from a metal tray on the counter and placed it on a meal plate. At this time, a surveyor intervened, and Dietary Aide #1 stated he has worked here since November and has not received education on hand hygiene. At this time, Dietary Aide #1 doffed gloves, sanitized his hands and donned new gloves before continuing to plate food. Review of Dietary Aide #1's Orientation Acknowledgement Checklist, dated 12/2/24, included receipt of facility policy, Infection Control/Exposure Control Plan but lacked evidence that Dietary Aide #1 received education on hand hygiene or safe food handling practices. On 1/22/25 at 12:38 p.m., the above finding was reviewed with the Quality Improvement Specialist. On 1/22/25 at 12:53 p.m., the finding was reviewed with the Dietary Manager, who stated new-hire training was conducted but that Dietary Aide #1 has not received formal hand hygiene or safe food handling training.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 37648 Based on an interview and review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan, meeting attendance sheet and Power Points provided, the facility failed to present evidence that the required members attended 3 of 4 quarters provided. Finding: The facilities QAPI Plan under Governance and leadership states, The Administrator is responsible for the successful implementation of the QAPI Program through enforcement of scheduling and education to participants. On 1/22/25 at 11:37 a.m., during an interview with 3 surveyors present, the Administrator was only able to provide an attendance sheet for the 12/19/23 QAPI meeting stating, the previous Director of Nursing put the power point presentations together, and he thought she was taking attendance. He then stated the Medical Director at the time was not at the 3rd quarter QAPI. Review of the QAPI power points from Quarter 1 (4/23/24), Quarter 2 (7/23/24) and Quarter 3 (11/26/24) lacked evidence of the required member's attendance. In addition, the QAPI failed to include the infection preventionists for 4 of 4 quarterly QAPI meetings reviewed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37648 Based on observation, interview and record review, the facility failed to maintain an Infection Control Program designed to help prevent the development of infections related to Subcutaneous injected medication for 1 of 1 resident observed for subcutaneous medication administration (Resident #60). Finding: The facilities Injectable Medication Administration policy revised 1/2018, states under Purpose: To administer medications via subcutaneous .routes in a safe, accurate and effective manner and Equipment Required . Examination gloves The facilities Medication Administration - General Guidelines policy revised 1/2018, states under Administration . Hands are washed before putting on examination gloves and upon removal for administration of . injectable medications. On 1/22/25 at 7:20 a.m. during observation of Resident #60's medication administration with a Register Nurse #1(RN#1). The RN#1 prepared the Novolog Insulin for a subcutaneous injection and entered the resident's room, without performing hand hygiene and donning gloves, he immediately cleansed the residents right lower abdomen with the alcohol prep and administered the NovoLog insulin subcutaneously. At this time, the RN#1 confirmed he should have performed hand hygiene and donned gloves prior to the medication administration. On 1/22/25 at 7:40 a.m., the above was discussed with the [NAME] President of Quality Improvement and Nursing Services.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33639 Based on immunization record review, review of the facility's immunization policy and interview, the facility failed to implement their Influenza, Pneumococcal, COVID policy for 1 of 5 residents whose immunization records were reviewed (#16) Finding: The facility's Immunization Policy indicated in Procedure I: Before offering the Influenza or Pneumococcal vaccine or COVID vaccine, each resident, and/or resident's legal representative will receive the appropriate Vaccine Information Statement (VIS) produced by the Maine and/or Federal Centers for Disease Control regarding the benefits and potential side effects of the vaccines for the current year. The resident's clinical record will include the following documentation: Signature of the person receiving the educational material, designating receipt and understanding of the material. Verbal consent may also be obtained if communication is done via a telephone conversation. Proof the resident either received the Influenza, COVID and/or the Pneumococcal vaccine, the vaccine(s) was contraindicated for medical reasons, or the resident refused the vaccine(s). ImmPact website can be utilized to see if these vaccines have been administered. Each resident will be offered an Influenza Vaccine October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period. Each resident will be offered a COVID Vaccine, upon admission unless the immunization is medically contraindicated, or the resident has already been immunized. VIS will also be provided to educate on risk vs benefit. Each resident will be offered a Pneumococcal Vaccine, upon admission unless the immunization is medically contraindicated, or the resident has already been immunized. Vaccines will be given in accordance with the Maine Center for Disease Control. For Immunocompromised adults aged [AGE] years or older. A single dose of PCV 20 may be administered or administered 1 dose of PCV 15, if not previously administered, followed by 1 dose of 23 valent pneumococcal polysaccharide vaccine (PPSV23) at a minimum interval of 8 weeks between both doses. The vaccine administration will be documented on the vaccine record in the medication administration record. Resident #16's clinical record indicated that the resident was admitted to the facility on [DATE]. Resident #16's immunization records lacked evidence that the resident's PCV 20 and Influenza immunization was current or offered and administered as directed by the facility's Immunization - Influenza, Pneumococcal, COVID Policy. On 1/23/25 at 10:27 a.m., a surveyor confirmed the above findings in an interview with the Quality Improvement Specialist.

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	01/23/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33639 Based on immunization record review, review of the facility's immunization policy and interview, the facility failed to implement their Influenza, Pneumococcal, COVID policy for 1 of 5 residents whose immunization records were reviewed (#16) Finding: The facility's Immunization Policy indicated in Procedure I: Before offering the Influenza or Pneumococcal vaccine or COVID vaccine, each resident, and/or resident's legal representative will receive the appropriate Vaccine Information Statement (VIS) produced by the Maine and/or Federal Centers for Disease Control regarding the benefits and potential side effects of the vaccines for the current year. The resident's clinical record will include the following documentation: Signature of the person receiving the educational material, designating receipt and understanding of the material. Verbal consent may also be obtained if communication is done via a telephone conversation. Proof the resident either received the Influenza, COVID and/or the Pneumococcal vaccine, the vaccine(s) was contraindicated for medical reasons, or the resident refused the vaccine(s). ImmPact website can be utilized to see if these vaccines have been administered. Each resident will be offered a COVID Vaccine, upon admission unless the immunization is medically contraindicated, or the resident has already been immunized. VIS will also be provided to educate on risk vs benefit. Resident #16's clinical record indicated that the resident was admitted to the facility on [DATE]. Resident #16's immunization records lacked evidence that the resident's COVID immunization was current or offered and administered as directed by the facility's Immunization - Influenza, Pneumococcal, COVID Policy. On 1/23/25 at 10:27 a.m., a surveyor confirmed the above findings in an interview with the Quality Improvement Specialist.

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	01/23/2025

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 51331 Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to monitor and ensure that the CNA attended the required 12 hours of annual in-service education training for 5 of 5 randomly selected CNAs employed greater than 1 year (CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5). Findings On 1/22/25, a surveyor reviewed the following employee education files: 1. CNA #1 was hired 12/5/1994. Review of CNA #1 Employee In-service/attendance Records lacked evidence that she completed the 12 hours of required continuing education for the year of 2024. 2. CNA #2 was hired 8/31/2020. Review of CNA #2 Employee In-service/attendance Records lacked evidence that she completed the 12 hours of required continuing education for the year of 2024. 3. CNA #3 was hired 3/18/2013. Review of CNA #3 Employee In-service/attendance Records lacked evidence that she completed the 12 hours of required continuing education for the year of 2024. 4. CNA #4 was hired 2/8/2021. Review of CNA #4 Employee In-service/attendance Records lacked evidence that she completed the 12 hours of required continuing education for the year of 2024. 5. CNA #5 was hired 6/8/2020. Review of CNA #5 Employee In-service/attendance Records lacked evidence that she completed the 12 hours of required continuing education for the year of 2024. On 1/22/25 at 1:34 p.m., during an interview with 4 surveyors present, the Administrator confirmed the above findings.