

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/26/2024
FORM APPROVED
OMB NO. 0938-0391

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 C 11/12/2024
NAME OF PROVIDER OR SUPPLIER BREAKWATER COMMONS			STREET ADDRESS, CITY, STATE, ZIP CODE 100 COMMONS DRIVE ROCKLAND, ME 04841		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/12/24 an unannounced, on-site visit was completed at Breakwater Commons for the purpose of investigating complaints #ME00049242, #ME00049334, and facility reported incidents #ME00049266, #ME00049391. It was determined that Breakwater Commons, was not in compliance with 42 CFR Part 483, Subpart B- Requirements for Long Term Care Facilities.	F 000			
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: 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.	F 557	F557 Investigations relating to allegations involving Residents #1 and #4 were initiated immediately upon learning of the concerns. There have been no further noted dignity issues regarding use of bedpans or insulting language to residents since conclusion of survey. CNA staff will be educated that residents using bedpans will be checked on within a reasonable intervals; and re-educated regarding right to be spoken to with respect & dignity as part of resident rights at all times. Dignity issues or suspicion of violation of same will be reported to the Administrator/designee upon discovery via chain of command. Data related to occurrence/lack of occurrence of dignity issues will be reported at the facility's QAPI Committee meeting monthly x 90 days.		10/21/24 & 10/31/24 12/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

 ADMINISTRATOR 11/27/24

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.

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F 557	Continued From page 1 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.	F 557			

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F 557	Continued From page 2 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." 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	F 557			

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F 557	Continued From page 3 being an asshole." The nurse stated "I walked in and talked to (Resident #4) and apologized for the way the CNA acted."	F 557			
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: 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	F 812	F812 Plate covers for food delivery to resident rooms was available at time of serving the meal referenced at time of survey. Additional plate covers were ordered prior to the conclusion of this survey and have since been implemented on the unit's country kitchens. Staff serving and delivering meal trays to resident rooms will be re-educated on the use of plate covers for meals in accordance with sanitary serving practices. Administrator/designee will randomly audit up to 3 meal service deliveries per week to assure sanitary serving practices are being followed. Results of audits will be reported to the facility's QAPI Committee meeting monthly x 90 days.	11/12/24 11/12/24 12/9/24	

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F 812	Continued From page 4 (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.	F 812			

