STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 B. WING	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAKWATER COMMONS	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
E 000	Initial Comments Federal Recertification Survey Date: 1/21/25 Breakwater Commons, a long term care facility, is not in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities Emergency Preparedness.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the	E 039	The faility will conduct a tabletop and full-scale exercise to test and train on its Emergency Operations Plan (EOP). All residents are at risk to be adversely affected by the identified deficient practice. No residents have been identified as being negatively impacted by the deficient practice. Staff education and training will take place upone conclusion of the drill exercises. The QAPI Committee will enforce testing and training of the facility's Emergency Operations Plan on an annual basis.	03/01/2025 03/04/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Douglas Gardner on behalf of Carl Chadwick

TITLE
Administrator

(X6) DATE
02/11/2025

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAKWATER COMMONS	100 COMMONS DRIVE ROCKLAND, ME 04841

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E 039	Continued From page 1 actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 2 (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a	E 039		

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E 039	Continued From page 3 facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group	E 039		

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E 039	Continued From page 4 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion,	E 039		

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E 039	Continued From page 5 using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to	E 039	RECEIVED FEB 11 2025 BY:	

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E 039	Continued From page 6 challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		

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E 039	Continued From page 7 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		

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E 039	Continued From page 8 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by:	E 039		

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E 039	Continued From page 9 Based on observation, record review, and interview, the long term care facility failed to participate in a full-scale exercise and a table top exercise of the Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: Based on interview and documentation review with the Administrator and Maintenance Director, witnessed by the Maintenance Worker on 01/21/2025 between the hours of 10:30 AM and 4:00 PM, this surveyor observed the following: While interviewing the Administrator, he provided emails that he was in contact with the local municipal Fire chief and Police Chief in regards to doing a community based drill for Active Shooter and Intruder. The emails were regarding a pre-meeting to discuss the table top exercise. The Administrator stated that he had tried to reach out to the local authorities but was not successful with any communication or scheduling a meeting with them, he stated that after trying to contact them there was "radio silence". The administrator then stated the facility has not done either required excesses required for the Emergency Preparedness Program. 1. A full-scale exercise has not been conducted at this facility, the facility failed to provide any documentation that a table top exercise had not been completed in the last 12 months. 2. A table top exercise has not been conducted at this facility, the facility failed to provide any documentation that a table top exercise had not been completed in the last 12 months.	E 039	RECEIVED FEB 11 2025 BY:	

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E 039	Continued From page 10 The surveyor confirmed this finding with the Administrator, Maintenance Director, and Maintenance Worker at the time of the observation.	E 039	RECEIVED FEB 11 2025 BY:	
K 000	INITIAL COMMENTS Federal Recertification Survey: Date: 01/21/25 Breakwater Commons, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-d) physical environment and is not in substantial compliance.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	K 222	K222 Visible signage noting 15 second delayed egress was installed on the South Courtyard exit door. All other exit doors with delayed egress contained the correct signage throughout the facility. The facility's routine door inspection program will include monitoring for the presence of appropriate egress signage. Door inspections that result in failures of any aspect will be reported to the Maintenance Director or Administrator immediately. Results of door inspections that include failures will be reported to the facility's QAPI Committee on a monthly basis x 90 days.	1/22/2025

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

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K 222	Continued From page 11 safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K 222	RECEIVED FEB 11 2025 BY:	

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BREAKWATER COMMONS	100 COMMONS DRIVE ROCKLAND, ME 04841

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K 222	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on Observations the facility failed to ensure doors at the means of egress meet the requirement of NFPA 101 life safety code 2012 edition 7.2.1.6.1 for requirements for delayed egress. Findings: On 01/26/25, between 10:30 AM and 4:00 PM, surveyor 39983, with the Maintenance Director and Maintenance Assistant present, observed the following: Courtyard exit door is equipped with delayed egress and not signed. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This finding was verified by the Director of Maintenance and Maintenance Assistant at the time of the observation.	K 222	RECEIVED FEB 11 2025 BY:	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 B. WING	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAKWATER COMMONS	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
K 351	Continued From page 13 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to ensure that Automatic sprinkler and standpipe systems are installed, in accordance with NFPA 13, 2010 edition, Standard for the Installation of Sprinkler Systems sections 6.3.6 and 6.3.6.1 Findings: On 1/26/25, between 10:30 AM and 4:00 PM, surveyor 39983, with the Maintenance assistant, and Maintenance Director, observed the following: 1. CPVC sprinkler pipe located in in the storage room in the Memory Care unit is exposed and not installed per manufacturer direction. CPVC is	K 351	Upon additional research, the CPVC sprinkler pipe located in the Memory Care storage closet is in fact installed per manufacturer direction and in accordance with NFPA 13 for Type I and Type II construction. Please see the attached documention, photos and attestation from High Tech Fire Protection regarding the Automatic Fire Sprinkler System installed at Breakwater Commons in Rockland, ME. (Attachment #1) RECEIVED FEB 11 2025 BY:	2/6/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 B. WING _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAKWATER COMMONS	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
K 351	Continued From page 14 required to be concealed (protected). 6.3.6.1 Other types of pipe or tube investigated for suitability in automatic sprinkler installations and listed for this service, including but not limited to CPVC and steel, and differing from that provided in Table 6.3.1.1 or Table 6.3.6.1 shall be permitted where installed in accordance with their listing limitations, including installation instructions. The surveyor 39983 confirmed this finding with the Maintenance assistant, and Maintenance Director at the time of the observation.	K 351		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, Life Safety Code, 2012 Edition, Section 19.7.1.4 through 19.7.1.7	K 712	The reuired number of fire drills (12) were conducted during the calendar year 2024 however the 3rd quarter drill was not conducted timely. All residents are at risk to be adversely affected by the identified dificient practice. No residents were identified as being negatively impacted. Fire drills well be doncuted monthly rotating between the three work shifts within the 2025 calendar year. An annual calendar has been developed to ensure the drills are conducted monthly and on the correct shift. Multiple Maintenance personnel will be trained to conduct a fire drill. Reports will be made to the facility QAPI Committee indicating that fire drills occured per the annual calendar on a monthly basis at the Committee's next three meetings.	02/14/2025

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

RECEIVED
FEB 03 2025
BY:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 _____ B. WING _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAKWATER COMMONS	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
K 712	Continued From page 15 Findings: On 01/21/25, between 10:30 AM and 4:30 PM, surveyor 50034, with the Maintenance Director present, observed the following: 1. The facility failed to conduct the proper number of fire drills during the previous 12 months. The following fire drills for the facility were not completed or missing: A. Third quarter of 2023, second shift The surveyor 47175 confirmed this finding with the Maintenance Director at the time of the observation.	K 712	RECEIVED FEB 11 2025 BY:	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed	K 920	K920 Power strips and extension cords were removed from the MDS Coordinator office upon discovery during inspection. — 1/21/2025 Other offices have been inspected and no further violations were discovered. — 1/22/2025 Fire safety training will be scheduled to include education of what is and is not permissible as to approved electrical outlets. Removal of discovered disallowed items will occur immediately. — 3/1/2025 Inspection results indicating use of disallowed electrical outlets within the facility will be reported to the Administrator/designee as discovered for consideration of action to be taken. Reports of violations will be shared with the facility's QAPI Committee monthly x 90 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 B. WING	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAKWATER COMMONS	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
K 920	Continued From page 16 immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to ensure that power strips and extension cords are not used for non-PCREE (Patient-care-related electrical equipment) and that power strips are not used as a substitute for fixed wiring in accordance with NFPA 99 Chapter 10, NFPA 70 chapter 4 {400.8(1)} On 1/26/2025, between 10:30 AM and 4:00 PM, surveyor 39983, with the Maintenance Assistant, and Maintenance Director observed the following: 1. In the MDS Coordinator office, a mini fridge, Microwave, Coffee Maker, and printer was found plugged into a power strip as a permanent power source. 2. In the MDS Coordinator office, a portable space heater and other charging devices was found plugged into a 4 way extension cord daisy chained to a power strip as a permanent power source. The surveyor 39983 confirmed this finding with the Maintenance Assistant, and Maintenance Director at the time of the observation.	K 920		

Attachment #1

HIGH TECH FIRE PROTECTION

PO Box 156 • Minot, ME 04258-0156
Phone: (207)998-2551•Fax: (207)998-4187

FIRE SPRINKLER SYSTEMS
24-HOUR SERVICE

NFPA Letter of Compliance

RECEIVED
FEB 11 2024
BY:

Date: July 14, 2023

To: Dan Cook – Allied Cook Construction

From: Jeremy A Foss

Re: Sprinkler System Compliance for Breakwater Commons

High Tech Fire Protection has provided a new fire sprinkler system throughout the Breakwater Commons Project located at 41 Cranberry Isles Drive in Rockland ME. The system consists of four wet pipe and three dry pipe sprinkler systems protecting the entire structure.

High Tech Fire Protection hereby guarantees the design, materials and workmanship for the Breakwater Commons Project to meet the requirements necessary for an approved NFPA #13 Automatic Fire Sprinkler System per State and local authority. Approved drawings for this project are filed with the SFMO under permit #FSP16981.

Sincerely,
Jeremy A Foss
Maine R.M.S. #808
Nicet Level IV #126801

Jeremy A Foss

Combustible Concealed Installations with Specific Use Sprinklers

In accordance with UL Listing, Spears® FlameGuard® CPVC Fire Sprinkler Products can be used in specific light-hazard, combustible and noncombustible concealed spaces that require sprinkler protection when installed with UL Listed specific application sprinklers. The system must be installed in accordance with the applicable sprinkler manufacturer's information contained in their designated data sheets shown in parenthesis "( )". These include: Victaulic Model V2502 (Submittal 40.09, Rev D) Upright Quick Response Sprinkler; Tyco Fire Products Model CC1 – 2.8 K-Factor (TFP630, July 2015) or Model CC2 – 5.6 K-Factor (TFP632, August 2016) or Model CC3 – 4.2 and 5.6 K-Factor (TFP633, December 2016) Combustible Concealed Space Sprinklers, Specific Application Upright; Viking VK900 COIN™ (Form F_110503 16.12.22 Rev 16.1) or VK901 COIN™ (Form F_021607 16.12.22 Rev 16.1) or VK950 COIN™ (Form F_081216 16.12.15 Rev 16.1) Quick Response Upright Sprinklers for Specific Application; Reliable Model KFR-CCS 5.6 K-Factor (Bulletin 044 Rev C) Combustible Concealed Space Upright Sprinkler; and Globe Model "IC" GL5608 (Bulletin GL5608, September 2015) Interstitial Combustible Specific Application Upright Sprinkler.

NOTICE: When installing Spears® FlameGuard® CPVC Fire Sprinkler Products in combustible concealed areas where sprinklers are required, the specific application sprinkler must be used in accordance with its UL Listing. Contact the local authority having jurisdiction with questions concerning code requirements.

Combustible Attic Spaces with Specific Use Sprinklers

Product Description

In accordance with the UL Listing, Spears® FlameGuard® CPVC Fire Sprinkler Products may be installed within the attic space provided the attic space is protected with UL Listed Specific Application Attic Sprinklers. Specific Application Attic Sprinklers are sprinklers designed to provide protection of specific light hazard combustible, as well as non-combustible, attic spaces requiring sprinkler protection.

Installation Requirements

When using the Specific Application Attic Sprinklers, Spears® FlameGuard® CPVC Fire Sprinkler Products may be installed to feed the wet system sprinklers below the ceiling and exposed to feed wet system specific application attic sprinklers provided the system is installed in accordance with the applicable sprinkler manufacturer's information contained in their designated data sheets shown in parenthesis "( )". These include: Tyco Fire Products Models BB, SD, HIP and AP (TFP610, August 2014) Specific Application Sprinklers for Protecting Attics; Reliable Models DD56-6, DD26-27, DD80-6 and DD80-27 (Bulletin 056, December 2016) Specific Application, Attic Sprinklers; Viking Model VK696 (Form F_042815 16.01.28 Rev 16.1) Attic Upright Specific Application Sprinkler or Model V-BB (Form F_042915 16.08.04 Rev 16.2) Specific Application Attic Sprinkler or Model V-SD (Form F_043015 16.02.19 Rev 16.1) Specific Application Attic Sprinkler.

Exposed Installations

Spears® FlameGuard® CPVC Fire Sprinkler Products are UL Listed for use in installations without protection (exposed), with the following restrictions:

Exposed CPVC Fire Sprinkler piping is installed below a smooth, flat, horizontal ceiling construction utilizing UL Listed support devices.

- Listed, Quick-Response, ordinary temperature-rated pendent sprinklers having deflectors installed within 8 inches from the ceiling. Listed, Residential, ordinary temperature-rated, pendent sprinklers located in accordance with their Listing. The maximum distance between sprinklers must not exceed 15 feet. The piping must be mounted directly to the ceiling.
- Listed, Quick-Response, ordinary temperature-rated horizontal sidewall sprinklers having deflectors installed within 8 inches from the ceiling and within 4 inches from the sidewall. Listed, Residential, ordinary temperature rated horizontal sidewall sprinklers located in accordance with their Listing. The maximum distance between sprinklers must not exceed 14 feet. The piping must be mounted directly to the sidewall.
- Listed, Quick-Response, upright sprinklers having a maximum temperature rating of 155° F (68° C) must be installed so that the deflectors are a maximum of 4" from the ceiling. The maximum distance from the ceiling to the centerline of the main run of pipe must be 7-1/2". The distance between a hanger and the centerline of an upright sprinkler shall not be less than 3in. (75mm). Rigid pipe hangers secured to the ceiling must be used.

Expanded Use with Light Hazard Extended Coverage and Residential Sprinklers

In accordance with the UL Listing, Spears® CPVC Fire Sprinkler products may be installed without protection (exposed) when subject to the following additional limitations.

The following installations shall be below a smooth, flat, horizontal ceiling construction and require the use of FS-5 one step solvent cement. The piping shall be mounted directly to the sidewall.

Listed quick response, 200° F (93° C) maximum temperature rated, horizontal sidewall sprinklers having deflectors installed within 12 inches (304 mm) from the ceiling and within 6 inches (152 mm) from the sidewall or Listed residential, 200° F (93° C) maximum temperature rated, horizontal sidewall sprinklers located in accordance with their Listing and a maximum distance between sprinklers not to exceed 14 feet (4.27 m).

The following installations shall be below a smooth, flat, horizontal ceiling construction, are limited to unobstructed construction, require the use of Schedule 80 fittings for sizes 1-1/2 in. and greater, and require the use of FS-5 one step solvent cement. The piping shall be mounted directly to the sidewall.· Listed light hazard, extended coverage, quick response, 175° F (79° C) maximum temperature rated, horizontal sidewall sprinklers having deflectors installed within 12 inches (304 mm) from the ceiling and within 6 inches (152 mm) from the sidewall, a maximum distance between sprinklers not to exceed 16 feet (4.87 m), and an application density not less than 0.10 gpm/ft² (4.08 mm/min).

- Listed residential, 165° F (74° C) maximum temperature rated, horizontal sidewall sprinklers having deflectors installed within 12 inches (304 mm) from the ceiling and within 6 inches (152 mm) from the sidewall, a maximum distance between sprinklers not to exceed 18 feet (5.48 m), and an application density not less than 0.10 gpm/ft² (4.08 mm/min).
- Listed light hazard, extended coverage, quick response 165° F (74° C) maximum temperature rated, horizontal sidewall sprinklers having deflectors installed within 12 inches (304 mm) from the ceiling and within 6 inches (152 mm) from the sidewall, a maximum distance


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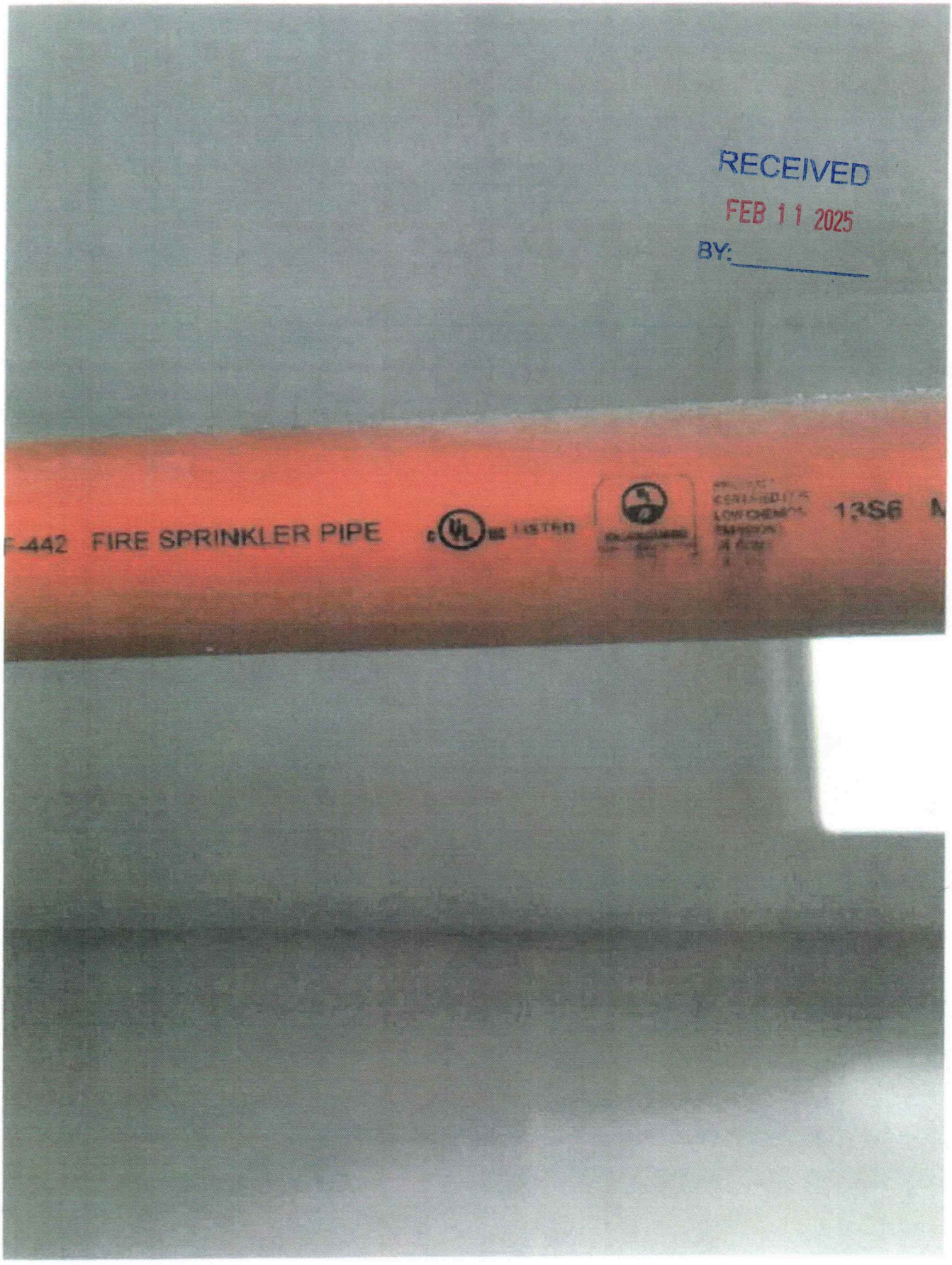
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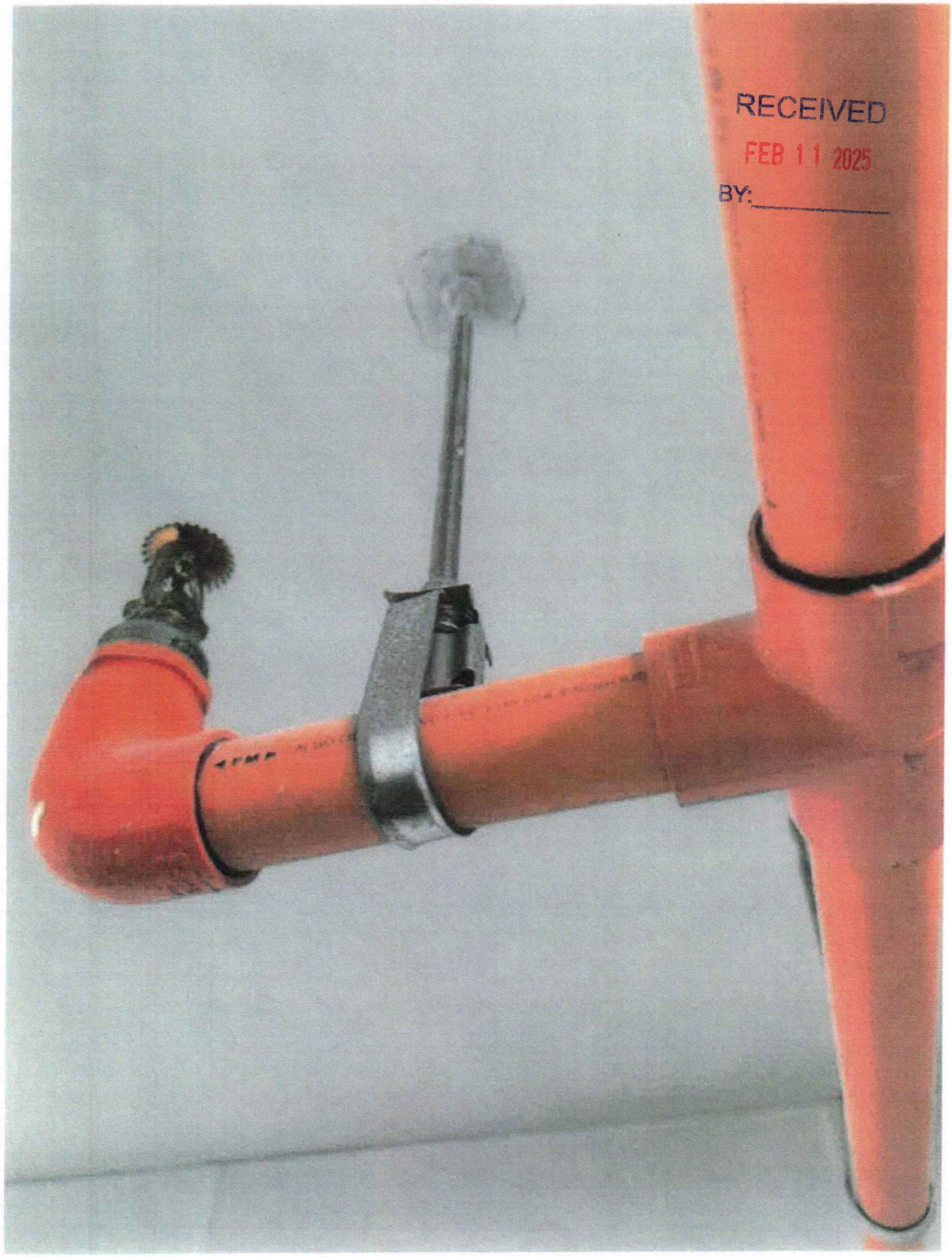
FEB 11 2025
BY:
-442 FIRE SPRINKLER PIPE
LISTED
1356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