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 _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOX CENTER FOR LONG TERM CARE	6 WHITE STREET 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 3/13/24, an unannounced on site visit was conducted at Breakwater Commons to investigate complaint #ME00046592. It was determined that Breakwater Commons was not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580	F580: Notification of Changes Timely notification of changes to Resident #1. Re-education was provided in person to RN#1 on 3/14/24 And Re-education was provided in person to RN#2 on 3/15/24. Documentation, timely notification to physician/ EMS/resident representative, and Stoke Education will be provided to all licensed nurses in a License Meeting on 4/4/24 with Substantial Compliance 4/12/24. On-going compliance will be monitored by monthly audit of transfers to hospital and reported out to QAPI monthly x 90 days.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 7/29/2024

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 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the physician and the resident representative of significant changes in the resident's condition in a timely manner for 1 of 1 sampled residents. (1#) Finding: On 3/13/24, a review of Resident #1's clinical record was completed. Resident #1's clinical record indicates he/she was hospitalized on 2/19/24 and diagnosed with a Hemorrhagic stroke. A Physician/Nurse Communication Tool dated 2/19/24 at 10:08 a.m. indicates Resident #1 had	F 580		

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F 580	Continued From page 2	F 580		

left sided weakness, slurring speech and drooping on the right side of his/her face. The blood sugar was noted to be 65 and Blood Pressure 196/90.

Nursing progress notes on 2/19/24 at 10:57 a.m. indicate that Resident #1 had a low blood sugar of 65 before breakfast and was given juice, also noticed left sided weakness, slurry speech and facial drooping as well as incontinence of bladder, leaning to the left side, lethargy and confusion noted. Resident #1's blood pressure was noted to be 196/90. Resident #1 was given the medication Hydralazine and a recheck of the blood pressure was 130/65. Resident #1 is still symptomatic. The physician assessed Resident #1 and ordered to send the resident to the emergency department for an evaluation and treatment. Emergency transport came and transported Resident #1 to the emergency department.

On 3/13/24 at 1:10 p.m. during an interview with Registered Nurse #1 (RN), he/she stated that Resident #1's blood sugar was taken between 7:30 a.m. and 8:00 a.m. and at that time the resident looked "funny". Resident #1 was given the medication Hydralazine for a high blood pressure.

On 3/13/24 at 1:00 p.m. during an interview with the physician, he stated that he believed he was notified of Resident #1's change in condition about 9:00 a.m. but feels he should have received a call sooner.

On 3/14/24 at 1:16 p.m., certified Nurses Aid #1 (CNA) stated that he/she was asked by RN #1 and RN #2 to assist Resident #1 with

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F 580	Continued From page 3 repositioning at approximately 8:10 a.m. CNA #1 states that he/she observed Resident #1 leaning to one side, facial drooping, left sided weakness, garbled speech and not making sense. At that time, CNA #1 expressed concern that Resident #1 may be having a stroke. CNA #1 states that he/she was told that Resident #1's symptoms were due to a low blood sugar and Resident #1 was just drooling. CNA #1 states that he/she entered the room of Resident #1 again at 9:00 a.m. to retrieve his/her breakfast tray. Resident #1 was found alone with facial drooping, left sided weakness and garbled speech. CNA #1 expressed concern again to RN #1 and RN #2 that Resident #1 may be having a stroke. CNA #1 recalls being told that Resident #1's vital signs and blood sugar were normal. Emergency Medical Services (EMS) documentation indicates that the call from the facility to transfer the resident to the emergency department was 10:21 a.m. EMS arrival time to the facility was 10:29 a.m. Additionally, the clinical record lacked documentation that the physician and resident representative were notified of a significant change in Resident #1's medical condition in a timely manner. On 3/13/24 at 2:30 p.m., a surveyor discussed the finding that the physician and resident representative were not notified of a significant change in Resident #1' medical condition in a timely manner.	F 580		