STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205105	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westgate Center for Rehab & Alzheimers Care	750 Union St Bangor, ME 04401

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 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. Based on observations and interviews, the facility failed to adequately provide housekeeping services necessary to maintain an environment free from offensive odors for 3 of 3 days of survey (5/11/26 through 5/13/26) on the locked Acadia Unit.Findings:On 5/11/26 at 11 a.m. and 12:56 p.m., upon entering the locked dementia/Alzheimer's Acadia Unit, a strong, foul urine odor was observed and it lingered throughout the unit.On 5/12/26 at 7:30 a.m., 11:55 a.m. and 2:00 p.m., upon entering the Acadia Unit, a strong foul urine odor was observed and it lingered throughout the unit. On 5/13/26 at 9 a.m., and 1p.m., upon entering the Acadia Unit, a strong foul urine odor was observed and it lingered throughout the unit. On 5/13/26 at 1:10 p.m., in an interview with the Acadia Unit RN-Charge Nurse, she stated the Unit does have a strong odor. They open windows when they can; housekeeping cleans daily and they have air freshener sprays.On 5/13/26 at approximately 1:35 p.m., in an interview with the Director of Nursing Services, the surveyor discussed the above findings.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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** Based on record reviews and interviews, the facility failed to ensure a care plan was updated and implemented for 2 of 14 residents reviewed on survey (Resident #3 [R3] and R9). Findings: 1. On [DATE], R3's clinical record was reviewed and indicated the following: -On [DATE], a provider order indicated, Do Not Resuscitate [Do not perform Cardio-Pulmonary Resuscitation (CPR)]. Review of the Care Plan indicated a code status of Full Code (Perform CPR), dated [DATE]. -On [DATE], a provider order indicated, change code status to DNR only not CPR or DNI one time a day. Review of the Care plan indicated a code status of Full Code (Perform CPR), dated [DATE]. -On [DATE], a provider order indicated, NovoLOG FlexPen Subcutaneous Solution Peninjector 100 UNIT/[milliliter (ML)] (Insulin Aspart) Inject as per sliding scale: if 0 - 299 = 0; 300 - 500 = 5, subcutaneously before meals and at bedtime for [Diabetes Mellitus (DMII)]. The care plan does not address R3's insulin orders including goals and interventions for the monitoring and management of its use. -On [DATE], a provider order indicated, NovoLOG FlexPen Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Aspart) Inject 7 unit subcutaneously before meals for DMII. The care plan does not address R3's insulin orders including goals and interventions for the monitoring and management of its use. -On [DATE], a provider order indicated, Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 32 unit subcutaneously one time a day for DM II. The care plan does not address R3's insulin orders including goals and interventions for the monitoring and management of its use. -Review of R3's care plan included a focus, goals and interventions for deficient self-care related to a Urinary Tract Infection (UTI) with sepsis, and dependent on staff for meeting some physical needs [related to (r/t)] SEPSIS DUE TO ESCHERICHIA COLI [bacteria native to the intestinal tract (e.coli)]. The clinical record lacked evidence that R3 was receiving interventions for a urinary tract infection or sepsis after [DATE]. On [DATE] 9:40 a.m., during an interview with a surveyor and the Director of Nursing (DON), R3's clinical record was reviewed. The DON confirmed with the surveyor that R3's care plan was not updated with R3's current end of life goals, urinary status, or goals and interventions for the monitoring and management of insulin. 2. On [DATE] , R9's clinical record was reviewed and indicated that he/she was hospitalized and treated for constipation twice ([DATE] and [DATE]). Review of R9's care plan lacks evidence that his/her care plan was revised to include treatment of his/her constipation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:54 a.m., during an interview with the Director of Nursing services the surveyor confirmed that R9's constipation was not addressed on his/her care plan and was not revised after the second hospitalization for the treatment of constipation.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record reviews and interviews the facility failed to ensure a duplicate order was removed from an electronic Medication Administration Record which resulted in the resident receiving duplicate doses of the same medication for 1 of 5 residents reviewed for unnecessary medications (Resident #10 [R10])Finding:On 5/13/2026 at 12:59 p.m. during a clinical record review R10's signed physician orders dated 4/23/26 indicated that R10 had an order for Senna oral tablet 8.6 milligrams (mg) give 2 tablets by mouth two times a day for constipation hold for loose stools. Review of R10's electronic Medication administration record (MAR) shows that since 3/26/26 R10 has been receiving two separate doses of Senna. On 3/26/26 a second order was entered onto the MAR and R10 received Senna 8.6mg, 2 tablets at 8:00 p.m. and senna docusate sodium (senna-s) 8.6-50 mg 2 tablets at 8:00 p.m. From the date 3/27/26 to 5/13/26 R10 has received both medications twice daily.On 5/13/26 during an interview with the Assistant Director of nursing services (ADNS), she was not able to identify the reason the senna-s was on the MAR. the ADNS reviewed the signed physician orders and the MARs for March, April and May and at this time the surveyor confirmed that R10 had been receiving a second dose of senna (senna-s) twice a day since 3/26/26.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record reviews and interview, the facility failed to ensure the attending Provider signed the medication Order Review History Report (Physician block orders) that is required during a visit at least every 60 days plus a 10 day grace period for 1 of 5 sampled residents reviewed for unnecessary medications. (Resident #40 [R40]Finding: 1. On 5/13/26, a review of R40's clinical record was completed. Documentation indicated a required regulatory visit was completed on 4/30/26. A provider progress note was completed on 4/30/26, but there was no evidence that the physician block orders were signed until a day later on 5/1/26. The facility was unable to provide evidence that the physician block orders were signed on the day of the required recertification visit. On 5/13/26 at approximately 1:35 p.m., the surveyor discussed and confirmed this finding with the Director of Nursing and the Regional Director of Clinical Operations.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, record review and interviews, the facility failed to ensure that a resident record contained accurate, complete, and/or readily accessible information for 1 of 1 resident(s) reviewed hospice (Resident #45 [R45]).Findings:On 5/11/26, R45's clinical record was reviewed and indicated the following:-On 3/26/26, a health status note indicated R45 was discharged from hospice services.-On 4/1/26 at 1:15 p.m., a provider note stated, [R45], . now on hospice level care. Patient is seen today for weekly hospice visit. The clinical record lacked evidence that R45 was receiving hospice services at the time of the visit.-On 4/8/26 at 11:30 a.m., a provider note stated, [R45], . now on hospice level care. Patient is seen today for weekly hospice visit. The clinical record lacked evidence that R45 was receiving hospice services at the time of the visit.-On 4/15/26 at 11:45 a.m., a provider note stated, [R45], .now on hospice level care. Patient is seen today for weekly hospice visit. Patient has been on hospice since 4/10/2024. The clinical record lacked evidence that R45 was receiving hospice services at the time of the visit.-On 4/30/26 at 9:30 a.m., a provider note stated, The patient continues to receive hospice services with aide support and RN visits. The clinical record lacked evidence that R45 was receiving hospice services at the time of the visit.-On 5/7/26 at 1:15 p.m., a provider note stated, [R45], . now on hospice level care. Patient is seen today for weekly hospice visit. The clinical record lacked evidence that R45 was receiving hospice services at the time of the visit.On 5/13/26 at 9:56 a.m., during an interview with a surveyor, the Director of Nursing stated that R45 was discharged from hospice services and confirmed the statements in the provider notes were not accurate. At this time, a surveyor confirmed R45's clinical record had inaccurate documentation regarding hospice services.