STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205180	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windward Gardens	105 Mechanic St Camden, ME 04843

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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 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** 42531 Based on record review and interview, the facility failed to notify the physician of significant change in condition when a resident was noted to have a change in meal intakes and significant weight loss for 1 of 3 residents reviewed during a complaint investigation (Resident #1). Findings: Review of policy Change of Condition dated 7/1/24 states A Center must immediately inform the patient, consult with the patient's physician, and notify, consistent with their authority, the patient's representative, where there is: .A significant change in patient's physical mental, or psychosocial status (that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications). A need to alter treatment significantly (that is, a need to discontinue or change and existing form of treatment due to adverse consequences, or to commence a new forma of treatment) . Resident #1 was admitted on [DATE] and has diagnoses to include recent Urinary tract infection, congestive heart failure, dementia, severe anxiety, and delirium. Review of Resident #1's provider orders revealed order with start date of 12/18/24 for Weight: Daily for Congestive Heart Failure. Review of Resident #1's documented weights between 12/18/24 through 12/30/24 (13 days) revealed daily weights were only obtained 3 times during this stay. Review of Resident #1's Weights revealed admission weight dated 12/18/24 for 188.4 lbs., on 12/25/24 weighed 167.6 pounds, and on 12/28/24 weighted 165.4 pounds, indicating a 23 pound weight loss. (12.20% weight loss). Further review of Resident #1's clinical record lacked evidence a provider was notified of this significant weight change. Review of Resident #1's meal intakes between 12/18/24 and 12/19/24 revealed he/she ate 50% of breakfast and lunch, no documented intake for diner, 12/20/24 25 % of breakfasts and 50% of lunch and dinner, on 12/21/24 consumed 0% of breakfast, and 25% of lunch. There is no documented intake for diner. 12/22/24. 12/22/24 consumed 0% of breakfast and lunch and there are no documented intakes for diner. Review of Resident #1's clinical record lacked evidence that a provider was notified of the above concerns. (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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Review of Resident # 1's Nutritional assessment dated [DATE] states: Person completing the assessment is: Dietitian: .Most recent weigh 167.6 on 12/25/24; BMI: 32.7. admitted for continuing care. hospitalized with UTI, spinal stenosis, heart failure, anxiety, depression medical history. Per hospital notes + for appetite change . States her [mother/father] likes most foods, denied any food dislikes. Recorded weights 12/18-188.4# 12/15-167.6 40 mg Lasix started on 12/19. Weight status: Resident has significant/severe loss/gain: [blank]; Resident has a weight loss/gain trend: [blank]; Resident BMI is less than 19 or equal to or greater than 25: yes; Intake: Most meals since admission</= 50% Dependent for feeding. Resident intake meeting needs compared to calculated needs: no; Evaluation/Nutrition Plan: [blank]; Is there a nutrition problem: yes, Nutrition Prescription: House shakes BID liquid protein x 1 /day . Further review of Resident #1's clinical record lacked evidence the Dietitian consulted with medical provider regarding the above concerns. Review of provided Provider Communication: dated 12/21/24 states Daughter is mildly concerned about patients' drowsiness. Patient didn't eat [his/her] breakfast and was sleepy most of the time: Review of Resident #1's After Hours Telehealth Consult dated 12/28/24 at 00:00 states Fall/agitation . Daughter concerned about intake: Daughter concerned that patient has not been eating or drinking. She is agitated and refusing fluids . Further review of Resident #1's entire clinical record lacked evidence that a provider was notified of these ongoing nutritional concerns until 12/28/24. During an interview with 2 surveyors on 1/2/25 at 12:01 p.m., Medical Doctor (MD) indicated it is his expectation that the provider be notified is a resident has not been eating appropriately as soon as possible. And would expect to be notified within 24-48 hours if someone isn't getting weights as ordered. At this time MD indicated he was only notified that Resident #1 had missed 1 meal when first admitted but had not been made aware of any further nutrition concerns, nor had he been made aware of any weight loss. During an interview on 1/2/24 at 2:28 p.m., Unit Manager (UM)1 indicated that the provider should be notified when a resident has weight loss or has not been eating well. During an interview on 1/2/24 at 1:08 p.m., Nurse Practitioner (NP) indicated that she had not been made aware of Resident 1's lack of nutrition intake or weight loss. During a telephone interview with 2 surveyors on 1/3/24 at 2:27 p.m., Registered Dietitian (RD) RD indicated the facility had not notified her that Resident #1 has not been eating adequately and wasn't receiving daily weights until she reviewed the clinical record on 12/25/24 and 12/26/24. RD further indicated she ordered a supplement, but did not notify a medical provider of the above concerns. During an interview with 2 surveyors on 1/3/24 at 2:26 p.m., the above was discussed with Director of Nursing.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on interviews, record review, and facility policy, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to care for 1 of 3 residents reviewed during a complaint investigation (Resident #1). Findings: Review of policy Person-Centered Care Plan dated 10/24/22 states .The Center must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each patient/resident that includes the instructions needed to provide effective and person-centered care that meet professional instructions needed to provide effective and person-centered care that meet professional standards of quality care. a baseline care plan must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient including, but not limited to: initial goals based on admission orders; physician orders; dietary orders; therapy services; social services; PASRR recommendation, if applicable . Resident#1 was admitted on [DATE] for skilled care services and has diagnoses to include heart failure. Review of Resident #1's provider orders revealed the following orders: -Order with start date of 12/19/24 for Furosemide Oral Tablet 40 MG (Furosemide) Give 40 mg orally one time a day for fluid overload. Review of Resident #1's baseline care plan dated 12/18/24 lacked evidence of goal and interventions in the areas of nutrition, or use of diuretic medications on admission. During an interview on 1/2/24 at 2:26 p.m., Director of Nursing (DON) indicated that it was her expectation that baseline care plans were completed within 48 hours of admission. At this time DON reviewed Resident 1's care plan and confirmed it did not contain goals and interventions for the above concerns.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review, interviews and facility policy, the facility failed to follow-up on significant weight loss, and reduced meal intake for 1 of 3 residents reviewed during a compliant investigation (Resident #1). Findings: Review of policy Nutrition/Hydration Care and Services dated [DATE] states .Staff will provide nutritional and hydration care and services to each patient, consistent with the patient's comprehensive assessment . Use the Diet Order and Communication Form to initiate consult with Dietitian, when indicated. Obtain orders per recommendations. Contact physician/advanced practice provider (APP) to convey the recommendations. Develop .Plan of care for enhancing oral intake, promoting adequate nutrition and hydration, and identifying individualized goals, preferences, and choices. Maintain fluid and hydration balance. Monitor patient's weight as ordered . Address any changes in condition that affect or potentially affect the patient's nutritional status with Dietitian and physician/APP . Review Dietitian's progress notes to identify ongoing progress and recommendations. Resident #1 was admitted on [DATE] for skilled care services and had diagnoses to include recent history of urinary tract infection, congestive heart failure (CHF), severe anxiety, depression, and delirium. Review of Resident #1's Weights revealed admission weight, dated [DATE] for 188.4 lbs., on [DATE] weighed 167.6 pounds, and on [DATE] weighted 165.4 pounds, indicating a 23 pound weight loss. (12.20% weight loss). Review of Resident #1's Meal Intakes revealed he/she consumed 25% for 8 of 25 documented meals, and 6 of 25 documented meal intakes of 0%. Review of Resident #1's clinical record revealed Resident #1 was seen by a provider on [DATE],[DATE], and [DATE]. There is no evidence that weight loss or nutrition concerns were addressed during these visits. Review of Resident #1's clinical record reveled admission Dietary Screening for Malnutrition: At Risk for Malnutrition, Morbid Obesity was not completed until [DATE] (7 days after admission). Review of Resident #1's Nutritional assessment dated [DATE] states: Person completing the assessment is: Dietitian: .Most recent weigh 167.6 on [DATE]; BMI: 32.7. admitted for continuing care . Per hospital notes + for appetite change . likes most foods, denied any food dislikes. Recorded weights ,d+[DATE]-188.4# , d+[DATE]-167.6 40 mg Lasix started on ,d+[DATE]. Weight status: Resident has significant/severe loss/gain: [blank]; Resident has a weight loss/gain trend: [blank]; Resident BMI is less than 19 or equal to or greater than 25: yes; Intake: Most meals since admission</= 50% Dependent for feeding. Resident intake meeting needs compared to calculated needs: no; Evaluation/Nutrition Plan: [blank]; Is there a nutrition problem: yes, Nutrition Prescription: House shakes BID liquid protein x 1 /day . Further review of Resident #1's clinical record lacked evidence the Dietitian consulted with medical provider regarding the above concerns. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with 2 surveyors on [DATE] at 12:03 p.m. Medical Doctor (MD) indicted it is his expectation that all residents have a nutrition evaluation completed on admission, a nutrition care plan is established upon admission and he or another provider should be notified of any change in condition, weight loss/gain or lack of food/fluid intake sooner than later. As far as he can recall has only been notified of one missed meal. During an interview with 2 surveyors on [DATE] at 1:08 p.m., Nurse Practitioner (NP) indicated she had not been made aware of Resident 1's lack of nutrition intake or weight loss. During a telephone interview on [DATE] at 2:27 p.m., Registered Dietitian (RD) indicated that all residents should be seen as soon as possible by the dietary department upon admission and the nutrition care plan should be initiated at that time. At this time, Dietitian confirmed she was not aware of Resident #1's possible weight loss, or decreased meal intake until she did the initial record review on [DATE]. RN further indicated she did not consult/notify provider of the above concerns. At this time RD confirmed above findings. During an interview with 2 surveyors on [DATE] at 2:43 p.m., the above was discussed with Director of Nursing. During a telephone interview on [DATE] at 3:15 p.m., emergency room Doctor ([NAME]): stated Resident #1 presented to Emergency Department on [DATE] in a near death state. His/her blood pressure was , d+[DATE], was hypotensive, gray, ashen and cold to touch. He/she was barely responsive. Resident #1's family member notified him of what medication he/she had been receiving and after a couple of doses of Narcan, Resident #1 became responsive and kept asking for water over and over again. Resident #1's blood work suggested profound dehydration, severe enough that she was in renal failure with multi system organ failures. After receiving multiple liters of fluid, his/her labs did start to improve, but due to the damage that had already been made, the discussion was made with daughter, to put /him her on comfort care. [NAME] indicted he noticed Resident #1 had a fentanyl patch on upon arrival and stated when someone is in renal failure the body stops metabolizing the fentanyl and it keeps building up because the kidneys aren't working and can't flush it out. States Resident #1 essentially died from dehydration, which could have been prevented .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review, interviews, and facility policy, the facility failed to monitor for side effects of psychotropic medications for 1 of 3 residents reviewed during a complaint investigation (Resident #1). Findings: Review of policy Medication Monitoring/Medication Management dated 1/24 states .When monitoring a resident receiving psychotropic medications, the facility must evaluate the effectiveness of the medications as well as look for potential adverse consequences . Resident #1 was admitted on [DATE] for skilled care services and had diagnoses to include severe anxiety, depression, and delirium. Review of Resident #1's care plan initiated on 12/19/24 states Resident is at risk for complications related to the use of psychotropic drugs : antipsychotic, anxiolytics, antianxiety Goal: Resident will have the smallest most effective dose without side effects throughout review period Intervention: .monitor for changes in mental status and functional level and report to MD as indicated. Review of active orders for December 2024 revealed the following: -Order with start date of 12/18/24 for anti-anxiety medication Buspirone HCL oral tablet 5 mg (Buspirone HCL) Give 5 mg orally three times a day for depression. -Order with start date of 12/19/24 for anti-anxiety medication Duloxetine HCL Oral Capsule Delayed Release Particles 20 mg (Duloxetine HCL) Give 40 mg orally one time a day for anxiety. -Order with start date of 12/19/24 for anti-anxiety medication Hydroxyzine HCL Oral Syrup 10 mg/5ml (Hydroxyzine HCL) Give 5 ml orally three times a day for anxiety- hold for sedation, notify provider. -Order with start date of 12/20/24 for anti-anxiety medication Lorazepam Oral concentrate 2 mg/ml (Lorazepam) Give 0.5 ml by mouth every 4 hours as needed for agitation. -Order with start date of 12/21/24 for anti-anxiety medication Lorazepam Oral concentrate 2 mg/ml (Lorazepam) give 0.5 ml by mouth two times a day for agitation. Lorazepam 1mg. -Order with start date of 12/19/24 for antianxiety medication Duloxetine HCL Oral Capsule Delayed Release Particles 20 mg (Duloxetine HCL) Give 40 mg orally one time a day for anxiety. -Order with start date of 12/19/24, 12/20/24, 12/23/24, and 12/26/24 for antipsychotic medication Olanzapine 2.5 mg tablet. Give 1 tablet twice daily for agitation. -Order with Start date of 12/18/24 Is resident free from side effects of psychotherapeutic medications?(if no, document side effects in [PN]Provider note) two times a day (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's entire clinical record lacked evidence he/she was monitored for side effects for the above medications. During an interview with 2 surveyors on 1/2/23 at 2:28 p.m., the Director of Nursing reviewed Resident 1's entire clinical record and confirmed Resident #1 was not being monitored for side effects of psychotropic medications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review, interviews, and facility policy, the facility failed to ensure that clinical records were complete and contained accurate information in the area of weights for 2 of 3 Residents (Resident #1, and #2), meal intakes for 3 of 3 Residents (Resident's #1, #2, and #3), palliative care for 1 of 3 Residents (Resident #1), falls for 1 of 1 Resident (Resident #1), and positioning for 1 of 1 Resident (Resident #2) reviewed during a complaint investigation. Findings: Review of policy Nutrition/Hydration Care and Services dated 2/1/23 states .Staff will provide nutritional and hydration care and services to each patient, maintain fluid and hydration balance. Monitor patient's weight as ordered. Resident #1 was admitted on [DATE] and has diagnoses to include heart failure, and dementia, and severe anxiety. Review of Resident #1's provider orders revealed the following orders: -Order with start date of 12/19/24 for diuretic Furosemide Oral Tablet 40 MG (Furosemide) Give 40 mg orally one time a day for fluid overload. -Order with start date of 12/18/24 for Weight: Daily for Congestive heart failure. Review of Resident #1's documented weights between 12/18/24 through 12/30/24 (13 days) revealed daily weights were only obtained 3 times during this stay. Review of Resident #1's meal intakes dated December 2024 lacked documentation of breakfast intakes on 12/7/24 12/16/24, 12/17/24, 12/24/24, 12/28/24 lunch intake on 12/8/24 and 12/15/24. 12/16/24, 12/17/24, 12/22/24, 12/25/24, 12/29/24, 12/30/24, and dinner on 12/8/24, and 12/28/24. Review of Resident #1's clinical record revealed Hospital Discharge Summary dated 12/18/24 states Palliative care was discussed and the patient's daughter expressed interest in outpatient palliative care follow up . Palliative care referral has been placed and follow up may be helpful. Review of Resident #'1s entire clinical record lacked evidence he/she was placed on palliative care. During an interview with 2 surveyors on 1/2/24 at 12:04 p.m., Medical Doctor (MD) indicated he was aware that the hospital placed a referral for palliative care for Resident #1, but it was not followed through with at the facility. Review of policy Falls Management dated 3/5/24 states .any patient who sustains an injury to the head from a fall/or has a fall unwitnessed by staff will be observed for neurological abnormalities by performing neurological check per policy .The patient's representative will be notified of the fall and any follow-up treatment needed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy Neurological Evaluation dated 2/1/23 states .When a patient sustains an injury to the head or face and/or has an unwitnessed fall, neurological evaluation will be performed: every1 15 minutes x two hours, then every 30 minutes x two hours, then every 60 minutes four hours, then every eight (8) hours until at least 72 hours has elapsed . Review of Resident #1's Revealed he/she had an unwitnessed fall on 12/28/24.Review of Resident #1's provided Neurological Evaluation Flow Sheet dated 12/23/24 reveled initial neurological exam was completed at 19:00. The flow sheet further states, dates and times for additional neurological exams, but the rest of the sheet is blank. Review of Resident #1's provider orders lacked evidence that an order was obtained to discontinue neurological checks. During an interview with 2 surveyors on 1/2/24 at 2:28 p.m., the Director of Nursing (DON) indicated that she retrieved Resident #1's Neurological Evaluation Flow Sheet out of the shred bin located at the nurse's station, but it is her expectation that neurological checks are completed according to policy, unless a provider gives an order to discontinue them. At this time DON confirmed there is no evidence Resident #1 received neurological checks after this fall, nor is there evidence that an order was obtained to discontinue them. 2. Resident #3 was admitted on [DATE] and has diagnoses to include Alzheimer's, dementia. Review of Resident #3's meal intakes dated December 2024 lacked documentation of breakfast intake on 12/7/24 12/16/24, 12/17/24, 12/24/24, 12/28/24 lunch intake on 12/8/24 and 12/15/24. 12/16/24, 12/17/24, 12/22/24, 12/25/24, 12/29/24, 12/30/24, And dinner on 12/8/24, and 12/28/24. 51669 3. Resident #2 was admitted on [DATE] and has diagnoses to include Alzheimer's disease, dementia, and heart failure. Review of Resident #2's active provider orders revealed the following: - An order with a start date of 12/2/24 to Weigh every day shift every Sun for 4 weeks AND every day shift every 1 month(s) starting on the 1st for 5 day(s). - An order with a start date of 11/28/24 for Furosemide 20mg tablet, Give 20 mg orally one time a day for CHF [Congestive Heart Failure]. Review of Resident #2's Medication Administration Record (MAR) for December 2024 revealed Resident #2 was not weighed on 12/8/24 and 12/15/24, and review of the nurse's progress notes for each of these dates lacked documentation indicating why Resident #2 was not weighed. Review of Resident #2's Care Plan, updated 12/2/24, revealed, [Resident #2] is at risk for decreased ability to perform ADL(s) in: .eating .Interventions: . Provide total assist of 1 for eating .; nutritional risk: due to Alzheimer's dementia, .10# wt [weight] loss over previous month . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's documented meal intake(s) for December 2024 lacked documentation of breakfast intake(s) on 12/24/24, 12/29/24, and 12/30/24; lunch intake(s) on 12/29/24 12/30/24; and dinner intake(s) on 12/21/24, 12/24/24, 12/25/24, 12/26/24, 12/27/24, 12/28/24, 12/29/24, 12/30/24, and 12/31/24; and documented drink intake for lacked evidence of fluids being offered between meals on 12/21/24, 12/22/24, 12/27/24, 12/28/24, 12/30/24, and 12/31/24. Review of Resident #2's clinical record revealed, Task, check and change resident after 2 hours. Further review revealed that Resident #2's clinical record lacked evidence that this was completed/offered and/or refused on 12/21/24, 12/25/24, 12/26/24, 12/27/24, 12/28/24, 12/29/24, 12/30/24, and 12/31/24. During a review of Resident #2's entire clinical record, with 2 surveyors, on 1/2/25 at 3:04 p.m., Unit Manager (UM) #1 confirmed the above findings, stating that documentation is a problem and has been for a while.