

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  205180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/17/2025
NAME OF PROVIDER OR SUPPLIER  Windward Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Mechanic St Camden, ME 04843	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review the facility failed to follow provider orders for wound care and failed to follow the facilities Skin Integrity and Wound Management policy for 1 of 2 Residents reviewed for pressure ulcer management. (Resident #310)</p> <p>Findings:</p> <p>The facilities Skin Integrity and Wound Management policy revised 5/1/25 states under Practice Standards, the Licensed nurse will: Evaluate any reported or suspected skin changes or wounds. Document newly identified skin/wound findings and the 24-hour report. Perform and document skin inspections on all newly admitted /readmitted patients weekly thereafter and with any significant change of condition. Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, within unanticipated decline in wounds . Perform daily monitoring of wounds or dressings for presence of complications or declines. Document daily monitoring of ulcer/wound site with or without dressing. Monitor: signs of decline in wound status.</p> <p>On 6/10/25, Adult Protective Services notified the Division of Licensing and Certification of the following. [Resident #310] was sent to the emergency room on 6/8/25 for an evaluation and was noted to have pressure sores on his/her heels due to not being moved by facility staff.</p> <p>On 6/17/25 review of Resident #310's medical record, showed he/she was admitted on [DATE] with a nursing admission note stating, resident's right heel was pinkness/boggy and he/she had an open wound dorsal R. foot. Provider orders, dated 5/27/25, instructed nursing to Apply skin prep to bilateral heels and ensure that heels are offloaded. Monitor skin for any changes to skin integrity, everyday shift and Wound Care treatment to the right dorsal/lateral foot. Cleanse with wound cleanser, gently pat dry. Apply calcium alginate to the wound bed only and cover with Kerlix daily and PRN(as needed) until resolved.</p> <p>A wound care consult note, dated 6/4/25 stated under Patient seen for initial evaluation and management of wound as requested by the primary medical team . Wound #1 Right, Dorsal Foot is a chronic [NAME] Grade 2 Diabetic Ulcer and has received a status of Not Healed . Wound #2 Right, Plantar Heel is an acute Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed . Wound #3 Right, Lateral Foot is an acute Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Under section Wound Orders instructs nursing staff for the following daily care: Cleanse wound #1, #2 and #3 with a wound cleanser, apply Betadine and leave the wounds open to air/no dressing needed.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Treatment Administration Records (TAR) from 6/4/25 through 6/8/25 revealed nursing failed to initiate the new orders from the wound consult on 6/4/25 and continued with the previous wound care orders. The nursing skilled evaluation notes from 5/21/25 through 6/8/25 lacked evidence of the pressure ulcer change in condition as nursing continued to document the right heel was pinkness/boggy. In addition, the weekly skin checks completed on 5/28/25 and on 6/4/25 stated his/her right heel was pinkness/boggy and lacked a description of the wound on the dorsal right foot.</p> <p>On 6/18/25 at 2:52 p.m., the above was discussed via email with the Clinical Lead Registered nurse.</p>		