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	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windward Gardens	105 Mechanic Street 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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on facility policy, record review, and interview, the facility failed to notify the State Agency after potential abuse concerns were identified, failed to investigate allegations of potential abuse, and failed to ensure that the facility's investigation was sent to the State Agency within 5 business days of the incident for 1 of 1 incident reviewed for abuse.Findings:Facility policy titled Abuse Prohibition states Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or Designee will preform the following.Report allegations to the appropriate state and local authority(s) involving neglect, exploitation, or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two hours after the allegation is made if the event results in serious bodily injury.Initiate an investigation within 24 hours of an allegation of abuse that focuses on: whether abuse or neglect occurred and to what extent.The investigation will be thoroughly documented within Risk Management Portal. Ensure that documentation of witnessed interviews is included . Report findings of all completed investigations within five working days to the Department of Health using the state on-line reporting system or state approved forms.On 9/18/25 the Division of Licensing and Certification received a complaint regarding abuse allegations.On 12/2/25 at 9:07 a.m., during an interview with a representative for Resident #37, he/she discussed concerns about a staff member being rough with Resident #37 and making the resident feel like the staff member hated him/her. During the interview with the representative, it was determined that the Facility Administrator was made aware of these concerns. Per the Resident Representative the Facility Administrator did an investigation and found nothing.On 12/3/25 at 10:25 a.m., during an interview with Resident #37 and another surveyor present. Resident #37 stated he/she was abused at this facility by a staff member. Stating a staff member pulled his/her shoulder hard causing pain. Furthermore he/she states it still is painful at times. He/She had alerted a staff member of this incident. Per the Resident, the Facility Administrator spoke to him/her and told him/her that he would investigate this matter and make sure it would not happen again.Review of Resident #37 clinical record revealed that on 9/22/25 he/she had a Brief Interview for Mental Status (BIMS) which showed a score of 12 of 15, indicating he/she is cognitively intact.Review of Resident #37 clinical record and incident reports/investigations lacked evidence of an investigation or notes regarding potential abuse.On 12/5/25 at 8:15 a.m., during an interview with an Adult Protective Case Worker who initially investigated the allegation of abuse, confirmed that on 9/10/25 the Facility Administrator was made aware of potential Abuse allegations regarding Resident #37.On 12/3/25 at 10:40 a.m., during an interview with the Market Lead Clinical Specialist it was confirmed that the facility failed to notify the State Agency after potential abuse concerns were identified, investigate allegations of potential abuse, and ensure that the facility's investigation was sent to the State Agency within 5 business days.

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record reviews, interviews, 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 5 of 16 residents reviewed for baseline care plans (Residents #1 [R1], R33, R76, R78, R2)Findings: 1.Resident #33 was recently admitted to the facility and has diagnoses to include alcohol abuse. Review of Resident #33 baseline care plan lacked evidence that goals and interventions were put into place for alcohol abuse During an interview on 12/4/25 at 1:12 p.m., confirmed with Market Lead Clinical Specialist confirmed the above. 2.R2 was recently admitted to the facility with multiple mental health diagnoses that included Attention Deficit Hyperactivity Disorder, Borderline Personality Disorder, Bipolar, anxiety, and depression as well as a Level II Pre-admission Screening and Resident Review (PASRR). A review of R2's baseline care plan lacked evidence that goals and interventions were put into place with 48 hours of admission. On 12/3/25 at 2:19 p.m. , during an interview with Market Lead Clinical Specialist, a surveyor confirmed this finding. 3. Facility policy, Person-Centered Care Plan, revised 9/15/25 states, . 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.Dietary orders.assistance with activities of daily living. 3.R1 was recently admitted with diagnoses to include Failure to Thrive and Severe Protein-Calorie Malnutrition. A review of R1's clinical record revealed dietary orders for Regular/Liberalized diet . and House Supplement two times a day . A review of R1's baseline care plan lacked evidence that goals and interventions were put into place in the area of dietary orders and instructions until 9 days after R1's admission. 4. R76 was recently admitted with diagnoses to include Dementia and repeated falls. Review of R76's baseline care plan indicates Resident requires assistance for bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting . but lacked evidence of the type of assistance R76 needs with his/her Activities of Daily Living (ADL). 5. R78 was recently admitted with diagnoses to include left femur fracture and recent left hip surgery. A review of R78's clinical record revealed an order for Regular/Liberalized diet .Note patient is allergic with lactose, capsicum annuum extract & derivatives (Bell pepper & capsicum), Cayene [cayenne] and green pepper. A review of R78's baseline care plan lacked evidence that goals and interventions were put into place in the area of dietary orders and instructions. Further review of the baseline care plan indicates Resident requires assistance for bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to recent left hip surgery. but lacked evidence of the type of assistance R78 needs with his/her Activities of Daily Living (ADL). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/3/25 at 2:18 p.m., a surveyor and the Market Clinical Lead reviewed the baseline care plans for the above residents and confirmed they lacked goals and interventions for the dietary orders and ADLs. Resident #75's was recently admitted to the facility. A review of Resident #37's baseline care plan indicated he/she requires assistance for bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting . The baseline care plan lacked evidence of the resident's level of assistance needed for Activities of Daily Living. On 12/3/25 at 2:30 p.m., During an interview with the Market Lead Clinical Specialist, the above information was confirmed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review the facility failed to update a care plan with goals and interventions after a resident obtained a leg fracture for 1 of 11 complaints reviewed during an annual survey (Resident #35).Findings:Resident #35 was admitted in 9/23 and had diagnoses to include dementia with psychotic disturbance and anxiety.Review of Resident #35's clinical record revealed he/she sustained a left leg fracture around 10/20/25.Review of Resident 35's care plan last reviewed 8/7/25 lacked evidence that goals and interventions were put into place after left leg fracture sustained [approximately]10/20/25.During an interview on 12/3/25 at 10:25 a.m., the above was discussed with Consulting Administrator-Maine

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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. Based on record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 16 sampled residents reviewed (Resident #2 [R2], R35).Findings: 1.Review of Resident #35's Medication Administration Record (MAR) and Treatment Administration Record (TAR) effective November 2025 revealed the following: -Diabetic foot check MAR/TAR lacked evidence this was completed/refused on 10/14/25 Does the patient need to have the Head of Bed elevated to avoid shortness of breath while lying flat? Every day and night shift: MAR/TAR lacked evidence this was completed/refused during night shift of 10/14/25. - Encourage deep breathing when awake every shift. every shift for Cough. MAR/TAR lacked evidence this was completed/refused on night shift on 10/14/25 - Resident free from side effects of psychotherapeutic medications?(if no, document side effects in PN) every day and night shift. MAR/TAR lacked evidence of this was completed/refused during the night shift on 10/14/25 Review of Resident #35's GG-Eating for November 2025 lacked evidence that evening meal was documented on 11/22/25 and 11/30/25 During an interview on 12/3/25 at 10:05 a.m., the above was discussed with Consulting Administrator-Maine. 2. On 12/3/25 at 9:19 a.m., R2's clinical record was reviewed and included a physician order, dated 5/22/25, to administer sliding scale insulin four times a day based on the resident's finger stick blood sugar (FSBS) results. November 2025's Treatment Administration Record (TAR) was reviewed with the Market Lead Clinical Specialist (MLCS) and it was noted that the TAR lacked evidence of FSBS results and if sliding scale was needed for 6:30 a.m. treatments on 11/3, 11/11, 11/17, and 11/20. MLCS stated she would check the record to see if it was documented elsewhere. On 12/3/25 at 10:35 a.m., the MLCS stated she was unable to find the missing documentation. The surveyor confirmed this finding at this time.