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	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windward Gardens	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on facility policy, record review, and interviews the facility failed to provide residents/representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for 14 of 17 residents reviewed for advanced directives (Resident's #5, #14, #19, #21, #22, #26, #27, #34, #44, #49, #52, #54, #58 and #219). Findings: Review of facility policy titled Review of facility policy Health Care Decision Making dated 1/8/24 states Centers must: Inform and provide written information to all patients concerning the rights to accept or refuse medical or surgical treatment and, at the patient's option, formulate an advance directive: .approach a capable patient who does not have an advance directive upon admission , . so that patient's rights will be honored and their wishes will be executed at the appropriate time .Upon admission, determine whether the patient has an advance directive and .If the patient/patient representative has copies with them, make copies, place in medical record, and notify the interprofessional team . 1. Resident #5 was admitted to the facility on [DATE]. A review of Resident #5's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 2. Resident #14 was admitted to the facility on [DATE]. A review of Resident #14's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive. 3. Resident #19 was admitted to the facility on [DATE]. A review of Resident #19's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #21 was admitted to the facility on [DATE]. A review of Resident #21's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive. 5. Resident #22 was admitted to the facility on [DATE]. A review of Resident #22's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive. 6. Resident #26 was admitted to the facility on [DATE]. A review of Resident #26's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive. 7. Resident #27 was admitted to the facility 5/22/23. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Brief Interview for Mental Status 14 of 15 indicating resident #27 is cognitively intact. During an interview on 4/24/24 at 12:48 p.m. Resident #27 indicated he/she does have an advanced directive and believed that it was provided to facility on admission. Review of Resident #27's clinical record lacked evidence of an advanced directive. 8. Resident #34 was admitted to the facility on [DATE]. A review of Resident #34's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 9. Resident #44 was admitted to the facility on [DATE]. A review of Resident #44's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive. 10. Resident #49 was admitted to the facility on [DATE]. A review of Resident #44's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive. 11. Resident #52 was admitted to the facility on [DATE]. A review of Resident #52's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 12. Resident #54 was admitted to the facility on [DATE]. A review of Resident #54's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. Resident #58 was admitted to the facility on [DATE]. A review of Resident #58's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 14. Resident #219 was admitted to the facility on [DATE]. A review of Resident #219's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. On 4/23/24 a 1:30 p.m., during an interview, the Senior Director of Nursing confirmed the above findings. 50218 33640 37440

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 37648 Based on record review and interview, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notices (SNFABN) Form 10055, which included appeal rights and liability of payment, were provided at least 2 days prior to the resident's last covered day, for 2 of 3 residents whose Medicare Part A services were discontinued, and remained in the facility (#274 and #276). Findings: 1. Resident #274's Medicare Part A coverage for skilled services ended on 11/24/23. The medical record lacked evidence that Resident #274 or his/her legal representative was provided a SNFABN when the Medicare A coverage for skilled services was discontinued. The resident remained living in the facility. 2. Resident #276's Medicare Part A coverage for skilled services ended on 3/14/24. The medical record lacked evidence that Resident #276 or his/her legal representative was provided a SNFABN when the Medicare A coverage for skilled services was discontinued. The resident remained living in the facility. On 4/25/24 at 8:28 a.m., during an interview, the Administrator confirmed the SNFABN notices were not provided to Resident #274 and #276.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable interior for the 4 of 4 units (Spring Gardens, North Wind, Penbscoto and Windward Center), the laundry room and hallways for 2 of 2 facility tours (4/22/24 and 4/25/24). Findings: 1. On 4/22/24 at 9:20 a.m., during a tour of Spring Gardens Unit, 2 surveyors, and the Corporate Nurse Educator (CNE) observed the following findings: > The shower room had a black headband, a white towel and a razor on the sink. > Resident room [ROOM NUMBER] - The toilet seat was visibly dirty/soiled and the call bell cord had blue yarn tied to it as an extender. > Resident room [ROOM NUMBER] - The toilet was continuously running. > Resident room [ROOM NUMBER] - The bathroom toilet was visibly dirty. There were 3 large holes in the wall above the toilet. The bathroom door was marred/gouged on the inside and outside of the door. > Resident room [ROOM NUMBER] - The room floor was dirty and cluttered. The bathroom sink was dirty/stained. On 4/22/24 at 9:20 a.m., in an interview, the Corporate Nurse Educator (CNE) confirmed the findings. 2. On 4/25/24 from 8:27 a.m. to 9:15 a.m., an environmental tour was conducted with the Senior Maintenance Director, the Administrator and the Housekeeping/Laundry Supervisor in which the following findings were observed: Laundry > The floor had numerous cracked/broken tiles and the walls had chipped/missing paint and missing cove base. North Wind > The wheelchair scale had ripped/missing non-skid surfaces creating an uncleanable surface. > There were multiple large stains on the hallway carpets throughout the unit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	> The sitting area, across from the nurse's station, had 2 dried liquid spills on the wall near the window. The end table near the window had a worn off surface exposing untreated wood which created an uncleanable surface. > Resident room [ROOM NUMBER] - The bathroom toilet bar was broken and laying on the floor. > Resident room [ROOM NUMBER] - The bathroom floor had a quarter size hole in the linoleum. The wooden bathroom door was chipped/gouged. > Resident room [ROOM NUMBER]- The floor was dirty and the caulking dirty/stained around the base of the toilet. The bathroom exhaust fan was dusty/dirty. The bathroom light had debris in the lens. > Resident room [ROOM NUMBER]- There were 9 small holes in the bathroom floor linoleum by the toilet. There was a plunger and another wooden plunger handle on floor behind the toilet. > Resident room [ROOM NUMBER] - There was a wash basin on floor under the sink. The floor was dirty around the base of the toilet. The bathroom light had debris in the lens. > Resident room [ROOM NUMBER] - The shower stall had non-slip grip tape peeling up. Penobscot House > Resident room [ROOM NUMBER] - The sink countertop had he edging missing exposing untreated wood and creating an uncleanable surface. > Resident room [ROOM NUMBER] - The shower stall had non-slip grip tape peeling up. > Resident room [ROOM NUMBER] - Resident #271's wheelchair was dirty and had dried food and liquid residue on it. Windward Center > Resident room [ROOM NUMBER] - The bathroom door was marked/marred. > Resident room [ROOM NUMBER] - The bathroom floor was dirty and had debris/trash on it. The bathroom walls were marked/marred. > Resident room [ROOM NUMBER] - The bathroom floor was dirty and had debris/trash on it. The bathroom walls were marked/marred. > Resident room [ROOM NUMBER] - The bathroom floor was dirty and had debris/trash on it. The bathroom walls were marked/marred. > Resident room [ROOM NUMBER]: The bathroom floor was dirty and had debris/trash on it. The bathroom walls were marked/marred. > Resident room [ROOM NUMBER] - The floor was dirty and had debris/trash on it. The walls were marred and dirty. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	> Resident room [ROOM NUMBER] - The bathroom floor was dirty and had debris/trash on it. The bathroom walls were marked/marred. The toilet tank lid was missing, On 4/25/24 at 9:15 a.m., in an interview, the Senior Maintenance Director, the Administrator and the Housekeeping/Laundry Supervisor confirmed the findings.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 33640 Based on record review and interview, the facility failed to notify the resident, family and/or the resident's representative in writing of the transfers/discharge to an acute care hospital for 2 of 6 residents sampled for hospitalization s (Residents #5 and #49). Findings: 1. Documentation in Resident #5's clinical record indicated that the resident was transferred to the hospital on 11/22/23 and 11/24/23 and subsequently admitted . The clinical record lacked evidence that Resident #5 and/or the resident representative were provided with written transfer/discharge notices upon either transfer. On 4/24/24 at 9:45 a.m., during an interview, the Licensed Social Worker stated he/she could not locate the transfer/discharge for the dates of 11/22/23 and 11/24/23. 2. Documentation in Resident #49's clinical record indicated that the resident was transferred to the hospital on 4/17/24 and subsequently admitted . The clinical record lacked evidence that Resident #49 and/or the resident representative were provided with a written transfer/discharge notice upon transfer. On 4/24/24 at approximately 10:15 a.m., the surveyor confirmed these findings with the Senior Director of Nurses. 37648

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 33640 Based on record review and interview, the facility failed to issue a bed hold notice which included the daily bed hold cost, to a resident, known family member and/or legal representative for 2 of 6 sampled residents who had been transferred to the hospital (Residents #5 and #49). Findings: 1.Resident #5's clinical record revealed the resident was transferred to an acute care hospital on 11/22/23 and 11/24/23 and subsequently admitted . The clinical record lacked evidence that Resident #5 and/or the resident representative were provided with a written bed hold notice for the dates of 11/22/23 and 11/24/23. On 4/24/24 at 9:45 a.m., during an interview, the Licensed Social Worker stated he/she could not locate the bed hold notice for the dates of 11/22/23 and 11/24/23. 2. Resident #49's clinical record revealed the resident was transferred to an acute care hospital on 4/17/24 and subsequently admitted . The clinical record lacked evidence that Resident #49 and/or the resident representative were provided with a written bed hold notice. On 4/24/24 at approximately 10:15 a.m., the surveyor confirmed these findings with the Senior Director of Nurses. 37648

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on record reviews and interview, the facility failed to ensure that 2 of 2 residents reviewed with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review Level II (PASRR) evaluation and determination (Resident #34 and Resident #52). Finding: 1. Resident #34 was admitted to the facility on [DATE] with diagnosis of Bipolar Disorder. Resident #34's clinical record contained a PASRR Level I determination letter dated 12/11/23 that stated further PASRR evaluation was not required due to Resident #34 met the criteria for a short-term convalescence admission. Resident #34 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after Resident #34's stay changed from short-term to long-term. 2. Resident #52 was admitted to the facility on [DATE] with diagnosis of Bipolar Disorder and Borderline Personality Disorder. Resident #52's clinical record contained a PASRR Level I determination letter dated 10/23/23 that stated further PASRR evaluation was not required due to Resident #52 met the criteria for a short-term convalescence admission. Resident #52 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after Resident #52's stay changed from short-term to long-term. On 4/25/24 at 12:25 p.m., in an interview, the Market Clinical Advisor confirmed that the PASRR Level I was not forwarded again to the State Mental Health Authority to determine if PASRR Level II evaluation and determination was needed for Resident #34 and Resident #52 after their stay changed from short-term to long-term.

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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. 42531 Based on record reviews and interviews, the facility failed to update/implement goals and interventions in the area of antipsychotic medication use for 1 of 6 residents reviewed for medications (Resident #10) Finding: Resident #10 was admitted to facility on 11/17/22 and has diagnoses to include dementia, and major depressive disorder. Review of Resident #10's active orders effective April 2024 revealed order with start date of 2/29/24 for antipsychotic Risperdal oral tablet (Risperidone). Give 0.125 mg by mouth two times a day for mood stabilizer, agitation. On 4/23/24 at 2:51 p.m., during review of Resident #10's entire clinical record, the Senior Director of Nursing confirmed Resident #10's care plan lacked goals/interventions and monitoring of side effects for antipsychotic use.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37648 Based on interview, observation and record review, the facility failed to revise the care plan to reflect a resident's current status for 1 of 3 residents reviewed for falls (#49). Findings: 1. On 4/23/24 at 8:01 a.m., during an interview, Resident #49 stated, I lost my balance and fell hit my head . I was getting up to take my walker to go to the dining room. The Surveyor asked if staff was with him/her when the fall occurred, resident stated, Yes, it happened so quick. At this time, the surveyor observed a rolling walker across the room. Resident #49's care plan initiated on 2/22/24 states, Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Recent illness, hospitalization , etc. resulting in fatigue, activity intolerance, confusion, etc. with intervention of: Provide resident/patient with extensive assist of 1 for ambulation using a wheelchair. Review of Therapy notes stated on 3/7/24 Resident #49 goals were met for Patient will safety ambulate on level surfaces 25 feet using two-wheeled walker with Contact Guard Assist (GCA). Review of the Interdisciplinary meeting that was held on 3/13/24 indicated Resident #49 was now using 2 wheeled walker .walking short distances 25'- 40' with CGA On 4/24/24 at 11:22 a.m., during an interview with the Senior Director of nursing, a surveyor discussed the above concerns that the care plan was not revised to reflect the current status of the residents need for ambulating after the Interdisciplinary meeting.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on care plan review, observations, interviews, and facility policy, the facility failed to provide residents with a continuous resident centered activities program. This failure has the potential to affect all residents that would normally participate in activities. Findings: Review of facility policy Recreation Services Policies and Procedures dated 8/7/23 states Centers/Communities must provide, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of an and support the physical, mental, and psychosocial wellbeing of each patient, encouraging both independence and integration in the community.Programs will be scheduled seven days a week. Weekend activities include secular and non-secular opportunities. 1. Resident #10 was admitted to the facility on [DATE] and relies on staff for Activities of Daily Living. Review of Resident # 10's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) 15 of 15 indicating he/she is cognitively intact. Further review of MDS revealed Section-F: Preferences for Customary Routine and Activities indicated he/she felt it was very important to do group activities, keep up with news, attend favorite activities and listen to music he/she likes. Review of Resident #10's care plan initiated 11/17/22 revealed .While in the facility, [Resident #10] states that it is important . has the opportunity to engage in daily routines that are meaningful relative to [his/her] preferences . On 4/22/24 at 10:27 a.m., Resident #10 indicated that he/she really likes to go to BINGO, but never knows when it is. Observation of Resident #10's room lacked evidence of an Activity Calendar. Review of facility provided Activity Calendar April 2024 revealed BINGO was held on 4/1/24, 4/5/24, 4/6/24, 4/8/24, 4/10/24, 4/13/24, 4/15/24, 4/17/24, and 4/22/24. Review of Resident #10's Activity Participation log dated April 2024 lacked evidence that he/she was invited or declined to join activities. Further review of April 2024 activity calendar revealed the following scheduled activities: -4/22/24: Activity Cart; 10:30am- Coffee Social; 2pm: Bingo in AR (activity room); 4pm Room to Room, 5:15pm Crossword game. Observations of activity room between 10:30am and 2:45 p.m. lacked evidence that any activities were being held. -4/23/24: Activity Cart; 10am Coffee and Music Social; 2pm arts & Crafts (bring your own craft) 4pm Mail Delivery and Socializing. Observation of activity room between 10:00 a.m., and 3:00 p.m., lacked evidence that any activities were held. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/24 at 3:08 p.m., Activities Director (AD) confirmed that there were no activities provided 4/22/24 and 4/23/24 stating I've been out for 10 days and I'm not feeling well and had been out for 10 DAYS, so I'm taking the opportunity to play catch up and do assessments. Further review of Activity Calendar dated April 2024 revealed the following scheduled activities: - 4/24/24 Activity Cart 10am- Coffee and Music Social; 2pm BINGO; 4pm Room to room. Observation of activity room on 4/22/24 at 10:09 a.m., the activity room door was closed, upon entrance, 4 residents were observed sitting at the table with coffee, and the room was quiet. AD was sitting at desk in the corner. -4/25/24 at 10:00 a.m., Review of April 2024 Activity calendar revealed Activity Cart, 10am-Coffee and Music Social At 10:10 a.m., a surveyor observed activity room to be empty, Activity Assistant (AA) indicated that they just made coffee, and residents will trickle in as they want, and they will go around and encourage people to come in. -When asked why the activity hasn't started yet as it says it begins at 10 a.m., AA indicated they don't normally start to go around until after the activity is supposed to start. On 4/25/24 at 10:25 a.m., observation of activity room revealed 3 residents sitting at table drinking coffee and listening to oldies on the television. AA did not respond when asked if the residents in the other 3 units were asked if they wanted to attend. (Review of resident census dated 4/25/24 revealed there were 66 residents un the facility). On 4/23/24 at 3:12 p.m., during an interview with 2 surveyors, the Senior Director of Nursing indicated that the expectation is to have Activities offered daily and documented. On 4/24/24 at 10:10 a.m., The Director of Nursing indicated that it was her expectation that the residents should already be in the activity room when the activity starts. On 4/25/24 at 10:28 a.m., the Senior Activity Director indicated that it was his expectation that the activity calendar was followed, residents should be invited and, in the room, when it starts.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on record reviews and interviews, the facility failed to follow physician orders for 2 of 11 sampled residents (Resident #219 and Resident #269). Findings: 1. On 4/24/24, Resident #219's clinical record was reviewed. Resident #219 had a medication order, dated 4/11/24, for Lorazepam Oral Tablet 0.5 MG (milligrams) Give 0.5 mg by mouth two times a day for anxiety. A review of Resident #219's Medication Administration Record indicated that Resident #219 did not receive Lorazepam on 4/20/24 and 4/21/24. On 4/24/24 at 12:05 p.m., in an interview, the Senior Director of Nursing confirmed that Resident #219 did not receive his/her Lorazepam on 4/20/24 and 4/21/24 as ordered. 2. Resident #269 was admitted to the facility on [DATE] with diagnosis of Benign non-nodular prostatic hyperplasia with lower urinary tract symptoms. A provider's note dated 3/8/24 stated, review of symptoms: genitourinary - frequency. Assessment/plan: urinary frequency- will check UA (urinalysis- urine sample). A Providers order dated 3/8/24 instructs nursing to, UA C&S (culture and sensitivity) one time only for 4 days, laboratory. Review of the Treatment Administration Record indicated on 3/8/24 a UA was obtained and signed off at 1405. Further review of the medical records lacked evidence of the UA C&S laboratory results. On 4/24/24 at 2:42 p.m., during an interview, the Senior Director of Nursing confirmed there are no records of the completed UA C&S in the resident's medical record or available through the laboratory they utilize. 37648

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on record review, observation, and interviews, the facility failed to ensure that treatment plans were followed, and resident records were accurate for 1 of 1 resident reviewed for pressure and venous ulcers (Resident #60). Finding: Resident #60 was admitted on [DATE] with a Pressure ulcer to his/her right hip, and venous ulcers to bilateral lower extremities (shin). Review of the medical record contained the following Provider orders: - Order dated 4/17/24 for Venous - Right shin: Cleanse with wound cleanser, apply xeroform to wound base and cover with foam dressing. Every day shift for Wound care. - Order dated 4/17/24 for Venous - Left shin: Cleanse with wound cleanser, apply xeroform to wound base and cover with foam dressing. Every day shift for Wound care. - Order dated 4/16/24 for Pressure Injury - Right hip: Cleanse with wound cleanser, apply maxorb AG to wound base and cover with foam border. Every day shift for Wound care AND as needed. - Order dated 3/6/24 for Wound(s): Monitor site(s) (L) shin, hip, (R) calf Daily for status of surrounding tissue and wound pain. Monitor for status of dressing(s), if applicable Additional Documentation in NN if needed every day shift. On 4/22/24 at 2:06 p.m., a surveyor observed Registered Nurse #1 (RN #1) perform a dressing change to Resident #60's right hip pressure ulcer and both right and left shin venous ulcers. Upon removal of the old dressings, both surveyor and RN#1 observed all 3 wound dressings dated with the date of 4/20/24 and initialed. At this time, the RN#1 confirmed the dressings were not changed on 4/21/24 stating, the dressings are supposed to be changed daily and upon changing the dressing the nurse will put the date and his/her initials for when it was completed. Further review, the treatment administration record indicated, by initials and a check mark, that the nurse had completed and signed off that all three dressing were completed on 4/21/24. In addition, the care plan for pressure ulcer, initiated on 3/11/24 states, Provide wound care per treatment order. On 4/24/24 at 11:22 a.m., during an interview with the Senior Director of Nursing, the surveyor discussed the failure to follow the physician's orders, the current treatment plan and to ensure accurate resident records.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to base board hot water heating units for 2 of 2 observations and failed to ensure that that chemicals were properly secured for 1 of 4 days of survey. (4/22/24) Findings: 1. On 4/22/24 at 11:45 a.m., a surveyor observed the following on the Penobscot House Unit: > Resident room [ROOM NUMBER]- The base board heating unit cover was partially off exposing sharp metal edges and hot pipes. > Resident room [ROOM NUMBER] - The base board heating unit was missing approximately an 18 inch section of pipe covering which exposed hot piping. > Resident room [ROOM NUMBER] - The base board heating unit was missing approximately an 18 inch section of pipe covering which exposed hot piping. On 4/22/24 at 11:55 a.m., in an interview, the Administrator confirmed the findings. 2. On 4/22/24 at 12:40 p.m., a surveyor observed the following in Resident room [ROOM NUMBER]. > There was a 7.7 ounce container of Disinfectant wipes in the room. > There was a 12.2 ounce container of [NAME] Fabric Softener in the room. > There was a 50 ounce container of Woolite Laundry Detergent in the room. > Resident room [ROOM NUMBER] - The base board heating unit cover was partially off exposing sharp metal edges and hot pipes. The Safety Data Sheet for Disinfecting Wipes(Fresh Scent) noted the following: 4. First Aid Measures Inhalation: Not a normal route of exposure. If symptoms develop move victim to fresh air. Skin contact: Rinse skin with water/shower. Get medical attention if irritation develops and persists. Eye contact: Hold eye open and rinse slowly and gently with water for 15 to 20 minutes. Remove contact lenses, if present, after the first 5 minutes, and then continue rinsing eye. Call Poison Control Center or doctor for treatment advice. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ingestion: not a normal route of exposure. Called poison Control Center or doctor for treatment advice. The Safety Data Sheet for Downy Liquid Fabric Softener noted the following: 4. First Aid Measures Skin and eye, oral ingestion. Mild eye and skin irritant. Prolonged skin contact or installation into the eye may result in transient, superficial effects similar to those produced by a mild toilet soap. Oral injection may result in gastro intestinal irritation with nausea, vomiting, or diarrhea. Eye contact: flush eyes with water. Oral ingestion: dilute with fluids and treat symptomatically. Skin contact: rinse exposed skin. Remove contaminated clothing and launder before reuse. The Safety Data Sheet for Woolite Damage Defense Laundry Detergent noted the following: 4. First Aid Measures Eye contact: immediately flush eyes with plenty of water, occasionally lifting the upper and lower eyelids. Check for and remove any contact lenses. Continue to rinse for at least 10 minutes. Get medical attention. Inhalation: remove victim to fresh air and keep at rest in a position comfortable for breathing period if not breathing, if breathing is irregular or if respiratory arrest occurs, provide artificial respiration or oxygen by trained professional. It may be dangerous to the person providing aid to give mouth to mouth resuscitation. Get medical attention if adverse health effects persist or are severe. If unconscious, place in recovery position and get medical attention immediately. Maintain an open airway. Loosen tight clothing such as a collar, tie, belt or waistband. In case of inhalation of decomposition products in a fire, symptoms may be delayed. The exposed person may need to be kept under medical surveillance for 48 hours. Skin contact: wash with plenty of soap and water. Remove contaminated clothing and shoes. Wash contaminated clothing thoroughly with water before removing it, or wear gloves. Continue to rinse for at least 10 minutes. Get medical attention. In the event of any complaints or symptoms, avoid further exposure. Wash clothing before reuse. Clean shoes thoroughly before reuse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ingestion: wash out mouth with water. Remove dentures if any period remove victim to fresh air and keep at rest in a position comfortable for breathing period if material has been swallowed and the exposed person is conscious, gives small quantities of water to drink. Stop if the exposed person feels sick as vomiting may be dangerous period do not induce vomiting unless directed to do so by medical personnel. If vomiting occurs, the head should be kept low so that the vomit does not enter the lungs. Get medical attention if adverse health effects persist or are severe. Never give anything by mouth to an unconscious person. If unconscious, place in recovery position and get medical attention immediately. Maintain an open airway. Loosen tight clothing such as collar, tie, belt or waistband. On 4/22/24 at 12:50 p.m., in an interview, the Administrator confirmed the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 37440 Based on observations, record reviews, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to oxygen and nebulizer mask/tubing for 2 of 2 residents reviewed for respiratory care (Residents #19 and #49) for 2 of 2 observations (4/22/24 and 4/23/24). Findings: 1. On 4/22/24 at 12:15 p.m., and on 4/23/24 at 8:50 a.m., a surveyor observed the unlabeled oxygen tubing for Resident #19. A review of the Resident #19's clinical record revealed that there was no order to change the tubing and no documentation showing that the tubing had been changed weekly. On 4/24/24 at 2:15 p.m., in an interview, the Senior Director of Nursing confirmed that Resident #19's oxygen tubing had not been changed weekly and that Resident #19's clinical record lacked evidence showing that the tubing had been changed weekly. 2. On 4/22/24 at approx. 10:03 a.m., and on 4/23/24 at 8:00 a.m., observations of Resident #49's nebulizer mask stored on the nightstand labeled with a dated of 4/1/24. In a brief interview Resident #49 stated, he/she uses the nebulizer twice daily. Review of Resident #49's medical record lacked evidence of an order or documentation of the nebulizer mask and tubing changed weekly. On 4/24/24 at 8:42 a.m., the above was discussed with the Senior Director of Nursing who stated, the nebulizer masks should be rinsed and air dried after use then placed in plastic bag for storage and all oxygen related tubing should be changed every Sunday. 37648

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 37440 Based on performance evaluation review and interview, the facility failed to complete annual performance evaluations at least every 12 months for 5 of 5 sampled employees (Certified Nursing Assistant [CNA]). Findings: 1. CNA #1 was hired on 2/4/2019. The last annual performance evaluation was completed in 2021. The facility was unable to provide evidence of a completed annual performance evaluations for 2022 and 2023. 2. CNA #2 was hired on 2/4/2020. The last annual performance evaluation was completed in 2021. The facility was unable to provide evidence of a completed annual performance evaluations for 2022 and 2023. 3. CNA #3 was hired on 4/5/2021. The facility was unable to provide evidence of a completed annual performance evaluations for 2022 and 2023. 4. CNA #4 was hired on 10/12/2021. The facility was unable to provide evidence of a completed annual performance evaluations for 2022 and 2023. 5. CNA #5 was hired on 7/2/2018. The last annual performance evaluation was completed in 2021. The facility was unable to provide evidence of a completed annual performance evaluations for 2022 and 2023. On 4/25/24 at 9:30 a.m., in an interview, the Market Clinical Advisor confirmed there was no facility documentation of annual performance evaluations for the CNAs since 2021.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50218 Based on record review, observations and interviews the facility failed to ensure that two people who are authorized to administer medications signed the Narcotic Bound Book Shift Count page indicating that they counted all the controlled substances at the change of shift for multiple shifts between 4/11/24 through 4/22/24 on 1 of 3 units observed. (North Wind) Findings: Genesis HealthCare policy titled Controlled Drugs: Management of states, A complete count of all Schedule II-IV controlled substances is required at the change of shifts per state regulation or at any time in which narcotic keys are surrendered from one licensed nursing staff to another. The count must be performed by two licensed nurses and/or authorized nursing personnel, per state regulations. Review of bound medication book labeled WWG, NW, Book 2 revealed that oncoming nurse failed to sign the shift count page on 4/11/24 at 7:00 a.m., 4/17/24 at 7:00 a.m. and 4/18/24 at 7:00 a.m. The outgoing nurse failed to sign 4/18/24 at 1900 and on 4/21/24 evening shift. On 4/24/24 at 10:41 a.m., during an interview, the Licensed Practical Nurse (LPN) unit manager for North Wind unit demonstrated the process of shift change with the narcotic bound book. The LPN explained that count is to occur every shift. Oncoming shift will check the medication cards and outgoing shift will use the narcotic book index to confirm count. After the count is confirmed both staff would sign the shift count in the back of the book. At this time, the LPN stated that signatures are not currently audited but should be and acknowledged there were holes on signature page. On 4/24/24 at 11:31 a.m., during an interview, the Director of Nursing(DON) and Senior Director of Nursing with DON confirmed the above.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42531 Based on record review, interview, and facility policy, the facility failed to show evidence of documentation to justify the use of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (#10). Findings: Review of facility policy Psychotropic Medication Use dated 11/28/16 states . All medications used to treat behaviors must have a clinical indication and be uses in the lowest dose to achieve the desired therapeutic effect. All medications used to treat behaviors should be monitored for: Efficacy, risks, benefits and harm or adverse consequences. Antipsychotic medications used to treat Behavioral or Psychosocial Symptoms of Dementia must be clinically indicated, be supported by adequate rational for uses, and may not be used for behavior with an unidentified causes .Facility should ensure that Physician/Prescriber has conducted a comprehensive assessment for the resident and has documented in the clinical record that the psychopharmacological medication is necessary .Facility staff should monitor the resident's behavior pursuant to facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication for organic mental syndrome with agitated or psychotic behaviors .Facility staff should inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with he use of psychotropic medications, per facility policy or applicable state regulations. Resident #10 was admitted to facility on 11/17/22 and has diagnoses to include dementia, depression, and major depressive disorder. Review of Resident #10's clinical record revealed active medication orders dated 4/2024 revealed the following: -Order with start date of 2/29/24 for antipsychotic medication, Risperdal oral tablet (Risperidone). Give 0.125 mg by mouth two times a day for mood stabilizer, agitation. -Order with start date of 11/3/23 for antidepressant Zoloft oral tablet 50 MG (Sertraline HCl). Give 1 tablet by mouth in the morning for major depression . On 4/23/23 at 2:50 p.m., during a review with Senior Director of Nursing (Corporate) Resident #10's entire clinical record lacked evidence of psychotropic assessment for use, signed consents, or side effect/behavior monitoring for above medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50218 Based on observations, interviews, record reviews, facility policy, and Centers for Disease Control (CDC) guidance, the facility failed to ensure proper vaccine storage temperatures for 2 of 2 medication storage room refrigerators (Spring Harbor and Penobscot House). Findings: Review of facility policy titled Medication Storage Guidance .influenza vaccine dated 2023 states, Store in the refrigerator at 36 degrees to 46 degrees Fahrenheit. Review of CDC guidance Vaccine Storage and Handling Toolkit dated 1/23 states .Refrigerators should maintain temperatures between 2 C and 8 C (36 F and 46 F) .Every vaccine storage unit must have a Temperature Monitoring Device (TMD). An accurate temperature history that reflects actual vaccine recommended temperature range. 1.On 4/23/24 at 7:15 a.m., two surveyors and Director of Nursing (DON) observed Spring Garden medication room refrigerator containing 3 vials of influenza vaccine available for use. Further observation of the medication room lacked evidence of monitoring refrigerator temperatures. At this time, the DON indicated that refrigerator temperatures should be monitored on a daily basis. 2. On 4/23/24 at 12:40 p.m., during observation of Penobscot House medication room with the Registered Nurse (RN#1), a surveyor noted the Temperature Log for Medication/Vaccine Refrigerators - Fahrenheit dated April 2024 which stated, Record temps twice each day lacked evidence that refrigerator temperatures were taken from 4/1/24 through 4/15/24 (15 days). RN#1 indicated that she had been at the facility for eight months and was not aware they needed to be documented. On 4/23/24 at 3:13 p.m., the Senior Director of Nursing was unable to provide refrigerator temperature logs from 1/1/24 through 4/15/24, confirming the facility did not start monitoring temperature for vaccine storage until 4/16/24.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on observations, interviews, record reviews and the facility's policies, the facility failed to ensure products in the walk-in refrigerator and freezer were labeled and/or dated and failed to remove expired foods available for use for 1 of 1 kitchen tours. Further, the facility failed to ensure that the freezers were monitored, and temperatures documented accurately and that the dish machine was maintaining proper temperature ranges for proper washing/cleaning. This has the potential to affect all residents. Findings: Facilities Cold food policy and procedure revised ,d+[DATE] states, All Time/Temperature Control for Safety (TSC) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. 4. An accurate thermometer will be kept in each refrigerator and freezer a written record of daily temperatures will be recorded. 5. All foods will be wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Facilities Machine Warewashing and Sanitizing policy effective ,d+[DATE] states: To ensure all dishware is cleaned and sanitized after use' and For high temperature machine, the wash cycle temperatures ranges between ,d+[DATE] degrees Fahrenheit for a sanitary rack, single temperature machine. 1. On [DATE] at 9:20 a.m., during a kitchen tour with the Dietary manager, the following was observed, Walk-in refrigerator contained: One opened bottle of Horseradish 32 oz with expiration date of [DATE] One opened container of Lobster base with expiration date of [DATE] One opened container of Gochujang Red pepper paste with expiration date of [DATE] One bottle of Kiwi Lime Flavored Dessert Sauce with expiration date of [DATE]. Walk-in Freezer contained: 2 bags of patties not labeled or dated 1 bag of pizza dough crust not labeled or dated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approx. 9:30 a.m., the Dietary Manger confirmed the above and removed the expired foods and unlabeled/dated products. 2. Review of the facilities Temperature logs from [DATE] to the current [DATE] revealed the freezer temperatures for [DATE], February 2024, [DATE] (except for 4 days in March) and [DATE] are all documented temperatures of 0 degrees twice daily. On [DATE] at 10:14 a.m., during an interview, the Dietary Manager stated the freezer was out of order from [DATE] through [DATE] and recently was fixed approx. 2 weeks ago. In the meantime, the facility had an outside refrigerator/freezer they were utilizing. The surveyor asked how all the freezer temperatures for 4 months are documented as 0 degrees. The Dietary Manager confirmed that the freezer temperatures fluctuates and it's very unlikely the temperatures would all be at 0 degrees, confirming accurate temperatures were not documented properly. 3. On [DATE] at approx. 10:20 a.m., both the surveyor and the Dietary Manager observed the dish machine wash and rinse cycles x2 which failed to reach the wash cycle temperatures ranges between ,d+[DATE] degrees. - wash temperature - 140 degrees, rinse temperature 188 degrees - wash temperature - 140 degrees, rinse temperature 192 degrees At this time, the Dietary Manager notified maintenance. Review of the facilities Dish Machine Temperature logs from [DATE] through the current [DATE] revealed the dish wash temperature was 155 degrees and the rinse temperatures were 180 degrees for breakfast, lunch and dinner daily. At this time, the dietary Manager could not explain why all the temperatures for the wash and rinse cycle were exactly the same, several times a day and for 4 months in a row. On [DATE] at 10:21 a.m., during an interview with the Market Clinical Advisor, the above concerns for both the freezer temperatures and dish wash/rinse temperatures all being the same temperature multiple times daily were discussed. On [DATE] at 10:34 a.m., the Senior Maintenance Director met with the surveyor and observed dish washer temperatures once again. He stated the screen in the dishwasher was out and being rinsed when the previous temperatures were being observed, so the water would go right down the drain during the wash, not holding proper temperature. Additional observations of wash temperatures: Wash temperature - 154 degrees, Rinse temperature - 194 degrees Wash temperature - 148 degrees, Rinse temperature - 194 degrees Wash temperature - 148 degrees, Rinse temperature - 196 degrees Wash temperature - 150 degrees, Rinse temperature - 196 degrees Once again at 10:44 a.m., additional wash cycle temperature was observed to reach 150 degrees (continued on next page)

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	205180	A. Building B. Wing	04/25/2024

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:47 a.m., a surveyor confirmed the above with the Administrator and the Market Clinical Advisor

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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 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. 37440 Based on record reviews and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 3 residents reviewed for medication administration (Resident #10 and #219). Findings: 1. Resident #10 was admitted to facility on 11/17/22 and has diagnoses to include dementia, and major depressive disorder. Review of Resident #10's active orders effective April 2024 revealed: -Order with start date of 2/29/24 for antipsychotic Risperdal oral tablet (Risperidone). Give 0.125 mg by mouth two times a day for mood stabilizer, agitation. Review of Resident #10's entire clinical record lacked evidence of behavior monitoring for side effects. - Order with start date of 11/3/23 for antidepressant Zoloft Oral Tablet 50 MG (Sertraline HCl). Give 1 tablet by mouth in the morning for major depression . Review of Resident #10s clinical record lacked evidence of behavior monitoring for side effects. On 4/23/24 at 2:50 p.m., review of Resident 10's entire clinical record with the Senior Director of Nursing confirming the above findings. 2. On 4/24/24 during a record review for Resident #219, it was noted that he/she had an order for Lorazepam Oral Tablet 0.5 MG (milligram)(Lorazepam) Give 0.5 mg by mouth two times a day for anxiety Pharmacy Start date 4/11/2024 16:00.(4:00 p.m.) On 4/21/24 at 20:04 (8:04 p.m.), a nursing note was written that noted Not enough ativan to get [resident] through weekend until providers arrive on Monday. [Resident] has BID dosing. On 4/22/24 at 00:28(12:28 a.m.), a nursing note was written that noted Note Text: Lorazepam Oral Tablet 0.5 MG Give 0.5 mg by mouth two times a day for anxiety not available when scheduled-delivered on midnight run resident sleeping On 4/24/24, review of the North Wind Medication Control Book #2 noted on page #23 that on 4/19/24 at 1645(4:45 p.m.), the last tablet was administered to the resident making the count zero. A new page, #27, was started for the resident and noted that on 4/21/24 at 2230(10:30 p.m.), 6 tablets were received and signed in from pharmacy. Medication was not given to the resident until 4/22/24 at 8:30 a.m Review of the resident's Medication Administration Record (MAR) showed documentation of Resident #219 receiving the medication, signed off by a nurse on the morning of 4/20/24 and not again until 4/22/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24 at 12:05 p.m., in an interview, the Senior Director of Nursing stated that the facility has an emergency kit for medications and the nurse could have called the pharmacy to get override code and get the medication for the resident. She further stated that it would be documented in the back of the North Wind Medication Control Book #2 that the emergency kit was used. The pharmacy would have documentation of the facility call and authorization to access the emergency kit. Upon review, she could not find documentation showing the emergency kit was accessed. She also called the pharmacy and found they were never called for access to the emergency kit. At this time, after reviewing Resident #219's clinical record with the surveyor, the Senior Director of Nursing confirmed that the MAR documentation was not accurate and that Resident #219 did not receive the medication on 4/20/24 and 4/21/24. 42531

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33640 37648 50218 Based on observations and interviews the facility failed to maintain an Infection Control Program designed to help prevent cross contamination and/or development of infection by maintaining a safe and sanitary environment related to personal toileting items, wash basins, medical supplies and linen for 2 of 4 days of survey on 3 of 4 units (Windward Gardens Penobscot and Spring Gardens). Findings: 1. On 4/22/24 and 4/23/24, a surveyor observed on Windward Gardens unit a bedpan and a wash basin located in a shared bathroom on the floor under the sink in room [ROOM NUMBER]. On 4/23/24 at approximately 9:45 a.m., in an interview with a surveyor, the Administrator confirmed the above observations did not support good infection control practice. 2. On 4/22/24 at 10:54 a.m. to 11:06 a.m., observation of Penobscot to have the following: - room [ROOM NUMBER] had bariatric bed pan stored on the floor next to the toilet and a wash basin on shower floor. - room [ROOM NUMBER] had a bed pan stored upside down on the toilet seat. - room [ROOM NUMBER] had a bed pan stored on the shower room floor On 4/23/24 at 8:12 a.m., observation of Penobscot room [ROOM NUMBER] with a bariatric bed pan stored on the floor with another bed pan stored inside of it. On 4/23/24 at 9:33 a.m., during an interview, the above was discussed with the Senior Director of Nursing 3. On 4/22/24 and 4/23/24 the following was observed on Spring Gardens by two surveyors: - room [ROOM NUMBER]-108 shared bathroom contained a soiled hospital gown and a used glove on the floor. - room [ROOM NUMBER]-102 shared bathroom contained an empty sealed specimen cup in a biohazard bag and an unlabeled urinal hanging on grab bar next to sink. - room [ROOM NUMBER] contained a bariatric commode stored over the toilet which contained urine and a bed pan was stored on floor with the emergency call bell string resting on the inside of the bed pan. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/24 at 9:20 a.m., the above findings were confirmed during a tour of Spring Gardens with 2 surveyors and the Corporate Nurse Educator (CNE).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 37440 Based on record review and interview, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on abuse, resident rights and dementia management by failing to ensure that 4 of 5 Certified Nursing Assistant's (CNAs) employed, completed the required annual training (CNA #1, CNA #2, CNA #4 and CNA #5). Findings: On 4/25/24, during a review of employee personnel records, the following was noted: 1. CNA #1 was hired on 2/4/2019. CNA #1's employee personnel record lacked evidence of mandatory resident rights education and dementia training within the last twelve months. 2. CNA #2 was hired on 2/4/2020. CNA #2's employee personnel record lacked evidence of mandatory abuse education, resident rights education and dementia training within the last twelve months. 3. CNA #4 was hired on 10/12/2021. CNA #4's employee personnel record lacked evidence of mandatory resident rights education within the last twelve months. 4. CNA #5 was hired on 7/2/2018. CNA #5's employee personnel record lacked evidence of mandatory abuse education, resident rights education and dementia training within the last twelve months. On 4/25/24 a 9:30 a.m., in an interview, the Market Clinical Advisor confirmed that CNA #1, CNA #2, CNA #4 and CNA #5 did not receive all required mandatory education and training within the last twelve months.