| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205180 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Windward Gardens | 105 Mechanic Street<br>Camden, ME 04843 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 environment on 4 of 4 wings (North Wind, Spring Gardens, Windward Center and Penobscot House) for 1 of 1 facility tours.(12/4/25)Findings:On 12/4/25 from 8:50 a.m. to 9:20 a.m., an Environmental tour was completed with the Senior Maintenance Director, the Administrator, and the Housekeeping/Laundry District Manager in which the following findings were discussed and/or observed: Spring Garden - Resident room [ROOM NUMBER] - The bathroom had an unlabeled dirty urinal on the back of the toilet. There were three cracked/broken floor tiles across from the sink. The bathroom door had gouged/chipped treated wood exposing untreated wood. The wall across from the toilet had chipped/[NAME] paint creating an uncleanable surface. The sink countertop had chipped/missing edge laminate and was also stained.- Resident room [ROOM NUMBER] - There were two wash basins on the floor under the sink. The bathroom door had gouged/chipped treated wood exposing untreated wood. The sink countertop had chipped/missing laminate. The wall across from the sink had chipped/missing paint creating an uncleanable surface. - Resident room [ROOM NUMBER] - There were two large bed pans on the floor under the sink. The bathroom, shared by four residents, had an unlabeled dirty urinal on the back of the toilet and also had an unlabeled denture cup and an unlabeled water pitcher on the sink countertop. There were nine broken floor tiles under the bed to the left. There was a graduated cylinder on the floor by the toilet. - Resident room [ROOM NUMBER] - There were two broken floor tiles by the head and foot of the bed. The bathroom door had gouged/chipped treated wood exposing untreated wood.North Wind- Resident room [ROOM NUMBER] - The bathroom had a bed pan and commode seat parts on the bathroom floor under the sink. Penobscot- Resident room [ROOM NUMBER] - The bathroom ceiling light fixtures had visible dust/debris in them. - Resident room [ROOM NUMBER] - The bathroom ceiling light fixtures had visible dust/debris in them. -- Resident room [ROOM NUMBER] - The bathroom ceiling light fixtures had visible dust/debris in them.- Resident room [ROOM NUMBER] - The bathroom ceiling light fixtures had visible dust/debris in them.- Resident room [ROOM NUMBER] - The bathroom ceiling light fixtures had visible dust/debris in them.Windward Center- Resident room [ROOM NUMBER]-Resident #10's wheelchair armrests were both ripped/torn creating uncleanable surfaces.On 12/4/25 at 9:20 a.m., in an interview with a surveyor, the Senior Maintenance Director, the Administrator, and the Housekeeping/Laundry District Manager confirmed the discussed and observed findings. |

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

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

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on record reviews, policy review, and interviews, the facility failed to issue a written transfer/discharge notice to a resident and their legal representative for a facility-initiated transfer/discharge for 3 of 3 sampled residents transferred/discharged to an acute care facility. (Residents #9, and #11). In addition, the facility failed to ensure that information was communicated to the Assisted Living Facility (ALF) to ensure a safe and effective transition of care when the facility failed to notify the ALF of a date before a resident was discharge and signed physician orders were not sent to the ALF until the day after discharge, for 1 of 2 sampled residents reviewed for discharge (Resident #80 [R80]).<br><br>Findings:<br><br>1. Documentation in Resident 9's clinical record indicated that he/she was transferred to an acute hospital on 9/8/25 and 9/16/25. The clinical record lacked evidence that the facility issued written transfer/discharge notices and bed hold notices to the resident and/or legal representative for both transfers.<br><br>On 12/3/25 at 12:09 a.m., in an interview with a surveyor, the Clinical Lead confirmed that Resident 9's clinical record lacked evidence that transfer/discharge notices and bed hold notices were given to the resident and resident family/representative in writing.<br><br>2. Documentation in Resident 11's clinical record indicated that he/she was transferred to an acute hospital on 6/30/2025, 7/19/25 and 9/11/25. The clinical record lacked evidence that the facility provided written transfer/discharge notices and bed hold notices to the resident legal representative for all three transfers.<br><br>On 12/3/25 at 11:00 a.m., in an interview with a surveyor, the Clinical Lead confirmed that Resident 11's clinical record lacked evidence that transfer/discharge notices and bed hold notices and were provided to the resident family/representative in writing for all three of the resident's transfers to an acute hospital.<br><br>3 The facility policy, Discharge Planning Process, revised 9/15/25, indicated that The Center must develop and implement an effective discharge planning process that focuses on the patient's/resident's (hereinafter patient) discharge goals, preparation of patients to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable re-admissions.<br><br>All patients being discharged to home, to an assisted living facility, or another community-based setting will be given a Discharge Transition Plan and Discharge Packet. The Discharge Transition Plan must include, but not be limited to:<br><br>-A final summary of the patient's status at the time of discharge that is available for release to authorized persons and agencies, with the consent of the patient or patient representative.<br><br>-Where the patient plans to reside, any arrangements that have been made for the patient's follow-up care and any post-discharge medical and non-medical services.<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 6/9/25, the Division of Licensing and Certification received a complaint from a Level 1 ALF, stating that R80 was discharged back to the ALF without notification of the date of discharge and that R80 returned 6/8/25 (Sunday) without signed physician orders. The ALF stated that Licensed Social Worker #2 (LSW2) was aware of the ALF's readmission practice and that they needed signed physician orders to administer medications to R80 upon his/her return as the Level 1 ALF does not have a physician to approve physician orders; the signed physician orders have to come from the discharging facility or the resident's personal primary care doctor (the doctor's office was not open on Sunday 6/8/25). On 6/7/25, the spouse returned to the ALF and informed staff of R80's return tomorrow after learning of the discharge from the facility. The ALF attempted telephone contact with staff at the facility to remind them that signed physician orders would be needed, or else R80 would not be able to receive medications until signed orders were received. On 6/8/25, staff at ALF again attempted calls to the facility but signed physician orders were not received by ALF.<br><br>On 12/2/25, a surveyor reviewed R80's clinical record and was unable to find documentation of communication with ALF (community-based setting that was providing services to R80 upon discharge) prior to or at the time of discharge to the ALF.<br><br>On 12/2/25 at 10:15 a.m., a surveyor reviewed R80's clinical record with Market Clinical Lead (MCL) - Maine, with the following information reviewed:<br><br>- 6/5/25, R80 received notification that skilled services were going to be discontinued on 6/7/25. R80, with help from LSW2, filed an appeal with R80's insurance company.<br><br>- 6/7/25 at 3:15 p.m. (Saturday), LSW2 checked the insurance website and saw that R80 lost the appeal to continue skilled services. LSW2 met with R80 and spouse and informed them of the discharge plan for 6/8/25.<br><br>- 6/8/25, R80 was discharged with the Discharge Transition Plan reviewed with the spouse by a nurse.<br><br>- 6/9/25, the day after discharge, LSW2 contacted R80 and informed him/her of a follow up date with R80's primary care and faxed signed physician orders to ALF.<br><br>- 6/9/25 at 3:49 p.m., LSW2 documented she faxed signed physician orders to ALF.<br><br>During this review, MCL - Maine stated that LSW2 would have been responsible for providing the receiving facility discharge orders before or on the day of discharge. The surveyor confirmed that LSW2 sent the signed physician orders to ALF the day after discharge.<br><br>On 12/2/25 at 10:48 a.m., a staff member at ALF stated that in order for the ALF to administer medications to R80, signed physician orders are needed.<br><br>Between 12/8/25 - 12/10/25, a surveyor spoke with the Director of ALF. The Director stated that when a resident is admitted to another facility, and there are plans to return to the ALF, whether it is a readmission from the hospital or a rehab facility, staff at the ALF will send a copy of our readmission policy stating the requirements the residents must meet before they can return to services. A potential discharge was discussed with the facility, but ALF had no actual discharge date . On 6/7/25, once R80's spouse told us that R80 might get discharged the next day (6/8/25), attempts were made to contact the facility to obtain signed physician orders. The Director stated that both R80<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and the spouse receive medication services from ALF and therefore could not administer medications to R80 on 6/8/25 until signed physician orders were received on 6/9/25. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>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:<br><br>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.<br><br>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.<br><br>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 .<br><br>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.<br><br>4. R76 was recently admitted with diagnoses to include Dementia and repeated falls.<br><br>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).<br><br>5. R78 was recently admitted with diagnoses to include left femur fracture and recent left hip surgery.<br><br>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.<br><br>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).<br><br>On 12/3/25 at 2:18 p.m., a surveyor and the Market Clinical Lead reviewed the baseline care plans for<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the above residents and confirmed they lacked goals and interventions for the dietary orders and ADLs.<br><br>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.<br><br>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 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record reviews, and interviews, the facility failed to ensure the pharmacist identified an irregularity for a scheduled II medication and failed to ensure that the physician responded to a pharmacist recommendation timely for 2of 5 residents reviewed for unnecessary medications (Resident [R2], R 35).<br><br>Findings:<br><br>The facility's policy, Medication Regimen Review and Reporting, revised 1/24, indicated the following:<br><br>The Medication Regimen Review (MRR) includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities<br><br>The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. Identification of irregularities may occur by the consultant pharmacist utilizing a variety of sources including medication administration records (MAR), prescriber's orders, progress notes, nurse's notes, the Resident Assessment Instrument ([NAME]), Minimum Data Set (MDS), laboratory and diagnostic test results, behavior monitoring information and information from the nursing care center staff and other health professionals involved in the resident's care.<br><br>In performing medication regimen review, the consultant pharmacist incorporates federally mandated standards of care, in addition to other applicable professional standards, such as the American Society of Consultant Pharmacists (ASCP) Practice Standards, and clinical standards such as the Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guidelines and American Medical Directors Association (AMOA) Clinical Practice Guidelines.<br><br>The nursing care center follows up on the-recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols. For those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record.<br><br>1. On [DATE], R2's clinical record was reviewed. R2's physician order's included orders for Oxycodone 10 milligrams (mg) (scheduled II narcotic), to be administered every 6 hours as needed for pain. This order entered on [DATE] had no duration and was in effect at time of review of the clinical record. Per State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, 10-144 CMR 110 Chapter 16.A.7 Orders for Schedule II controlled substances shall be in effect for no longer than one (1) week, unless there are specific written orders to the contrary. In no case shall the order be in effect for a period of more than thirty (30) days. According to the November Medication Administration Record (MAR), the resident continued to receive the Oxycodone without a valid physician's order. On [DATE] at 8:39 a.m., during an interview with Market Lead Clinical Specialist, a surveyor confirmed this finding.<br><br>2.Review of Resident #35 pharmacy MD Recommendations dated [DATE] states this resident has<br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | been taking the antidepressant citalopram 20 mg since 2023. Please evaluate the current dose and consider a dose reduction. This resident is also on Seroquel 25 mg twice daily and is due for an AIMS test (every 6 months).<br><br>Review of Provider response dated [DATE] states Disagree: condition is not well controlled. Review of Resident #35's clinical record lacked evidence that the provider responded to this recommendation prior to surveyor intervention on [DATE].<br><br>During an interview on [DATE] at 8:26 a.m., with 3 surveyors Clinical Marketing Specialist confirmed above findings |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observations, record review, and interviews, the facility failed to ensure expired medications and unlabeled medications were removed from the supply available for resident use for 1 of 4 medication carts observed (Penobscot Unit) for 1 of 4 days of survey. Furthermore, the facility failed to adequately ensure medications and biologics were monitored in 4 of 4 refrigerators observed for 3 of 3 months of medication refrigerator logs reviewed.Findngs:1. On 12/3/25 at 12:45 p.m., observation of Penobscot Unit medication cart with LPN #1 (Licensed Practical Nurse) revealed expired and unlabeled medication listed below:-Magnesium Oxide 400mg tablets expired on 11/2025.-Calcium 600 and DS tablets expired on 7/2025.-Acidophilus Probiotic tablets expired on 10/2025.-Lantus Insulin pen containing a little over 220 Units with no resident identifier and no open date.-Humalog Kiwi pen with no open date.On 12/3/25 at 1:35 p.m., the above information was confirmed with the Facility Administrator.2. On 12/3/25 at 2:00 p.m., observation of the Spring Garden medication storage room refrigerator which contained 2 shingles vaccinationsOn 12/3/25 a surveyor reviewed the facilities Temperature Log for Medication/Vaccine Refrigerator for the months of September, October, and November:-September 1st through September 30th lacked evidence of twice daily temperature readings for 21 out of the 30 days.-October 1st through October 31st lacked evidence of twice daily temperature readings for 4 out of the 31 days.-November 1st through November 30th lacked evidence of twice daily temperature readings for 6 out of the 30 days.3. On 12/3/25 at 2:05 p.m., Observation of the Windward Center medication storage room refrigerator which contained 1 Flu vaccine, 1 COVID vaccine, and 1 Prevnar 20 vaccineOn 12/3/25 a surveyor reviewed the facilities Temperature Log for Medication/Vaccine Refrigerator for the months of September, October, and November:-September 1st through September 30th lacked evidence of twice daily temperature readings for 21 out of the 30 days.-October 1st through October 31st lacked evidence of twice daily temperature readings for 4 out of the 31 days.-November 1st through November 30th lacked evidence of twice daily temperature readings for 5 out of the 30 days.4. On 12/3/25 at 2:10 p.m., Observation of the Penobscot medication storage room refrigerator which contained 8 Flu vaccines and 2 Covid Vaccines.On 12/3/25 a surveyor reviewed the facilities Temperature Log for Medication/Vaccine Refrigerator for the months of September, October, and November:-September 1st through September 30th lacked evidence of twice daily temperature readings for out 14 of the 30 days.-October 1st through October 31st lacked evidence of twice daily temperature readings for 18 out of the 31 days.-November 1st through November 30th lacked evidence of twice daily temperature readings for 14 out of the 30 days.5. On 12/3/25 at 2:00 p.m., Observation of the North Wind medication storage room refrigerator which contained 40 Covid vaccines, 12 Flu vaccines, 13 Prevnar 20 vaccines, and 1 Hep B vaccine.On 12/3/25 a surveyor reviewed the facilities Temperature Log for Medication/Vaccine Refrigerator for the months of September, October, and November:-September 1st through September 30th lacked evidence of twice daily temperature readings for 22 out of the 30 days.-October 1st through October 31st lacked evidence of twice daily temperature readings for 18 out of the 31 days.-November 1st through November 30th lacked evidence of twice daily temperature readings for 19 out of the 30 days.6. On 12/4/25 at 12:12 p.m., During an interview with the Market Lead Clinical Advisor, she states that Windward Gardens follows Centers of Disease Control and preventionl (CDC) guidelines for temperature monitoring for immunizations.A review of CDC guidelines titled Handle with Care: Protect Your Vaccine, Protect Your Patients states Check and record current temperatures a minimum of 2 times (at start and end of workday).On 12/4/25 at 12:12 p.m., During an interview with Market Lead Clinical Specialist, the above information was confirmed. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and review of the facility's Food Storage: Dry Goods policy/procedure, the facility's Food Storage: Cold Foods policy/procedure and the facility's Refrigerated/Frozen Storage policy/procedure, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for fans, floors, a food mixer, a food processor, and metal shelving; failed to ensure kitchen staff with facial hair wore facial protection; failed to ensure foods were dated/labeled and/or secured shut in the reach in a walk-in refrigerator, a walk-in freezer, a dry storage room and in kitchen work areas; and failed to ensure the ice machine was properly installed to prevent backflow as required by the Maine State Plumbing Code requirements to prevent food contamination for 1 of 1 kitchen tour. (12/1/25)Findings: The facility's Food Storage: Dry Goods policy/procedure, revised 2/2023 noted:5. All packaged and canned foods items will be kept clean, dry, and properly sealed.6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. The facility's Food Storage: Cold Foods policy/procedure, revised 2/2023 noted:5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The facility's Refrigerated/Frozen Storage policy/procedure, revised 9/2017 noted:1.4 All foods are labeled with name of product and the date received and use by date once opened. 1.5 Prepared foods are labeled and dated with name of product, date opened, and use by date. This direct connection of wastewater and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one-inch (2.54 cm) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils. On 12/1/25 from 7:45 a.m. to 8:20 a.m., an initial kitchen tour was completed by a surveyor in which the following findings were observed:- There was a male kitchen worker, with facial hair, that was was observed not wearing facial hair protection. - There was a dish room wall mounted fan that was dusty/dirty.- There was a section of cement floor, under the dich machine, that had chipped/missing paint creating an uncleanable surface. - There was a food mixer that had dried food particles and dried liquid residue on the unit base and the mix arm area. Additionally, the mix arm had chipped/missing paint. - There was a food processor that had dried food particles on the lid and the unit- There was a round table fan that was running, next to a food preparation area being used at the time, that was missing the front screen guard and was dusty/dirty.- There was a clear 2-quart pitcher, on a food preparation table with a white powder-like substance in it, that was not labeled and dated.- There was a metal shelf, under large storage bins, that had chipped/missing paint and was rusty creating an uncleanable surface. - The dry storage room had 2 previously opened packages, containing a brown powder type substance, that were not sealed and had not been labeled and dated. - The walk-in refrigerator had 2 fruit cups, a container of a chicken salad, a package of cheese slices and a previously opened package of shredded cabbage that were not labeled and dated. - The walk-in freezer had 2 packages of French toast and 2 packages of pan cakes that were not labeled and dated. Additionally, there was a case of pizza dough and a case of biscuit dough that had been previously opened and that were open to the air and not secured closed. - The ice machine was observed to not be plumbed with an appropriate air gap. On 12/1/25 at 8:20 a.m., in an interview with a surveyor, the Food Service Director confirmed the findings. |

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| Windward Gardens | 105 Mechanic Street<br>Camden, ME 04843 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>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:<br><br>1.Review of Resident #35's Medication Administration Record (MAR) and Treatment Administration Record (TAR) effective November 2025 revealed the following:<br><br>-Diabetic foot check MAR/TAR lacked evidence this was completed/refused on 10/14/25<br><br>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.<br><br>- 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<br><br>- 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<br><br>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<br><br>During an interview on 12/3/25 at 10:05 a.m., the above was discussed with Consulting Administrator-Maine.<br><br>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. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and facility procedure, the facility failed to follow their own Enhanced Barrier Precautions (EBP) procedure for 1 of 1 resident reviewed for urinary catheters (Resident #1 [R1]) and failed to provide a sanitary environment to help prevent the development and transmission of infections related to personal protective equipment (PPE) for 1 of 4 units observed (Windward).<br><br>Findings:<br><br>1 Facility Procedure Enhanced Barrier Precautions, revised 5/1/25 states, .Post the appropriate Enhanced Barrier Precautions (EBP) sign on the patient's room door. Personal protective equipment (PPE) should be readily accessible and located outside of the patient's room. perform hand hygiene upon exiting the room. The procedure also states, Follow the Centers for Disease Control and Prevention [CDC] guidance per table below . The table indicates gown and gloves are required PPE during urinary catheter care and that .Face protection may also be needed if performing activity with risk of splash or spray.<br><br>R1 was admitted in October 2025 with diagnoses to include Retention of Urine, indwelling urinary catheter, and Urinary Tract Infection (UTI).<br><br>On 12/1/25 at 10:06 a.m. observation of R1's urinary catheter to gravity drainage on R1's bed frame. There was no EBP sign posted on R1's door, and there was no PPE cart located outside R1's room.<br><br>A review of R1's care plan indicated .has UTI due to infectious organism . and . at risk for MDRO colonization/infection due to: indwelling devices .Enhanced Barrier Precautions.<br><br>A review of R1's active physician orders revealed an order with a start date of 11/28/25 for Ciprofloxacin HCl Oral Tablet 500 MG. Give 1 tablet by mouth two times a day for bacterial infection.<br><br>A review of R1's November and December 2025 Treatment Administration Records (TAR) indicated Registered Nurse #2 (RN2) changed R1's indwelling catheter on 11/3/25 and performed R1's indwelling catheter care on 11/1/25, 11/3/25, 11/6/25, 11/7/25, 11/10/25, 11/13/25, 11/15/25, 11/16/25, and 12/1/25.<br><br>On 12/1/25 at 1:59 p.m. during an interview, a surveyor and RN2 observed R1's room. At this time, RN2 stated that R1 is on EBP for his/her urinary catheter, and there should be a sign outside his/her door and stated when staff provide catheter care they need to wash their hands and wear gloves. When a surveyor asked RN2 if she wears any additional PPE for R1's urinary catheter care, RN2 stated just gloves.<br><br>On 12/1/25 at 2:10 p.m. the above finding was discussed with the Administrator and the Market Clinical Lead.<br><br>2. On 12/3/25 at 9:00 a.m., a surveyor observed Certified Nursing Assistant #3 (CNA3) enter R1's room to set up his/her breakfast tray. CNA3 then exited the room and without sanitizing her hands, proceeded to walk down the hallway. At this time, a surveyor intervened, and CNA3 stated that she was wearing gloves to set up R1's breakfast tray since he/she is on EBP. CNA3 then stated that she (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | doffed (took off) her gloves in R1's room and that she usually sanitizes her hands after doffing her gloves but forgot.<br><br>On 12/3/25 at 9:21 a.m., the above finding was discussed with the Market Clinical Lead.<br><br>3.During an observation of contact precaution room [ROOM NUMBER]-2 on 12/1/25 at 12:10 p.m., Certified Nursing Assistant (CNA1) was observed wearing gloves in the room leaning over resident who was on contact precautions for shingles. At this time CNA1 stated that she was aware that resident was on contact precautions and should be wearing a gown and gloves, and did gown and glove when giving care earlier this am but just needed to get his/her oxygen saturation (02 sat) really quick.<br><br>During an interview on 21/1/25 at 12/1/25 at 12:15 p.m., the above was confirmed with Registered Nurse (RN3) |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>Based on interviews, the facility failed to designate a qualified staff member to function as the Infection Preventionist who works at least part time and who is responsible for the facility's Infection Control Program since September 2025. This has the potential to affect all residents in the facility.<br><br>Findings:<br><br>On 12/4/25 at 7:49 a.m., during an interview with 2 surveyors, the Director of Nursing (DON) stated that she had completed the Infection Preventionist (IP) Training and was the IP until September, when she took the role of DON and had worked full time in the role of DON since then. Licensed Practical Nurse/Infection Preventionist (LPN/IP) stated she was hired as the Infection Preventionist and currently is working 20 hours a week in that role, in addition to working the floor as a Charge Nurse. The Market Lead Clinical Specialist stated that part time is considered 20 hours a week. When a surveyor asked if LPN/IP had completed the training for the role of IP, LPN/IP stated that she was on module 12 for training and had not completed the training yet. The surveyors confirmed the facility did not have a qualified IP who worked at least 20 hours in the IP role. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on facility policy review, record reviews and interview, the facility failed to ensure physician orders for an as needed (PRN) anti-psychotic contained a duration/stop date and failed to ensure the physician evaluated a resident and wrote a new physician order to renew the PRN anti-psychotic medication every 14 days, for 1 of 5 residents reviewed for unnecessary medications (Resident #10 [R10]). Finding: The facility's policy, Medication Management, revised 1/25, indicated that PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. On 12/3/25, R10's clinical record was reviewed and included a physician order, dated 10/9/25, for Haloperidol, an anti-psychotic medication, to administer 2 tablets of 0.5 milligrams (mg) every 8 hours as needed and did not have a stop date. On 12/2/25 at 12:07 p.m., during an interview with the Market Lead Clinical Specialist, a surveyor confirmed this finding. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>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. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on record reviews and interview, the facility failed to ensure that the admission Minimum Data Set (MDS) 3.0 was coded accurately to indicate that a resident had a Level II Pre-admission Screening and Resident Review (PASARR) for 1 of 2 residents reviewed for PASRR (Resident #2 [R2]).Finding:On 12/2/25, R2's clinical record was reviewed and included a PASRR Level II uploaded the day of admission in the documents section of the electronic record. R2's admission MDS 3.0, dated 5/27/25 under Section A1500, was coded as NO for the question: Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? On 12/2/25 at 9:30 a.m., during an interview with the MDS Registered Nurse, a surveyor confirmed this finding. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>Based on record reviews and interview, the facility failed to incorporate recommendations from the Preadmission Screening Resident Review (PASRR) Level II determination outcome into a resident's assessment, care planning, and transitions of care for 1 of 2 sampled resident (Resident #2 [R2]). Findings:On 12/2/25, R2's clinical record was reviewed and included a Notice of PASRR Level II outcome, dated 4/22/24, that indicated R2 qualified for Level II services due to serious mental health diagnoses that included bipolar disorder and anxiety. The PASRR Outcome Notice of Nursing Facility Approval indicated that R2 was to receive specialized services while at the nursing home that included ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. In addition, R2 was to receive individual therapy by a licensed behavioral health professional for ongoing counseling services. On 12/2/25 at 9:07 a.m., the Licensed Social Worker, Administrator, and surveyor reviewed R2's care plan; the surveyor confirmed that there was no evidence that the care plan included that R2 qualified for PASRR Level II specialized services. On 12/2/25 at 9:54 a.m., during an interview with a surveyor, Market Clinical Lead - Maine stated that R2 had not been set up with a psychiatrist but was seeing a licensed behavioral health professional for ongoing counseling services. The surveyor confirmed that R2's PASRR Level II was not being followed for psychiatrist specialized services. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on interviews and record review the facility failed to ensure a care plan was accurately revised for 1 of 2 residents reviewed for nutrition. (Resident #37)Findings:Resident #37 was admitted in June of 2025 with a Gastrostomy Tube (G-Tube). A review of his/her clinical record shows the removal of his/her G-Tube on 9/18/2025. Further review of the clinical record shows a care plan meeting taking place on 9/23/25. Review of Resident #37's care plan does not reflect the removal of his/her G-Tube.On 12/4/25 at 1:30 p.m., During an interview with the Market Lead Clinical Specialist, the above information was confirmed. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on record review, observations, and interviews, the facility failed to ensure a physician order was followed for 1 of 3 residents reviewed for nutrition. (Resident #37)Findings:Review of Resident #37 clinical record shows physician orders to have All meals DIRECTLY SUPERVISED. Small bites and sips. Pt (patient) to be bolt upright in chair. Please stay up 30-45 mins (minutes) after meals. Discontinue intake if pt begins to cough significantly, ordered on 6/12/25. On 12/1/25 at 9:05 a.m., observation of Resident #37 being served breakfast by CNA #2 (Certified Nursing Assistant). The surveyor then witnessed CNA #2 leaving the dining room for approximately 30 seconds. At 9:10 a.m. CNA #2 was then observed leaving the dining room with no additional staff present.On 12/1/25 at 12:43 p.m., observation of Resident #37 being served lunch by CNA #2, who then left the resident in an unattended dining room from 12:43 p.m. to 12:45 p.m During this time the surveyor observed Resident #37 take 2 bites of cake. At 12:45 p.m. to 12:50 p.m., the surveyor observed RN #1 (Registered Nurse), RN #2, and CNA #2 in dining room, but frequently out of eyesight to him/her. At 12:50 p.m. to 12:51 p.m. Resident #37 was left in the dining room unsupervised by staff. At 12:51 p.m. CNA #2 sat down at the table with Resident #37.On 12/1/25 at 2:03 p.m., During an interview with the Market Lead Clinical Specialist, the above information was confirmed. |

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| | 205180 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Windward Gardens | 105 Mechanic Street<br>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 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>Based on observation and interview, the facility failed to post nurse staffing information on a daily basis for 1 of 4 days of survey (12/1/25).Finding:On 12/1/25 at 7:30 a.m., upon entry to the facility, 2 surveyors observed posted staffing sheets that were dated Wednesday, 11/26/25; Thursday, 11/27/25; and Friday 11/28/25.On 12/4/25 at 2:30 p.m. the above finding was discussed with the Administrator, Market Clinical President, and Market Clinical Lead during the exit conference. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205180 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Windward Gardens | 105 Mechanic Street<br>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 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>Based on observations, record review, and interviews, the facility failed to provide food that accommodates resident allergies, intolerances, and preferences for 1 of 1 resident reviewed for food choices (Resident #78 [R78]).Finding:On 12/1/25 at 8:48 a.m. a surveyor observed Certified Nursing Assistant #2 (CNA2) deliver R78's breakfast tray, consisting of a main entree of pancakes. R78 asked if the pancakes were made without milk. CNA2 stated she was not sure and would have to find out, then left R78's room. At 8:54 a.m., CNA2 returned and stated an alternative entree would be sent. At this time, during an interview, R78 stated that he/she has a dairy allergy and has had to ask at every meal since he/she was admitted if the meal was prepared according to his/her allergy needs. Surveyor review of R78's breakfast tray meal ticket, indicated Allergies: Lactose, bell pepper, Pear, Green/Red Peppers and allergic to cayene [cayenne] Further review of the ticket states, .Pancakes-2 .2% Milk- 8 Oz.A review of R78's clinical record revealed a physician order for Regular/Liberalized diet .Note patient is allergic with lactose, capsicum annuum extract & derivatives (Bell pepper & capsicum), Cayene [cayenne] and green pepper. On 12/3/25 at 9:03 a.m., during a follow-up observation, R78's breakfast tray included scrambled eggs and a biscuit. R78 stated he/she doesn't know if the scrambled eggs or biscuit were prepared with milk, so he/she is eating his/her own snacks that he/she brought into the facility. R78 then stated that he/she has not been able to choose his/her meals and has not even seen a menu since being admitted . Surveyor review of R78's breakfast tray meal ticket again indicated R78's food allergies and Scrambled Egg- 1/4 cup.Biscuit-1.2% Milk-8 Oz. On 12/3/25 at 9:55 a.m., a surveyor discussed the above concerns during an interview with the Food Services Director (FSD). The FSD stated that she reviews menu options with newly admitted residents within 72 hours of admission, but until then, a newly admitted resident automatically receives the first menu option. The FSD then stated meal tray tickets are printed based on the facility's meal tracker system and that 2% milk should not be indicated on R78's tickets, and that a lactose-free milk option should have been triggered in the system. The FSD then stated the pancakes and biscuits are both frozen items and that she is unsure if they are prepared with milk, but that she personally prepared the scrambled eggs without milk. At this time, a surveyor discussed the concern that R78 is aware of his/her food allergies and to check his/her meal tray, but a cognitively impaired resident may not have the ability to ensure that his/her own meal tray is safe. On 12/3/25 at 10:17 a.m. a surveyor discussed the above finding with the Administrator, Market Clinical Lead, and the Market Clinical President. |