

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Windward Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Mechanic Street Camden, ME 04843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record reviews and interviews, the facility failed to ensure physician orders were followed for 4 of 19 sampled residents (Resident #22 (R22), R3, R34, and R29). Findings: 1. R22's Treatment Administration Record (TAR) for March was reviewed and contained an order (dated 5/22/24) to inject 8 units of Lispro Insulin before meals but to hold the insulin if blood sugar was less than 100. The following was observed as documented on the March 2026's TAR: -On 3/4/26, the 11:30 a.m. blood sugar was 110, but insulin was not administered. -On 3/5/26, the 7:30 a.m. blood sugar was 103, but insulin was not administered. -On 3/15/26, the 7:30 a.m. blood sugar was 102, but insulin was not administered. -On 3/20/26, the 7:30 a.m. blood sugar was 115, but insulin was not administered. -On 3/26/26, the 7:30 a.m. blood sugar was 96, but insulin was administered. -On 3/29/26, the 7:30 a.m. blood sugar was 110, but insulin was not administered. On 5/20/26 at 11:07 a.m., during an interview with a surveyor, the Market Clinical Lead stated she could find no additional information on why the blood sugar or insulin was held or given outside of parameters. R22's Treatment Administration Record (TAR) for April was reviewed and contained an order (dated 4/14/26) to administer insulin as needed per sliding scale if blood sugar is as follows: -If 150-200, administer 2 units; -201-250, administer 4 units; -251-300, administer 6 units; -301-350, administer 8 units. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following was observed as documented on the April 2026's TAR: -On 4/16/26, the 9:00 p.m. blood sugar was 162, but insulin was not administered. -On 4/17/26, the 11:30 a.m. blood sugar was 175, but insulin was not administered. -On 4/18/26, the 9:00 p.m. blood sugar was 154, but insulin was not administered. On 5/20/26 at 12:20 p.m, during an interview with a surveyor, the Market Clinical Lead stated she could not find any information on why the insulin was held when outside of parameters. 2. On 5/18/26 at 2:30 p.m., during an interview with a surveyor, R3 stated he/she has been to the hospital recently a couple of times. On 5/20/26, R3's clinical record was reviewed and contained a Physician Order (dated 4/9/26) to notify the provider if there is a weight gain greater than 3 pounds (lbs) in 1 day or 5 lbs in one week. On 4/9/26 at 6:35 a.m., R3's documented weight was 245.4 lbs and on 4/10/26 at 9:50 a.m., R3's documented weight was 250 lbs, a weight gain of 4.6 lbs in one day. On 5/6/26 at 7:00 a.m., R3's documented weight was 242.6 lbs, and on 5/7/26 10:06 a.m., R3's documented weight was 246.6 lbs, a weight gain of 4 lbs in one day. On 5/20/26 at 12:20 p.m., during an interview with a surveyor, the Market Clinical Lead stated she was unable to find evidence that the provider was notified per Physician Order. 3. On 5/20/26, R34's clinical record was reviewed and included an order (dated 3/27/25) for Metoprolol succinate Extended Release 24 hour 100 milligram tablet to be held in systolic blood pressure is less than 110 or heart rate less than 60; a review of the March and April TARs indicated the following: -On 3/24/26, R34's systolic blood pressure was 107, but the medication was documented as administered. -On 3/27/26, R34's systolic blood pressure was 109, but the medication was documented as administered. -On 3/31/26, R34's systolic blood pressure was 107 and the heart rate was 56, but the medication was documented as administered. -On 4/17/26, R34's systolic blood pressure was 106, but the medication was documented as administered. On 5/20/26 at 1:45 p.m., during an interview with Market Clinical Lead, a surveyor confirmed that the medication was administered when it should have been held according to the parameters. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 3/20/26, R29's clinical record was reviewed and included the following: -On 3/7/26, a provider order stated, Outline redness of stump and call provider if redness spreads outside the line. Every day and night shift. -On 5/7/26-5/11/26, documentation on the Treatment Administration Record (TAR) indicated the redness of the stump was outlined and assessed for spread of the redness. -On 3/10/26, the wound documentation and photo lacked evidence that the redness was outlined to monitor for spread of the redness outside of the line. On 5/20/26 at 12:16 p.m., during an interview, a surveyor and the Market Clinical Director reviewed R29's clinical record and confirmed that the redness around R29's stump was not outlined in the photos as ordered.		

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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. Based on observations and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by not storing dishes and food in a sanitary manner, monitoring food temperatures to prevent food borne illness prior to serving residents, and not ensuring that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 2 of 3 days of survey (5/18/26 and 5/19/26). Findings: 1. On 5/18/26 at 10:55 a.m., a surveyor and the Food Service Manager (FSM) observed and confirmed the following were on the shelf and available for use in the walk-in refrigerator: -3 Open beverage containers. The FSM stated the open beverages belonging to dietary staff and confirmed they should not be stored with resident's food storage. -1 open package, containing 22 hot dogs, labeled with an expiration date of 5/17/26. -1 open, 5-pound package of shredded cheese, labeled with an expiration date of 5/15/26. -1 container of chopped lettuce, labeled with an expiration date of 5/17/26. On 5/18/26 at 11:00 a.m., a surveyor and the FSM observed and confirmed the following were on the shelf and available for use in dry food storage: -1 open, 5-pound package of seasoned breadcrumbs, labeled with an open date of 4/8/26 and an expiration date of 5/8/26. At 11:15 a.m., a surveyor and the FSM observed and confirmed the following: -food debris was observed on the shelves around stacked clean dishes. A rubber glove was pressed between 2 piles of clean plates. All kitchen surfaces were moderately soiled with food debris unrelated to the meal service. At 11:23 a.m., a surveyor observed the cook pick up a wet cloth that had been laying on a countertop throughout the kitchen observation and use it to wipe a food thermometer, then begin to check the food temperature of the macaroni and cheese. There appeared to be green food debris on the cloth. Surveyor requested to look closer at the cloth and the cook immediately threw the cloth in a large trash bin, then closed the lid over it with bare hands. The cook picked up the food thermometer and began to check the temperature of the broccoli. At this time the surveyor confirmed with the cook that she had not washed her hands after being in contact with the trash bin and prior to touching the thermometer. This was also confirmed with the FSM at the time of the observation. On 5/18/26 at 11:36 a.m., a surveyor observed the cook serve the mechanical soft turkey onto a (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plate. At 11:37 a.m., during an interview with a surveyor, the cook confirmed she had not taken food temperatures on the mechanical soft turkey, the pureed turkey, the green bean and potato puree, or either of the 2 pans of gravy. At 11:44 a.m., a surveyor and the FSM observed and confirmed the holding temperature for the mechanical soft turkey was 123.6 degrees Fahrenheit (F), the holding temperature for the pureed turkey was 122.6 degrees F, and the holding temperature for the green bean and potato puree was 118 degrees F. The FSM confirmed the minimum holding temperature is 135 degrees F. 2. On 5/19/26 at 1:57 p.m., a surveyor observed a dietary staff member stack large steam table pans dripping with water. The surveyor confirmed the presence of wet stacking with the FSM at the time of the observation. On 5/18/26, between 11:35 a.m. - 11:40 a.m., during a tour of the Spring Gardens Unit, the refrigerator was observed with the following: - An opened container of Thickened Apple Juice not dated to indicate when it was opened. The directions on the carton indicated to discard after 7 days from opening. - Multiple opened food items including milk-based seafood chowder brought in on 5/14/26, a salad dated 5/13/26 with wilted lettuce with moisture inside the container, and half a meat sandwich with wet lettuce with bites missing (bread appeared wet along the bitten edges) with a sell by date of 5/14/26. These were confirmed with Certified Nursing Assistant #1 (CNA1) at the time of the observations. The Licensed Social Worker and Assistant Director of Nursing who were on the Spring Gardens Unit, both stated that the limit was 3 days and that these items needed to be discarded. On 5/18/26 at 1:06 p.m., the Maintenance Director and surveyor observed an improper air gap on the ice machine located in Spring Gardens. 3. On 5/18/26, between 11:15 a.m. and 11:55 a.m., an initial tour of the North Wind Unit was completed. During the tour, an ice machine located on the kitchenette counter was observed to have an improper air gap. On 5/18/26 at approximately 1:00 p.m., the improper air gap was discussed with the Maintenance Director. 4. On 5/18/26, between 11:55 a.m. and 12:30 p.m., an initial tour of the Windward Center unit was done. During the tour, an ice machine located on the kitchenette counter was observed to have an improper air gap. On 5/18/26 at approximately 1:00 p.m., the surveyor confirmed the improper air gap with the Administrator and the Maintenance Director.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record reviews, and interviews, the facility failed to ensure that clinical records contained complete and accurate information for 3 of 19 residents reviewed on survey (Resident #38 [R38], R22, and R29). Findings: 1. On 5/19/26 at 8:52 a.m. during a medication administration observation with an RN, it was observed that the medication that was scheduled was not available. R38 had an order for fluticasone prop 50 microgram (mcg) spray (Flonase) 1 spray in each nostril two times a day for allergies. This medication was not in the medication cart or in the medication supply room. The RN stated she would look for it later and give it to R38. On 5/20/26 at 6:30 a.m. during a review of R38's Medication administration record (MAR) the documentation indicated that R38 did receive two doses of Flonase on 5/19/26. On 5/20/26 during an observation of the medication cart with LPN2, the Flonase for R38 was not in the cart and was not available. Review of the MAR with LPN2 and the night nurse who was at the end of her shift they both stated that the box was green and had a check mark with staff initials LPN3 indicating that the medication was administered. The surveyor at this time confirmed that the medication was signed off indicating the medication was administered and that the Flonase was not available nor was it in the cart for use. On 5/20/26 at approximately 1:30 p.m. the Market clinical advisor stated she spoke to the nurse who initialed the medication as being given (LPN3). The nurse stated she did sign the medication as being given because she thought the other nurse just forgot to sign it. The Market clinical advisor educated the nurse that she could not have given the medication as it was not available, and she should not sign for something she did not do herself. The Flonase was picked up at the local pharmacy that morning and R38 received her scheduled morning dose on 5/20/26. 2. On 5/20/26, R22's clinical record was reviewed and contained a treatment dated 12/17/25, to inject a Dexcom sensor (continuous glucose system sensor) every 10 days. The Treatment Administration Record (TAR) indicated that this treatment was held on 3/7/26, 3/17/26, 4/6/26, 4/26/26, and 5/16/26. The TARs were documented that these were held or to see nurse's notes on why these were not completed but the clinical record lacked that documentation. On 5/20/26 at 10:15 a.m., during an interview with a surveyor, the Consulting Administrator - Maine and Market Clinical Lead stated they were unable to find the documentation in R22's clinical record on why these treatments were not completed. 3. R22's Treatment Administration Record (TAR) for March was reviewed and contained an order (dated 5/22/24) to inject 8 units of Lispro Insulin before meals but to hold the insulin if blood sugar was less than 100. The following was observed as documented on the March 2026's TAR: (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/26, the 7:30 a.m. blood sugar was 103 but insulin not administered and the TAR was documented to see nurses notes. On 3/20/26, the 7:30 a.m. blood sugar was 115, but insulin was not administered and the TAR was documented to see nurses notes. On 5/20/26 at 11:07 a.m., during an interview with a surveyor, the Market Clinical Lead stated she could not find documented nurses notes as indicated on the TAR. 4. On 3/20/26, R29's clinical record was reviewed and included the following: -On 3/3/26, a provider order stated, WOUND MONITOR: Right [Above Knee Amputation (AKA)]. Monitor sites daily for status of surrounding tissue and wound pain. Monitor for status of dressings, if applicable Additional Documentation in [Nurse Notes (NN)] if needed every shift. -On 3/3/26 at 11:49 a.m., a Skin Issues note stated, Skin issue has been evaluated. Location: Right above knee & amputation site. Issue type: Surgical wound. Progress: Stable: previously deteriorating wound characteristics plateaued. Incision approximated: Yes. Dehiscence: partial or complete separation of the outer layers of the joined incision: No. -On 3/4/26 at 6:31 p.m., a Skilled Evaluation note stated, Skin issue has not been evaluated. Location: Right above knee & amputation site. Issue type: Surgical wound. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/5/26 at 11:46 a.m., a progress note stated, Skin: Skin on [R29's] right residual leg is viewed. Incision is with more redness than previous when compared to pictures. -On 3/6/26 at 12:46 a.m., a Skin Check note stated, Skin warm [and(&)] dry, skin color [within normal limits (WNL)] and [elasticity of the skin (turgor)] is normal. Skin issue has not been evaluated. Location: Right above knee & amputation site. Issue type: Surgical wound. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/6/26 at 6:17 p.m., a Skilled Evaluation note stated, Skin issue has not been evaluated. Location: Right above knee & amputation site. Issue type: Surgical wound. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/7/26 at 12:30 a.m., a clinical note stated, Skin warm & dry, skin color WNL and turgor is normal. Skin issue has not been evaluated. Location: Right above knee & amputation site. Issue type: Surgical wound. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/7/26, a provider order stated, Outline redness of stump and call provider if redness spreads outside the line. Every day and night shift. Review of documentation on the Treatment Administration Record (TAR) from 5/7/26-5/11/26, indicated the redness of the stump was outlined and assessed for spread of the redness. Wound documentation, pictures, and clinical notes indicate the surgical (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound was outlined or evaluated for spread of redness (see F684). -On 3/7/26 at 5:47 p.m., a Skilled Evaluation note stated, Skin issue has not been evaluated. Location: Right above knee & amputation site. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/8/26 at 2:26 p.m., Skin issue has not been evaluated. Location: Right above knee & amputation site. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/9/26 at 12:20 p.m., a progress note stated, Skin: Skin on [R29's] right residual leg is viewed. Surgical sites not viewed today. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/9/26 at 2:26 p.m., a Skilled Evaluation note stated, Skin issue has not been evaluated. Location: Right above knee & amputation site. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/10/26 at 10:00 a.m., a Skin Issues note stated, Skin issue has been evaluated. Location: Right above knee & amputation site. Issue type: Surgical wound. Progress: Deteriorating: wound characteristics deteriorated. Tunneling: Yes. Number of tunnels: 1. Tunnel length [centimeters (cm)]: 10. -On 3/10/26 at 2:29 p.m., a general note stated, [R29] was sent to [Emergency Room(ER)] for further evaluation of right above knee amputation stump wound drainage and tunneling. -On 3/17/26 at 4:10 p.m., a general note stated R29 returned to the facility with an intact dressing over the AKA. Wound documentation contained a blank photo. -On 3/17/26 at 7:53 p.m., a Skin Issues note stated, Skin issue has not been evaluated. Location: Right above knee & amputation site. Issue type: Surgical wound. Tunneling: Yes. Number of tunnels: 1. The note indicates the wound was not evaluated but contained identical documentation of the Skin Issue prior to R29's transfer to the ER. -On 3/18/26 at 2:04 a.m., a Skilled Evaluation note stated, Skin issue has not been evaluated. Location: Right above knee & amputation site. Issue type: Surgical wound. Tunneling: Yes. Number of tunnels: 1. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/18/26 at 8:08 p.m., a Skilled Evaluation note stated, Skin issue has not been evaluated. Location: Right above knee & amputation site. Issue type: Surgical wound. Tunneling: Yes. Number of tunnels: 1. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/19/26 at 2:49 a.m., a Skilled Evaluation note stated, Skin issue has not been evaluated. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Location: Right above knee &ndash; amputation site. Issue type: Surgical wound. Tunneling: Yes. Number of tunnels: 1. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/19/26 at 2:13 p.m., a Skilled Evaluation note stated, Skin issue has not been evaluated. Location: Right above knee &ndash; amputation site. Issue type: Surgical wound. Tunneling: Yes. Number of tunnels: 1. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/19/26 at 2:48 p.m., a progress note stated, Skin on [R29's] right residual leg is viewed. Surgical sites not viewed today. Inspection: Right [above knee (transfemoral)] amputation. There is a dressing in place and wounds are not viewed. Photographs are viewed of the wound from 3/10, which shows non-healing areas around the incision with some open ulceration and scabbing. Skin surrounding the wound looks pink. The photo was taken prior to the hospitalization for deteriorating wound condition. The clinical record lacks evidence that the surgical wound was monitored for improvement or deterioration. -On 3/24/26, a photo in the wound documentation shows Dehiscence of the surgical wound on the right AKA. The clinical record does not identify when or how dehiscence occurred. The clinical record lacks documentation of wound progression. The clinical record lacks evidence that nursing staff notified the provider of deteriorating wound conditions. On 5/20/26 at 11:24 a.m., during an interview with a surveyor, the Market Clinical Lead, the Administrator, and the Market Clinical Director, the clinical record for R29 was reviewed. At this time the surveyor confirmed that multiple notes indicate the wound was not assessed, there was no documentation to show the provider was notified of the deteriorating wound condition, and no documentation of how or when dehiscence occurred. The Situation Background Assessment and Recommendation (SBAR) does not contain information to what occurred, only contains ER recommendation and a set of vitals. There was no documentation following the incident to identify when or how dehiscence occurred. The Market Clinical Lead and the Market Clinical Director requested more time to find more information. On 5/20/26 at 11:30 a.m., the Market Clinical Director stated the notes are not where they would look. She stated if you look at the TAR you can see there were dressings done every day so the wound would be assessed by staff. Surveyor confirmed the TAR did not contain documentation of wound improvement or deterioration, and that the clinical record did not reflect this information or if it were communicated with the provider. The Market Clinical Director provided a provider note that stated ATSP (Asked to see patient) at the beginning and stated this is how they know staff communicated with the provider. At this time the surveyor confirmed the clinical record lacked complete and accurate documentation regarding R29's right AKA surgical wound.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on record reviews, and interviews, the facility failed to ensure that residents and/or resident representatives received assistance/follow up assistance concerning the right to formulate an advanced directive, or appoint a surrogate, for 2 of 24 residents reviewed (Resident #37 [R37], and R63). Findings: 1. On 5/9/26, R37's clinical record was reviewed and indicated the following: R37 was admitted in the spring of 2023. On 12/26/25, a social services assessment indicated R37 has an advanced directive, that there is not a copy in the medical record, and there was no additional conversation regarding advanced care planning provided. The clinical record lacked evidence that the facility followed up to obtain a copy of R37's advanced directive, or that the resident received assistance/follow up assistance concerning the right to formulate an advanced directive. On 3/11/26, a social services assessment indicated R37 has an advanced directive, that there is not a copy in the medical record, and there was no additional conversation regarding advanced care planning provided. The clinical record lacked evidence that the facility followed up to obtain a copy of R37's advanced directive, or that the resident received assistance/follow up assistance concerning the right to formulate an advanced directive. On 3/31/26, a social services assessment indicated R37 has an advanced directive, that there is not a copy in the medical record, and there was no additional conversation regarding advanced care planning provided. The clinical record lacked evidence that the facility followed up to obtain a copy of R37's advanced directive, or that the resident received assistance/follow up assistance concerning the right to formulate an advanced directive. On 5/19/26 at 3:20 p.m., during an interview with a surveyor and the Licensed Social Worker (LSW), R37's clinical record was reviewed. The LSW confirmed that according to the medical record R37 has an advanced directive, but the clinical record lacked evidence that the facility obtained a copy. 2. On 5/19/26, R63's clinical record was reviewed and indicated R63 had an advanced directive. The clinical record lacked evidence that the facility followed up to obtain a copy of R63's advanced directive, or that the resident received assistance/follow up assistance concerning the right to formulate an advanced directive. On 5/19/26 at 3:20 p.m., during an interview with a surveyor and the LSW, R63's clinical record was reviewed. The LSW confirmed R63's spouse visits daily and that according to the medical record R63 has an advanced directive, but the clinical record lacked evidence that the facility followed up to obtain a copy. On 5/20/26 at 8:00 a.m., during an interview with a surveyor and the Market Clinical Director, the clinical record for R63 was reviewed. The Market Clinical Director stated, R63 does not have an advanced directive, and more follow-up is needed as some people don't really understand which form is needed and may not have an advanced directive. At 8:06 a.m., a surveyor and the Market Clinical Director reviewed and confirmed R37's clinical record lacked evidence that the facility followed up to obtain a copy of R37's advanced directive, or that the resident received assistance/follow up assistance concerning the right to formulate an advanced directive. At this time, the surveyor confirmed the above findings.		

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NAME OF PROVIDER OR SUPPLIER Windward Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Mechanic Street Camden, ME 04843	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure an as needed (PRN) psychotropic medication met the required 14-day limit and the facility failed to provide evidence of documentation to justify the use of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #10 [R10])Finding: A review of the clinical record for R10 revealed that he/she had an order dated 4/21/26 for Lorazepam Gel 2 milligram/milliliter (mg/ml), apply to wrist, neck, back, arms topically every 8 hours as needed (PRN) for agitation/anxiety, dementia like behavior to give 1ml dose. This order's 14-day limit would end on 5/5/26. Review of his/her medication administration record (MAR) documented that R10 received 12 doses after the 14-day limit ended on 5/5/26. He/she also had an order dated 4/14/26 for diazepam 2 mg, give 1 tablet by mouth every 12 hours as needed for agitation, anxiety, calling out until 5/14/26 x 30 days, this orders 14-day limit would end on 4/28/26 the clinical record lacks evidence of the rationale for the extended time limit past the required 14-day limit and his/her MAR for May documents that he/she received 1 dose after the 14-day limit ended on 4/28/26. Review of R10's nursing notes in his/her clinical record lacks evidence of documentation that justifies the use of his/her PRN lorazepam and diazepam orders. On 5/20/26 at 10:30 a.m. during interviews with the Market Clinical Advisor and the Market Clinical Lead the surveyor confirmed that the prn lorazepam and prn diazepam did not have correct stop dates (14-day limit) and that R10 received 12 doses of the lorazepam beyond the 14-day limit. At this time the surveyor also confirmed that the clinical record lacked evidence of documentation to justify the use of PRN psychotropic medications.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record reviews and interviews, the facility failed to develop and implement a person centered care plan for suicidal ideations for 1 of 2 residents reviewed for mood and behaviors. (Resident#8 [R8]) and failed to to implement a care plan in the area of oxygen use for 1 of 1 resident reviewed for respiratory care (Resident #3 [R3]).Finding: 1. On 5/19/26, a review of R8's clinical record was completed. Documentation in the nurse note, dated 3/22/26, indicated the resident stated he/she would rather be dead. R8 was sent to the emergency department (ED) for evaluation of his/her suicidal ideations. On 3/23/26, documentation indicated R8 told the ED Provider that he/she did not want to be around anymore but was not going to harm himself/herself. On 3/23/26, after R8 had his/her room changed, R8 voiced not wanting to be around anymore. On 3/26/26, R8 was seen by telehealth Provider and the assessment indicated R8 has suicidal ideations with expressed intent to go into traffic, decreased oral intake with concern for dehydration, and behavioral changes with threatening statements. The plan is to send R8 to hospital for psychiatric evaluation. On 4/10/26, resident seen by Provider for suicidal ideations. On 4/12/26, R8 expressed wanting to be dead but does not have a plan for self harm and that he/she is depressed. On 5/19/26 at 2:05 p.m., in an interview with the surveyor, the facility Market Clinical Lead confirmed that there was not a specific care plan problem developed to address R8's suicidal ideations. 2. On 5/18/26 at 2:36 p.m., during an interview with R3, a surveyor observed the resident wearing a nasal cannula attached to the oxygen concentrator which was set at 8 liters per minute (LPM). Licensed Practical Nurse #1 (LPN1) entered the room to change the nasal cannula R3 was wearing that was attached to the oxygen concentrator. R3's clinical record was reviewed and indicated the current oxygen order was for 3 - 5 LPM for the diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and that staff were to check this setting each shift &ndash; 3 times a day to keep saturation between 88-92 percent. On 5/18/26 at 3:03 p.m., during an interview with a surveyor, LPN1 stated that she attached the new nasal cannula to the oxygen concentrator but did not observe the LPM setting. LPN1 stated that she did not provide any education regarding the LPM setting when she changed the cannula but stated that R3 changes the setting all the time, but she would go check on it. R3's care plan was reviewed under the care area of Respiratory complications related to . The care plan indicated that the oxygen settings were to be 3-5 LPM and that staff was to provide education regarding risk factors and interventions. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/26 at 2:48 p.m., during an interview with R3, a surveyor observed the oxygen concentrator settings at 6 LPM. R3 stated that he/she changed that later yesterday afternoon and that he/she often changes it between 6 - 8 LPM depending upon what he/she is doing. On 5/19/26 at 3:14 p.m., during an interview with Consulting Administrator - Maine, R3's Treatment Administration Record (TAR) and care plan were reviewed. The May TAR directed staff to check R3's oxygen saturations 3 times a day (each shift) but did not have a place to document what the oxygen LPM on the concentrator was set at. This TAR contained documentation that R3's oxygen saturations were above 92%, 26 times out of 56 shifts documented. The clinical record lacked evidence of adjustments to the settings or education provided when the oxygen LPM were greater than 5 LPM. On 5/19/26 at 3:37 p.m., during an interview with a surveyor, the Consulting Administrator - Maine stated she had updated R3's care plan and TAR.		

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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. Based on observations, interviews, and record review, the facility failed to update a care plan in the area of oxygen use for 1 of 1 resident reviewed for respiratory care (Resident #3 [R3]). Finding: On 5/18/26 at 2:36 p.m., during an interview with R3, a surveyor observed the resident wearing a nasal cannula attached to the oxygen concentrator which was set at 8 liters per minute (LPM). R3's clinical record was reviewed and indicated the current oxygen order was for 3 - 5 LPM for the diagnosis of Chronic Obstructive Pulmonary Disease (COPD). On 5/18/26 at 3:00 p.m., during an interview with a surveyor, R3 stated that he/she changed the LPM setting to 8 and that he/she often changes it. On 5/18/26 at 3:03 p.m., during an interview with a surveyor, Licensed Practical Nurse #1 (LPN1) stated that R3 changes the setting all the time, but she would go check on it. R3's care plan was reviewed under the care area of Respiratory complications related to . The care plan, last updated 4/27/26, indicated that the oxygen settings were to be 3-5 LPM but did not indicate that R3 would made changes themselves and that staff needed to monitor. On 5/19/26 at 2:48 p.m., during an interview with R3, a surveyor observed the oxygen concentrator settings at 6 LPM. R3 stated that he changed that later yesterday afternoon and that he/she often changes it between 6 - 8 LPM depending upon what he/she is doing. On 5/19/26 at 3:14 p.m., during an interview with Consulting Administrator - Maine, R3's care plan was reviewed and did not include an intervention that noted that R3 would increase this setting often themselves. On 5/19/26 at 3:37 p.m., during an interview with a surveyor, the Consulting Administrator - Maine stated she had updated R3's care plan		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation and interview the facility failed to provide or offer a lunch meal to a resident on 1 of 3 days of survey on 5/19/26. (Resident #33 [R33]. Finding: On 5/19/26 at 12:45 p.m., during an interview with a family member for R33, she stated she was waiting for R33's lunch. Lunch meal service normally comes to the floor at 11:45 a.m. The surveyor asked staff who were in the dining area where R33's lunch tray was. R33's lunch tray was found in the meal cart towards the back of the cart with his/her meal slip on the tray. When the tray was removed and the cover was lifted it was observed there was a small dish of macaroni salad on the plate and the egg salad sandwich was not there, remnants of the sandwich (egg crumbs) were observed on the plate. During interviews with staff, they could not say where R33's full lunch was. The CNA who was assigned to care for R33 stated she did not bring R33 or offer R33 his/her lunch tray because she thought R33's daughter had brought her a crab cake for lunch. R33 is a dependent resident for all care including meals. On 5/19/26 at approximately 12:50 p.m., during an interview with the Market Clinical Advisor, the surveyor and R33's daughter. R33's daughter stated that even if she brings in things for R33 to eat she would expect R33 to receive their meals as scheduled. The surveyor confirmed at this time that R33 was not delivered or offered their lunch meal.		