STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205180	A. Building B. Wing	06/03/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review, interviews, and facility policy, the facility failed to assess a resident after returning from a surgical procedure for 1 of 3 residents reviewed during a complaint investigation (Resident #1), and failed to complete admission assessment for 1 of 3 residents (Resident #3). Findings: 1. Review of Resident #1's clinical record revealed progress note dated 5/15/24 stated Received call from [Doctor] at [Hospital], wants resident transferred to surgery ASAP for a pacemaker battery change, Resident returned at 1830 (6:30 p.m.), set up the Medtronic relay, device is on the nightstand and working properly, provided the dinner food tray resident ate 50%, increased confusion, not following restriction protocol, family informed back at facility. Review of Resident #1's clinical record lacked evidence that Resident #1' s surgical wounds were assessed upon his/her return to facility. On 5/23/24 the Department of Licensing received a complaint indicating Resident #1 underwent a surgical procedure for pacemaker battery replacement on 5/15/24 and cardiology department made multiple attempts to contact facility for post op wound care and did not get in contact with facility staff until 5 days later. When contact was made, the nurse was not aware the resident had 2 wound sites. During a telephone interview on 5/30/24 at 7:56 a.m., complainant indicated that Resident #1 had his/her pacemaker battery replaced on 5/15/24 and even though Resident #1 was returned to the facility would specific wound care orders for right groin area and left chest wall, they still expect to have a nurse to nurse report. Complainant further indicated that she had tried calling facility multiple times and left multiple messages and no one returned her call until 5 days later and at that time, it was evident that the nurse was not aware of the surgical site on Resident #1's left chest. Review of facility policy Skin Integrity & wound Management dated 5/1/24 states .For surgical wounds (e.g. flaps, grafts, donors, incisions, etc.) follow specific orders from the surgeon. Implement special wound care treatments/techniques, as indicated and ordered . Collaborate with the wound provider to review co-morbid conditions that may affect healing . Notify dietitian and/or rehabilitation services as indicated . Notify physician/APP to obtain orders . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facilty policy Pacemaker Care dated 6/1/21 states Upon admission of patient who has a pacemaker: Identify pacemaker type, serial number, and manufacturer of pacemaker, date and sit of implementation, and cardiologist's surgeon's name and document in medical record; .Determine date/time of next pacemaker follow-up/check-up appointment For post-operative patient (two to three weeks), provide and/or assist patient with daily care of pacemaker. Cleanse pacemaker site gently with soap and water when taking shower or bath. Leave incision line open to air; Inspect site daily. Notify physician/advanced practice provider (APP) of discomfort, redness, or discharge at site; Check apical pulse for one minute daily. Pulse rate should be the same as pacemaker rate or faster. Notify physician/APP if pulse is more than 5-10 beats lower than pacemaker's setting .Place pacemaker instructions (if available) and copy of identification card in patient's health information record. These items must accompany patient if transferred or discharged ; Monitor for function of pacemaker. Perform pacemaker checks according to schedule and instructions of pacemaker clinic/physician/APP During an interview on 6/3/24 at 1:56 p.m. Licensed Practical Nurse (LPN)1 reviewed Resident #1's clinical record, confirmed there was no evidence that a nurse to nurse report was completed, no skin assessment, no wound orders obtained. During an interview on 6/3/24 at 2:31 p.m., Acting Director of Nursing confirmed the above concerns. 2. Resident #3 was admitted on [DATE] with diagnoses to include peripheral vascular disease, and hypertension. On 6/3/24 at 12:40 p.m., a pacemaker monitor was observed on Resident #3's bedside table. On 6/3/24 at 12:45 p.m., Resident #3 was observed in dining room wearing headphones for hearing assistance. When asked if he/she had a pacemaker, Resident #3 moved his/her shirt off his/her left side and stated, I have a pacer right here and my recorder is in my room . Review of Resident #3's entire clinical record lacked evidence of pacemaker. Review of Resident #3's clinical record revealed Admission assessment dated [DATE] Section: Cardiovascular: Pacemaker-Care Profile is blank. During a telephone interview on 6/3/24 at 1:00 p.m., Resident #3's family member indicated that he/she has had the pacemaker at least 5 years and the facility was made aware of its presence during his/her admission. During an interview on 6/3/24 at 1:45 p.m. Registered Nurse (RN) indicated that she was not aware that Resident #3 had a pacemaker, but it is something that she should have been made aware of. RN further indicated that when a resident is admitted or returns from the hospital a skin check should be performed by the nurse and there should be treatment orders for care. During an interview on 6/3/24 at 2:31 p.m. Acting Director of Nursing confirmed Resident #3's clinical record did not include information regarding a pacemaker but the admitting nurse should have noticed it during the admission assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record reviews, interviews, the facility failed to update/implement goals and interventions for 3 of 3 care plans reviewed during a complaint investigation (Resident's #1, #2, and #3). Findings: 1. Resident #1 was admitted on [DATE] with diagnoses to include heart failure, hypertension, and complete atrioventricular block requiring pacemaker placement in 2010. Review of Resident #1's care plan, initiated 2/2/24, states Resident is at risk of complications related to pacemaker/internal defibrillator .Monitor for signs/symptoms of pacemaker complications i.e.: S.O.B., weakness, syncope, fatigue, cyanosis, bradycardia .Notify physician as needed. Review of Resident #1's clinical record lacked evidence that he/she was being monitored for above pacemaker complications. 2. Resident #2 was originally admitted on [DATE] with diagnoses to include osteoarthritis and recent total right hip replacement. Review of Resident #2's clinical record revealed Discharge Summary Orthopedics dated 3/13/24 states Status post total replacement of left hip .Patient has a surgical incision on the left hip. Dressing will be changed at the first post-op appointment . Review of Resident #2 care plan initiated 11/15/23 lacks evidence that care plan was updated after left total hip replacement on 3/13/24. 3. Resident #3 was admitted on [DATE] with diagnoses to include peripheral vascular disease, and significant hearing loss. During an observation of Resident #3's room on 6/3/24 at 12:40 p.m., a pacemaker monitor was observed on bedside table. On 6/3/24 at 12:45 p.m., Resident #3 was observed in dining room wearing hearing magnifying headphones. When asked if he/she had a pacemaker, Resident #3 moved his/her shirt off his/her left side and stated, I have a pacer right here and my recorder is in my room . Review of Resident #3's care plan initiated 5/22/24 lacked evidence that goals and interventions were put into place for pacemaker, and communication. During a telephone interview on 6/3/24 at 1:00 p.m., Resident #3's family member indicated that he/she informed nurse his/her father/mother had a pacemaker on admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Activities of Daily Living (ADLs) dated 5/1/23 states .the Center must provide the necessary care and services to ensure that a patient's activities of daily living (ADL) abilities are maintained or improved and do not diminish unless circumstances of the patient's clinical condition demonstrate that a change was unavoidable. Activities of Living (ADLs) include: .Communication-including speech, language, and other functional communication The care plan will address the patient's ADL needs and goals . During an interview on 6/3/24 at 2:31 p.m., Acting Director of Nursing confirmed the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review, interview, and facility policy, the facility failed to adequately assess, and obtain wound care orders for 1 of 3 residents reviewed during complaint investigation (Resident #1). Findings: On [DATE] the Department of Licensing received a complaint indicating Resident #1 underwent a surgical procedure for pacemaker battery replacement on [DATE] and cardiology department made multiple attempts to contact facility for post op wound care and did not get in contact with facility staff until 5 days later. When contact was made, the nurse was not aware the resident had 2 wound sites. Review of Resident #1's clinical record revealed progress note, dated [DATE] stated Received call from [Doctor] at [Hospital], wants resident transferred to surgery ASAP for a pacemaker battery change, Resident returned at 1830 (6:30 p.m.). Review of Resident #1's clinical record lacked evidence that Resident #1' s surgical wounds were assessed upon his/her return. Review of Resident #1's clinical record revealed order, dated [DATE] at 20:09 (8:09 p.m.) states R groin area: Keep incision clean and dry for ,d+[DATE] days, no showers/baths ,d+[DATE] days. Monitor Right groin femoral site for redness/swelling/pain. Two times a day everyday BID 9a.5p for .Pacemaker battery insertion [DATE] . Further review of Resident s clinical record lacked evidence that orders were obtained or entered for wound care for pacemaker insertion site on left upper chest. Review of Resident #1's clinical record revealed progress note dated [DATE] states [nurse] from [Hospital} Cardiology called this nurse and states that she left message and never had a return call, then stated that resident needed a daily wound check and that our nurse needs to report to cardiology tomorrow to discuss [his/her] wound. [this] nurse agreed to call for wound check . During a telephone interview on [DATE] at 7:56 a.m., complainant indicated that Resident #1 had his/her pacemaker battery replaced on [DATE] and even though Resident #1 was returned to the facility would specific wound care orders for right groin area and left chest wall, they still expect to have a nurse to nurse report. Complainant further indicated that she had tried calling facility multiple times and left multiple messages and no one returned her call until 5 days later and at that time, it was evident that the nurse was not aware of the surgical site on Resident #1's left chest and indicated that the nurse informed her that Resident #1's bandied was still intact in his/her groin (7 days after the procedure). During an interview on [DATE] at 1:56 p.m. Licensed Practical Nurse (LPN)1 reviewed Resident #1's clinical record, confirmed there was no evidence that a nurse to nurse report was completed, no skin assessment, no wound orders obtained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Skin Integrity & wound Management dated [DATE] states .For surgical wounds (e.g. flaps, grafts, donors, incisions, etc.) follow specific orders from the surgeon. Implement special wound care treatments/techniques, as indicated and ordered . Collaborate with the wound provider to review co-morbid conditions that may affect healing . Notify dietitian and/or rehabilitation services as indicated . Notify physician/APP to obtain orders . During an interview on [DATE] at 2:31 p.m., Acting Director of Nursing confirmed above concerns.