STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205180	A. BUILDING 01 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWARD GARDENS	105 MECHANIC ST CAMDEN, ME 04843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Federal Recertification Survey Survey Date: 04/23/24 Windward Gardens, a long-term care facility, is not in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities for Emergency Preparedness.	E 000	Please note that the filing of this Plan of Correction does not constitute any admission as to the alleged violation set forth in this statement of deficiencies. This Plan of Correction is being filed as evidence of the facility's continued compliance with an applicable law.	
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and	E 037		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5/3/2024

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 037	Continued From page 1	E 037		

procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency

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E 037	Continued From page 2 procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency	E 037		

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E 037	Continued From page 3 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected	E 037		

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E 037	Continued From page 4 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review, the long term care facility failed to maintain a training and testing program for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 04/23/2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. A sample of three employee's taken one had no testing or training in 2023 of the emergency preparedness plan that is required annually in accordance with the plan for staff training and	E 037	Staff will be in-serviced according to 483.73(d):] (1), An Emergency Preparedness Plan (EPP) training, to include policies and procedures will be conducted with the Center staff. An audit will be conducted to ensure employees have received EPP training at the appropriate interval(s). The findings will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting. Administrator/Designee will monitor.	5/10/24

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E 037	Continued From page 5 testing of the emergency preparedness plan. The surveyor confirmed this finding with the Maintenance Director and Administrator at the time of the record review.	E 037		
E 039 SS=E	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of	E 039		

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E 039	Continued From page 6 this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited	E 039		

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E 039	Continued From page 7 to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to	E 039		

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challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency

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E 039	Continued From page 9	E 039		

plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

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E 039	Continued From page 10 (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 039		

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E 039	Continued From page 11 [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at	E 039		

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E 039	Continued From page 12 least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205180	A. BUILDING 01 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWARD GARDENS	105 MECHANIC ST CAMDEN, ME 04843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 13 following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review, the long term care facility failed to participate in a full-scale exercise of the Emergency Preparedness Plan in accordance with 42 CFR 483.73	E 039		

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	205180	A. BUILDING 01 BY: _____ B. WING _____	04/23/2024

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E 039	Continued From page 14 Finding: On 04/23/2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. The Long term care facility could not provide documentation that one of the two annual emergacy prepardness drills that is required had taken place. The surveyor confirmed this finding with the Maintenance Director and Administrator at the time of the record review.	E 039	Maintenance will provide appropriate documentation to include After Action Report and signed attendance sheets for each emergency preparedness drill. Documentation will be uploaded into TELS and a copy of the documentation will be placed in the EPP binder. Maintenance staff will be in-serviced on 483.73(d):] . Drills and documentation will be reviewed at the monthly QAPI Committee meeting. Administrator/Designee will monitor.	5/1/24
K 000	INITIAL COMMENTS Federal Recertification Survey Survey Date: 04/23/24 Windward Gardens , a long term care facility was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) - Physical Environment and is not in substantial compliance.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced	K 211		

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	205180	A. BUILDING 01 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWARD GARDENS	105 MECHANIC ST CAMDEN, ME 04843

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K 211	Continued From page 15 by: Based on observation, the long-term care facility failed to maintain the Exit Corridor required width per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.2.1, 7.1.10.1 Findings: On 04/23/2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. Windward center wing 1st floor corridor had a refridgerator and a table with coffee maker on the top stored within the corridor. 2. North wing, 2nd floo,r an air mattress was found being stored in the egress exit corridor. The surveyor confirmed this finding with the Administrator and Maintenance Director at the time of the observation.	K 211	The refrigerator and table with appliances on Widward Center, and the air mattress on North Wind have been removed from the corridor. Maintenance staff will be in-serviced on NFPA 101, life safety code, 2012 Edition, Sections 19.2.1, 7.1.10.1. The exit corridor required width will be inspected monthly for the next three months. The findings will be reviewed at the monthly QAPI Committee meeting. Administrator/Designee will monitor	4/24/24
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of	K 222		

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	205180	A. BUILDING 01 BY: _____ B. WING _____	04/23/2024

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K 222	Continued From page 16	K 222		

locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.
18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6
SPECIAL NEEDS LOCKING ARRANGEMENTS
Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.
18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4
DELAYED-EGRESS LOCKING ARRANGEMENTS
Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.
18.2.2.2.4, 19.2.2.2.4
ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS
Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.
18.2.2.2.4, 19.2.2.2.4
ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS
Elevator lobby exit access door locking in

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWARD GARDENS	105 MECHANIC ST CAMDEN, ME 04843

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K 222	Continued From page 17 accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on Observations the facility failed to ensure doors at the means of egress meet the requirement of NFPA 101 life safety code 2012 edition 19.2.2.2.5.1, 19.2.2.2.6 for locking. Findings: On 04/23/ 2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. North Wing,1st floor Exit door with delayed egress. The delayed egress function would not operate properly because the exit door was locked. The door could not be opened until the Maintance supervisor disengaged the locking device. This finding was observed with the Maintenance Director and the Administrator.	K 222	The North Wind exit door will have delayed egress installed by a qualified secure care vendor. Maintenance staff will be in-serviced on NFPA 101, life safety code 2012 edition 19.2.2.2.5.1, 19.2.2.2.6 for locking. A quarterly task will be added to TELS to inspect doors to hazardous areas. All delayed egress doors will be inspected monthly for the next three months. The findings will be reviewed at the monthly QAPI Committee meeting. Administrator/Designee will monitor.	5/1/24
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		

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	205180	A. BUILDING 01 RECEIVED B. WING MAY 03 2024	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWARD GARDENS	105 MECHANIC ST BY: CAMDEN, ME 04843

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K 353	Continued From page 18 available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the long-term care facility failed to ensure that Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems sections 7.3.1 and 14.2.1.1 Findings: On 4/23/2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director, and Administrator present observed the following: 1. The facility failed to complete the full flow trip test of the dry valve during the required 3 year interval. The quarterly sprinkler system inspection report indicated that this assessment was due in 2021. 2. The facility failed to complete system testing for air leakage during the required 3 year interval. The quarterly sprinkler system inspection report indicated that this assessment does not have any record of last time of completion.	K 353	The full flow trip test of the dry valve and the air leakage test will be completed by a qualified vendor. A list of sprinklers installed on the property will be posted in the spare head box. The escutcheon rings in the soiled utility room in Windward Center, and the clinical reimbursement office will be replaced. Maintenance staff will be in-serviced on NFPA 25, standard for the Inspection, Testing, and Maintaining of water-based fire protection systems sections 7.3.1 and 14.2.1.1 The results of the tests will be reviewed at the monthly QAPI Committee meeting and escutcheon rings will be inspected monthly for the next three months. The findings will be reviewed at the monthly QAPI Committee meeting. Administrator/Designee will monitor.	5/10/24

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K 353	Continued From page 19 3. The quarterly sprinkler system inspection report indicates that the required list of sprinklers installed on the property is not posted on the spare head box. 4. Escutcheon rings were found missing in the soiled utility room in windward center on the 2nd floor, and in the Clinical Reimbursement office. The surveyor confirmed this finding with the Maintenance Director, and Administrator at the time of the observation and review.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation during facility tour the facilty failed to ensure that all fire extingishers were properly installed as per NFPA 101 2012 19.3.5.12 and NFPA 10 6.1.3.4 Findings: On 04/23/24 between the hours of 09:00 AM and 12:00 PM with the Maintenance Director and the Administrator the following was observed. 1. Fire Extingisher located in the Physicial therapy room first floor was not properly installed. The extinguisher was discovered sitting on a counter	K 355	The fire extinguisher located in the Physical Therapy room will be properly mounted. Maintenance staff will be in-serviced on NFPA 101, 2012 19.3.5.12 and NFPA 10 6.1.3.4 Extinguishers and mounts will be inspected monthly. The findings for the next three months will be reviewed at the monthly QAPI Committee meeting. Administrator/Designee will monitor.	5/1/2024

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K 355	Continued From page 20 top with the bracket and signage sitting beside it. This finding was verifiyed by the Maintanance director and Administrator time of observationon.	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		

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K 363	Continued From page 21 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to ensure that corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware and resist the passage of smoke in accordance with the requirements of NFPA 101 2012 edition section 19.3.6. On 4/23/2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director, and Administrator present observed the following: 1. The door to room 201 was found with a metal bracket installed on the lower section of the door creating an obstruction and not allowing the door to latch. 2. The doors to the linen closet next to room 204 do not latch when the door is allowed to self-close. The surveyor confirmed this finding with the Maintenance Director, and the Administrator at the time of the observation.	K 363	The door to room 201 will be adjusted to allow proper latching. The doors to the linen closet next to room 204 will have the proper latches installed to ensure latching when allowed to self-close. Maintenance staff will be in-serviced on NFPA 101, 2012 edition section 19.3.6. Corridor doors will be inspected monthly for the next three months. The findings will be reviewed at the monthly QAPI Committee meeting. Administrator/Designee will monitor.	5/1/2024
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm	K 712		

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K 712	Continued From page 22 signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to ensure that fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, Life Safety Code, 2012 Edition, Section 19.7.1.4 through 19.7.1.7 Findings: On 4/23/2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director, and Administrator present, observed the following: 1. The facility failed to conduct the proper number of fire drills during the previous 12 months. The following fire drills for the facility were not completed or missing: A. 3rd Shift, 1st quarter of 2024 B. 1st Shift, 3rd quarter of 2023 The surveyor confirmed this finding with the Maintenance Director, and the Administrator at the time of the observation.	K 712	A fire drill schedule will be created and implemented to ensure all drills are completed during the appropriate times and shifts. Maintenance staff will be in-serviced on NFPA 101, life safety code 2012 edition section 19.7.1.4 through 19.7.1.7. The fire drills and schedule will be reviewed montly for the next three months at the monthly QAPI Committee meeting. Administrator/Designee will monitor.	5/1/2024
K 754 SS=E	Soiled Linen and Trash Containers CFR(s): NFPA 101	K 754		

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K 754	Continued From page 23 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by: Based on observation , the long-term care facility failed to maintain the Exit Corridor required width per NFPA 101, Life Safety Code, 2012 Edition, Sections , 19.7.5.7, 7.1.10.1 Findings: On 04/23/2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. Storage of trash receptacles exceed 0.5 gallons/square feet within the exit corridor 1st floor at rooms 105,114,109,and room 111 2. Storage of trash receptacles exceed 0.5 gallons/square feet within the exit corridor 2nd floor at room 31	K 754	The trash receptacles within the exit corridor 1st floor at rooms 105, 114, 109, and room 111 will be removed. The trash receptacles within the exit corridor 2nd floor at room 31 will be removed. Maintenance staff will be in-serviced on NFPA 101, life safety code 2012 edition sections, 19.7.5.7, 7.1.10.1. Exit corridors will be inspected monthly for the next three months. The findings will be reviewed at the monthly QAPI Committee meeting. Administrator/Designee will monitor.	5/1/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 754	Continued From page 24 The surveyor confirmed this finding with the Maintenance Director and Administrator at the time of the observation.	K 754		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to ensure that the generator had a remote annunciator at a location that could be monitored 24 hours a day while facility was on auxiliary generator power Per NFPA 99, (2012) 6.4.1.1.17. Finding: On 4/23/2024, between 9:00 AM and 12:00 PM, the surveyor, with the Maintenance Director, and Administrator present observed the following: 1. The Generator annunciator panel located in the nurses station had been unplugged. This item was corrected during survey. The surveyor confirmed these observations with	K 916	The outlet that the generator annunciator panel plugs into will have a locking cover installed to ensure that it can not be unplugged. Maintenance staff will be in-serviced on NFPA 99, (2012) 6.4.1.1.17. The Generator Annunciator panel will be inspected monthly for the next three months. The findings will be reviewed at the monthly QAPI Committee meeting. Administrator/Designee will monitor.	5/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205180	A. BUILDING 01 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWARD GARDENS	105 MECHANIC ST CAMDEN, ME 04843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 916	Continued From page 25 the Maintenance Director and the Administrator at the time of the observation.	K 916		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to ensure that power strips are not used for non-PCREE (Patient-care-related electrical equipment) and that power strips are not used as a substitute for fixed wiring in accordance with 2012 edition NFPA 99 Chapter 10, NFPA 70 chapter 4 {400.8(1)}	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205180	A. BUILDING 01 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 920	Continued From page 26 On 4/23/2024, between 9:00 AM and 12:00 PM, the surveyor, with the Maintenance Director, and Administrator present observed the following: 1. In the Payroll Manager's office, a mini-fridge was found plugged in to a power strip. This item was corrected during survey. 2. In the Clinical reimbursement coordinator office, a mini-fridge and an air conditioning unit were found plugged in to a power strip. This item was corrected during survey. 3. In the Unit Clerk office, a mini-fridge and an air conditioning unit were found plugged in to a power strip. This item was corrected during survey. 4. In the employee break room, a soda dispensing machine was found plugged in with an extension cord. The surveyor confirmed this finding with the Maintenance Director, and the Administrator at the time of the observation.	K 920	The mini-fridge in the Payroll Manager's office will be plugged directly into an outlet. The mini-fridge and air conditioning unit in the clinical reimbursement coordinator office will be plugged directly into an outlet. The mini-fridge and air conditioning unit in the Unit Clerks Office will be plugged directly into an outlet. The soda dispensing machine in the employee break room will be relocated so the power cord can reach an outlet without the use of an extension cord. Maintenance staff will be in-serviced on 2012 edition NFPA 99 chapter 10, NFPA 70 chapter 4 {400.8(1)} Appliances and air conditioning units will be inspected monthly for the next three months to ensure they are plugged directly into the outlet. The findings will be reviewed at the monthly QAPI Committee meeting. Administrator/Designee will monitor.	5/1/2024