

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

PRINTED: 06/30/2025
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 C 06/17/2025
NAME OF PROVIDER OR SUPPLIER WINDWARD GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 000	INITIAL COMMENTS On 6/17/25 an unannounced on site visit was conducted at Windward Gardens to investigate complaint #'s ME00051859, ME00051974 and ME00051997. It was determined that Windward Gardens is not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000	Windward Gardens Provides this Plan of Correction without admitting or denying the validity or existence of the alleged deficiencies. This Plan of Correction is prepared and executed as evidence of the facility's continued compliance with State and Federal Regulations.		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to follow provider orders for wound care and failed to follow the facilities Skin Integrity and Wound Management policy for 1 of 2 Residents reviewed for pressure ulcer management. (Resident #310) Findings: The facilities Skin Integrity and Wound Management policy revised 5/1/25 states under	F 686	This event happened in the past and cannot be corrected. An audit was conducted of the facility s wounds to ensure that new or worsening PU are communicated to the resident and/or resp party and MD. An audit was conducted to ensure treatment recommendations from wound care specialists have been implemented after approval of the primary MD. The facility validates that new wounds or worsening wounds are communicated to the res/resp party and Provider. The facility validates that wound care specialist orders are reviewed and followed after the approval of the primary care provider. Licensed nurses will be educated in this process.		7/9/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Administrator

7/7/2025

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.

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F 686	Continued From page 1 Practice Standards, the Licensed nurse will: "Evaluate any reported or suspected skin changes or wounds. Document newly identified skin/wound findings and the 24-hour report. Perform and document skin inspections on all newly admitted/readmitted patients weekly thereafter and with any significant change of condition. Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, within unanticipated decline in wounds ... Perform daily monitoring of wounds or dressings for presence of complications or declines. Document daily monitoring of ulcer/wound site with or without dressing. Monitor: signs of decline in wound status. On 6/10/25, Adult Protective Services notified the Division of Licensing and Certification of the following. [Resident #310] was sent to the Emergency room on 6/8/25 for an evaluation and was noted to have pressure sores on his/her heels due to not being moved by facility staff. On 6/17/25 review of Resident #310's medical record, showed he/she was admitted on 5/20/25 with a nursing admission note stating, resident's right heel was "pinkness/boggy" and he/she had an "open wound dorsal R. foot." Provider orders, dated 5/27/25, instructed nursing to "Apply skin prep to bilateral heels and ensure that heels are offloaded. Monitor skin for any changes to skin integrity, everyday shift" and "Wound Care treatment to the right dorsal/lateral foot. Cleanse with wound cleanser, gently pat dry. Apply calcium alginate to the wound bed only and cover with Kerlix daily and PRN(as needed) until resolved." A wound care consult note, dated 6/4/25 stated	F 686	DON/designee will complete audits of new and/or worsening wounds to ensure notification to MD and resident and/or responsible party was completed. DON/designee will complete audits of residents seen by wound care specialists to ensure treatment recommendations from wound care specialists have been implemented after approval of the primary MD. These audits will be weekly x 4 weeks then monthly audits x 3 months. Results of these audits will be submitted to the QAPI committee for further review and recommendation.		

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F 686	Continued From page 2 under "Patient seen for initial evaluation and management of wound as requested by the primary medical team ... Wound #1 Right, Dorsal Foot is a chronic Wagner Grade 2 Diabetic Ulcer and has received a status of Not Healed ... Wound #2 Right, Plantar Heel is an acute Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed ... Wound #3 Right, Lateral Foot is an acute Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed". Under section "Wound Orders" instructs nursing staff for the following daily care: Cleanse wound #1, #2 and #3 with a wound cleanser, apply Betadine and leave the wounds open to air/no dressing needed. Review of the Treatment Administration Records (TAR) from 6/4/25 through 6/8/25 revealed nursing failed to initiate the new orders from the wound consult on 6/4/25 and continued with the previous wound care orders. The nursing skilled evaluation notes from 5/21/25 through 6/8/25 lacked evidence of the pressure ulcer change in condition as nursing continued to document the right heel was "pinkness/boggy". In addition, the weekly skin checks completed on 5/28/25 and on 6/4/25 stated his/her right heel was "pinkness/boggy" and lacked a description of the wound on the dorsal right foot. On 6/18/25 at 2:52 p.m., the above was discussed via email with the Clinical Lead Registered nurse.	F 686			