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 _____	C 06/17/2025

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
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		
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		

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

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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 would 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		

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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		