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	205180	A. BUILDING _____ B. WING _____	C 06/03/2024

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

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F 000	INITIAL COMMENTS From 6/3/24, an on-site visit was conducted at Windward Gardens for the purpose of investigating complaint #ME00047553. It was determined that Windward Gardens was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: 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	F 641		

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

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F 641	Continued From page 1 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 ..." Review of facilty policy "Pacemaker Care" dated 6/1/21 states "Upon admission of patient who has	F 641		

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F 641	Continued From page 2	F 641		

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 5/22/24 with diagnoses to include peripheral vascular disease, and hypertension.

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F 641	Continued From page 3 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 5/22/24 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.	F 641		

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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F 656	Continued From page 5	F 656		

plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
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 2/2/24 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 11/15/23 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

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...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 5/22/24 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.

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

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F 656	Continued From page 7 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.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 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 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	F 684		

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resident had 2 wound sites.

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.). 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 5/15/24 at 20:09 (8:09 p.m.) states "R groin area: Keep incision clean and dry for 2-3 days, no showers/baths 7-10 days. Monitor Right groin femoral site for redness/swelling/pain. Two times a day everyday BID 9a.5p for ...Pacemaker battery insertion 5/15/24 ..." 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 5/21/24 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 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

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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 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.

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 ..."
During an interview on 6/3/24 at 2:31 p.m., Acting Director of Nursing confirmed above concerns.