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 ______	04/17/2025

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 From 4/14/25 through 4/17/25, on-site visits were conducted at Windward Gardens for the purpose of a Recertification Survey and investigating intakes #ME00050896, #ME00050897, #ME00050741, #ME00050552, #ME00050237, #ME00050214, #ME00050079, #ME00050049 and #ME00051268. 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	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. The events for resident #59 happened in the past and therefore can't be corrected.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580	An audit was conducted to ensure notifications to responsible party following resident falls in the last 14 days were completed timely. Licensed staff educated regarding timely notification to Responsible Party following a fall. DON/ designee will conduct audit of falls in facility to ensure notifications to responsible party are completed timely. These audits will be conducted weekly x4 weeks and monthly x3 months.	5/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 5/15/2025

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 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, interview and facility policy, the facility failed to ensure the resident's representative was notified timely of a significant change and/or incident for 1 of 3 residents reviewed for falls (Resident #56). Finding: On 2/26/25 the Division of Licensing and Certification received a complaint that after a resident obtained a fall, the family was not notified.	F 580	The results of these audits will be discussed at QAPI for further review/ recommendations.	

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F 580	Continued From page 2	F 580		

On 4/17/25, review of Resident #59's medical record contained an Interdisciplinary Team (IDT) meeting dated 1/23/25 at 12:10 p.m., which stated, "family was updated about the recent unwitnessed fall which happened night of 01/22/25. The family mentioned that they were not informed of the fall from last night."

Review of the nursing documentation dated 1/22/25 at 7:37 p.m. stated, "Called to patient room for fall in the bathroom, observed patient lying on the floor on [his/her] back with pants down below the waist, patient stated [he/she] was going to the bathroom and slipped and fell, no obvious bone deformities, no redness or bruising at this time, c/o low back pain 3/10." Further review of the medical record lacked evidence of the family being notified of the fall until the next day approximately 17 hours later.

The facilities "Change in Condition: Notification of" policy and procedure revised on 7/1/24 states, "The center must immediately inform the patient, consult with the patient's' physician, and notify, consistent with the their authority, the patient's representative, when there is: An incident involving the patient which results in injury and has the potential for requiring physician intervention ... Purpose: To provide appropriate and timely information about changes relevant to the patient's condition."

The facilities Falls Management Policy and Procedure, revised 3/24 states "Patients experiencing a fall will receive appropriate care and post fall interventions will be implemented ... Post fall management: ... The patients representative will be notified of the fall in any follow up treatment noted."

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

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F 580	Continued From page 3 On 4/17/25 at 9:29 a.m., the above, the lack of family notification of fall on 1/22/25 until the next day at IDT was discussed with the Market Clinical Advisor.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	F 584	All identified environmental issues have been addressed specific to the garbage bin, the kitchen and service hallway ceiling tiles, the window screen and floor in the laundry room, marred walls in room 2 and sitting area in Penobscot House , the baseboard heating cover in room 3, the bathroom floor in room 8, chipped/ missing paint on door frames for rooms 3, 201-208 and entrance doors for Windward Center and Penobscot House, chipped/missing laminate on bathroom sink in room 106 and 205 , loose grab bars in room 106, privacy curtains for rooms 202-205, 208, and 25, and the sit to stand lifts. An audit was conducted of resident areas to ensure the facility is providing a safe, comfortable, homelike environment, specific to the garbage bin, ceiling tiles, marred walls, chipped/ missing paint, chipped/missing laminate, grab bars, and privacy curtains, and sit to stand lifts.	5/30/2025

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F 584	Continued From page 4 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 4 of 4 wings (North Wind, Spring Gardens, Windward Center and Penobscot House), the laundry room and a hallway for 2 of 2 facility tours. Findings: 1. On 4/14/25 at 9:05 a.m., a surveyor and the Administrator observed a large open top, wheeled garbage bin outside the facility with trash in it. At this time, the Administrator confirmed the trash storage bin didn't have a cover and the trash was not maintained in a condition to prevent the harborage and feeding of pests. 2. On 4/17/25 from 8:10 a.m. to 8:45 a.m., an Environmental tour was conducted with the Senior Maintenance Director and the Administrator in which the following findings were observed and discussed: Support Service Hallway > The hallway had 2 ceiling tiles that had brown stains on them.	F 584	Housekeeping and Maintenance staff will be educated on maintaining a safe orderly, and comfortable environment. Administrator/designee will perform audit of resident rooms and common areas to ensure the facility is maintaining a safe, orderly, and comfortable environment. These audits will be conducted weekly x4 weeks, then monthly x 3 months. The results of these audits will be discussed at QAPI for further review and recommendation	

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F 584	Continued From page 5 Laundry Room > An open window by a washing machine had a screen with a large tear/hole in it. Additionally, the entire floor was soiled and dirty. North Wind > Resident Room 2 - The bathroom walls were marred with black marks. Both armrests on the resident's wheelchair were ripped/torn. > Resident Room 3 - The base board heater metal cover was hanging down off the unit. The bathroom wall had chipped/missing paint by the sink. The resident nightstand had missing sealant exposing bare wood. > Resident Room 8 - The floor was dirty around the base of the toilet and the toilet had liquid around the base. > Resident Room 12 - There was a wash basin on the bathroom floor under the sink. Spring Gardens > Resident Room 106-2 - The bilateral grab bars were very loose on the bed. The sink counter was stained and faded and the front edge and side edge laminate was broken and missing. > A lower cabinet in the kitchenette had a bottom section approximately five inches by two inches of the wooden door and wooden corner that were missing. Windward Center > The Unit entrance doors had chipped/missing paint by the push bars and black marks on the lower sections. > The room entrance door frames, for resident Rooms 201, 202, 203, 204, 205, 206, 207 and 208 had chipped/missing paint creating uncleanable surfaces. >	F 584		

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F 584	Continued From page 6 > Resident Room 202 -The privacy curtain was missing hooks, hanging down and in disrepair. > Resident Room 203 - The privacy curtain was missing hooks, hanging down and in disrepair. > Resident Room 204 - The privacy curtain was missing hooks, hanging down and in disrepair. > Room 205 - The bathroom sink counter was stained and faded and also had chipped/broken laminate on the front left edge. > Room 208 - The wall above bed B had chipped/peeled paint above the bed. > The sit-to-stand patient lift outside resident Room 203, had food debris and dirt in the foot base area. Penobscot House > The Unit entrance doors had chipped/missing paint by the push bars and black marks on lower sections. > The wall by the sitting area bookcase was marred with black marks. > Resident Room 25 - The privacy curtain was missing hooks, hanging down and in disrepair. On 4/17/25 at 8:45 a.m., in an interview, the Senior Maintenance Director and the Administrator confirmed the findings.	F 584		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 645	A PASARR was completed for resident 18 on 4/18/2025. An audit of resident records was conducted to validate a PASARR was completed prior to admission for all residents and for those meeting criteria that PASARR level 1 Screen was forwarded to the State Mental Health Authority to determine if the resident met the State of Maine's	5/30/2025

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F 645	Continued From page 7 authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,	F 645	definition of a serious mental health disorder and to determine if a Level II assessment was needed. The facility requires that all admissions have a Preadmission Screening prior to entry into the facility. The facility requires a full PASARR for those individuals with intellectual disability if the stay is expected to be >30 days. NHA, Social Services, and DON will be re-educated to this process. NHA/ Designee will complete audits to validate all residents have a PASARR completed prior to admission and those who have a mental disorder and individuals with ID have a full PASARR completed for stays >30 days. These audits will be conducted weekly x4 weeks, then monthly x3 months. Results of these audits will be brought to QAPI for further review and recommendation.	

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F 645	Continued From page 8 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 3 residents reviewed with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review Level II (PASRR) evaluation and determination (Resident #18). Finding: 1. Resident #18 was re-admitted to the facility in May 2024 with diagnoses of generalized anxiety and bipolar disorder. Resident #18's clinical record contained a PASRR Level I Screen, dated 5/22/24, and indicated the screen was for a change in condition and that Resident #18 would reside in the facility for "permanent placement (LTC) [Long Term Care]." The clinical record	F 645		

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F 645	Continued From page 9 lacked evidence to indicate that the PASRR Level I was forwarded to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed. On 4/15/25 at 11:15 a.m. the above findings were discussed with the Market Clinical Advisor.	F 645		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on care plan review, observations, interviews, and facility policy, the facility failed to provide a resident with a continuous resident centered activities program. This failure has the potential to affect all residents that would normally participate in activities. Findings: Review of facility policy "Recreation Participation Record" dated 8/7/23 states "Recreation Participation Records: are maintained monthly; Document each person's involvement and response in specific opportunities/experiences in accordance with the person's preferences,	F 679	Resident 13 provided with an activity calendar in their room that is posted within their view. Education will be provided to activity staff regarding proper implementation of individualized preference based participation logs while highlighting the process of documenting refusals attendance and defining responses during program opportunities. Administrator or designee will perform audit of scheduled activities to ensure a continuous resident centered activities program is being implemented for all residents. These audits will be conducted weekly x4 weeks, then monthly x3 months. The results of these audits will be discussed at QAPI for further review and recommendation	5/30/2025

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F 679	Continued From page 10	F 679		

interest, routines, and plan of care. Independent, individual, and group recreation participation will be documented on the participation record. the Current participation record will be maintained daily, organized, and easily accessible ..."

1. Resident #13(R13) was admitted in the fall of 2022 and has diagnoses to include schizoaffective disorder, major depression and is considered bedbound and reliant on staff for activities of daily living.

Review of annual Minimum Data Set (MDS), dated 8/14/24 revealed R13 had a Brief Interview for Mental Status (BIMS) 15 of 15 indicating he/she is cognitively intact. Further review of MDS revealed Section-F: Preferences for Customary Routine and Activities" indicated he/she felt it was very important too, keep up with news, attend favorite activities and listen to music he/she likes, and participate in religious services or practices."

Review of R13's care plan initiated updated 3/3/25 revealed ...While in the facility, [R13] states that it is important ... has the opportunity to engage in daily routines that are meaningful relative to [his/her] preferences ...I am of the Christian faith and would like to participate in religious services/practices as they become available in the center.

Review of Activity Calendar, dated March 2025 revealed the following scheduled activities: BINGO on 3/5/35, 3/8/35, 3/12/25, 3/19/25, 2/22/25, and 3/26/25. Church services were held on 3/2/25, 3/5/35, 3/9/25, 3/19/25, and 3/23/25. Live music was held on 3/21/25. Review of R13's March 2025 activity participation sheet lacked

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F 679	Continued From page 11 evidence that he/she was invited/refused to go to these activities. Review of April 2025 Activity Calendar dated April 2025 revealed the following scheduled activities: BINGO 4/1/25 and 4/9/25. Live music on 4/2/25, 4/3/25, 4/10/25, and 4/15/25, and church service on 4/6/25. Review of R13's April 2025 activity participation sheet lacked evidence he/she was invited/refused to attend these activities. On 4/9/25 at 10:15 a.m., observation of activity room revealed residents participating in BINGO. During a follow-up interview on 4/9/25, at this time R13 was found in bed and informed a surveyor that he/she was not aware that they were playing BINGO this morning and it would have been nice to know. R13 further stated he/she loves music and is very religious. Observation of R13's room revealed activity calendar posted on closet door, close to room entrance and not in view of R13. During an interview on 4/15/25 at 11:25 a.m., the Activity Director (AD) stated that residents that are bed bound or those that don't enjoy group activities should have a 1:1 at least 2 times a month and should still be invited to activities of choice. At this time AD confirmed that she does not have any documentation that R13 was asked/refused to go to activities or had been offered/refuses 1:1. During an interview on 4/15/25 at 11:45 a.m., Market Clinical Advisor stated that residents should be invited to activities of choice and offers/refusals should be documented daily.	F 679		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		

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WINDWARD GARDENS	**105 MECHANIC ST CAMDEN, ME 04843**

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F 684	Continued From page 12 § 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 and interviews, the facility failed to assess and monitor a resident after a fall, and failed to follow their own "Fall management" and "Neurological evaluation" policies and procedure by obtaining neurological assessments a resident who has an unwitnessed fall for 1 of 3 residents reviewed for falls. (Resident #18). In addition, the facility failed to ensure a resident received wound care/orders for 1 of 1 residents reviewed for pressure ulcers. (Resident #37). Findings: 1. On 3/16/25 Resident #18 had an unwitnessed fall and was found lying on the floor. The post fall neurological evaluation flow sheet lacked continued neurological assessments with only 3 of the 9 shifts completed for the 72 hour monitoring. On 3/22/25 Resident #18 had an unwitnessed fall and was found on the bathroom floor. The nurses note dated 3/22/25 at 5 a.m., stated, "per patient he/she hit the post auricular area [behind the ear] on the right, no c/o (complaint) pain at this time, small raised bump on the right post auricular ..."	F 684	The events for resident #18 happened in the past and therefore cannot be corrected. Resident #37 discharged from facility on 4/14/2025. An audit was completed to ensure all residents that have experienced an unwitnessed fall received a Neurological Evaluation and continued Neurological assessments, residents requiring orders for wound care are obtained and addressed upon admission, and residents with indwelling Foley catheters receive catheter care and monitoring as ordered. Licensed staff educated regarding performing Neurological evaluations following an unwitnessed fall, obtaining and addressing wound orders upon admission, and appropriate catheter care and monitoring. DON/ Designee will perform audit to ensure Neurological evaluations are completed following unwitnessed falls, wound care orders are obtained and addressed upon admission, and catheter care and monitoring is being performed and documented. Audits will be conducted weekly x4 weeks, then monthly x3 months. The results of these audits will be brought to QAPI for further review and recommendation.	5/30/2025

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F 684	Continued From page 13	F 684		

Further review of the post fall neurological evaluation flow sheet lacked continued neurological assessments after the first 2 hours and only 3 of the 9 shifts completed for the 72 hour monitoring.

The facilities Falls Management Policy and Procedure, revised 3/24 states "Patients experiencing a fall will receive appropriate care and post fall interventions will be implemented ... Post fall management: ... any patient who sustains an injury to the head from a fall and or has a fall unwitnessed by staff will be observed for neurological abnormalities by performing neurological check, per policy ..."

The facilities Neurological Evaluations policy and procedure, reviewed on 2/23 states, "Neurological evaluation will be performed as indicated or ordered. When a patient sustains an injury to the head or face and/or has an unwitnessed fall, neurological evaluation will be performed: Every 15 minutes x (times) two hours, then every 30 minutes for 2 hours, then every 60 minutes x four hours, then every eight hours until at least 72 hours has elapsed."

On 4/17/25 at 8:16 a.m., the above was confirmed with the Market Clinical Advisor.

2. On 4/14/25 the Department of Licensing received a complaint stating the facility failed to provide wound care for Resident #37's pressure ulcers.

Resident #37 has diagnoses to include and diabetic ulcers on his/her bilateral feet, congestive heart failure, Diabetes type II and

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F 684	Continued From page 14 tinea cruis (imbedded penis) requiring an indwelling foley catheter. Review of Resident #37's "Admission: After Hours Telehealth Consult" dated 3/7/25 lacked evidence that wound orders were addressed/obtained for Resident #37 upon admission. Review of Resident #37 "After Hours Telehealth Consult" dated 3/8/25 states "History of Present Illness: CHIEF COMPLAINT: ... 2. Wound management ...HPI TODAY: 03/08/2025: ASSESSMENT AND PLAN: presenting with fluid overload, now stable. 1. Fluid Overload - Assessment: SHORT SUMMARY: ...wound management, and strengthening ...." Further review of Resident #37's clinical record lacked evidence that wound care orders were obtained. Review of Resident #37's care plan initiated 3/7/25 states "Resident at risk for skin breakdown related to fragile skin and decreased mobility. Diabetic ulcer to Left 5th toe, Right foot, Left 1st Halux, DTI to Left heel.:. INTERVENTION : Provide wound treatment as ordered for Management of Pressure Ulcer : Wound Will Show Signs of Improvement INTERVENTION: Provide wound care per treatment order." Review of Resident #37's "[Hospital] Wound Care" note dated 2/27/25 (8 days prior to his/her admission) states "Reason for consult: bilateral feet diabetic ulcers. Recommendations: Continue plan of care as follows: Dressing change to bilateral foot ulcers every 2 days. 1. Cleanse with 1/40 strength Dakin's 5-minute	F 684		

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F 684	Continued From page 15	F 684		

soak (document in MAR), pat dry.
2. Protect peri-wound skin with Skin Prep
3. Tear off just enough Promogran Prisma (or equivalent antimicrobial collagen dressing) to cover wound base, press gently to make good contact with tissue.
4. cover with Mepilex Border (or equiv) reinforced with stretch netting.
5. Offload with Heel Medix foam boots in bed or modified footwear when OOB, minimize weight bearing.
Return visit to wound clinic should be rescheduled within 2-3 weeks of discharge."
Review of Resident #37s' clinical record lacked evidence that the above wound orders were implemented/ or new one obtained. Further review lacked evidence Resident #37 was taken to this follow-up wound care appointment.

Review of Resident #37'sclinical record revealed order with start date of 3/20/25 for "Wound care to bilateral foot ulcers:1. Cleanse with 1/40 strength Dakins 5-minute soak, pat dry 2. Protect peri wound skin with skin prep. 3. Tear off just enough [promogran prisma[(or equivalent antimicrobial collagen dressing) to cover wound base, press gently to make good contact with tissue. 4. Cover with mepilex border (or equivalent). Reinforce with stretch netting. 5. Offload with heel medix foam boots in bed or modified footwear when OOB(out of bed), minimize weight bearing. one time a day every other day for wound care." (Order obtained 13 days after admission).

During an interview on 4/17/25 at 9:05 am. (Doctor) reviewed Resident #37's clinical record and confirmed he/she was admitted on 3/7/25, but did not receive wound care orders until

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F 684	Continued From page 16 3/20/25. Further review of Resident #37's "After Hours Telehealth Consult" dated 3/7/25 states Chief complaint: fluid overload. Currently on 2L fluid restriction... Assessment/Plan: 1. Fluid overload: Daily weights ordered for monitoring. ..3. Congestive heart failure: Continue fluid restriction to 2L(liters) daily weights for monitoring. ... there is no order/mention of Resident #37's indwelling catheter." Review of Resident #37's "output measured" lacked evidence this was completed on the evening shift on 3/22/25, 3/26/25, 4/4/25, 4/5/25, 4/7/25, 4/9/25, or 4/11/25. During the day shift on 3/26/25, 3/27/25, 3/28/25, 3/29/25, 3/31/25, 4/7/25, 4/9/25, or 4/11/25. and during the overnight shift on 3/22/25, 3/26/25, 4/4/25, 4/9/25, or 4/11/25. Review of Resident #37's care plan updated 3/18/25 states: "Resident requires indwelling foley catheter due to Tinea Cruis: imbedded penis: Goal: Resident will have no signs and symptoms of urinary tract infection x 30 days. Interventions: Record output... Catheter care twice a day and PRN, monitor urine for sediment, cloudy, odor, blood and amount..." Review of Resident #37's clinical record lacked evidence that this was done. During an interview on 4/17/25 at approximately 9:13 a.m., the Clinical Market Advisor confirmed above concerns.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 17 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards by ensuring room, closet and bathroom doors had laminate that was not gouged and splintered creating sharp edges on 2 of 4 units(North Wind and Windward Center) for 2 of 2 environmental tours (4/14/25 and 4/16/25). In addition, the facility failed to store oxygen tanks securely for 1 of 4 days. Findings: 1. On 4/14/25 at 8:10 a.m., 3 surveyors observed the following chemicals in the unlocked office on the Administrative wing which residents had access to. The Administrative unit is separated from the Windward Center unit by unlocked double doors that residents can access and get through. On 4/14/25, Resident #51 was observed on the administrative unit by a surveyor. - Poopsy Daisy Pre-Toilet Spray/ 2 ounces bottle - Febreze Air Freshener/ 8.8-ounce bottle - Purell Hand Sanitizer/ 20-ounce bottle The Safety Data Sheet for Poopsy Daisy Pre-Toilet Spray noted the following: 4. First Aid Measures: Eye Contact: immediately flush eyes with plenty	F 689	Chemicals removed from Administrative unit. Laundry detergent removed from resident room. The Chipped/splintered laminate on the hallways closet door and bathroom doors in rooms 2,3,4,8, and 12 on North Wind Unit and room 205 on Windward Center Unit have been addressed . Unsecured O2 tank removed. Education will be provided to Nursing staff, NHA , and Maintenance Staff regarding maintaining an environment free of accident/hazards. Administrator or designee will perform audit of resident areas to ensure areas are free of accident hazards. These audits will be conducted weekly x4 weeks then monthly x3 months. Results of these audits will be discussed at QAPI for further review/ recommendation.	5/30/2025

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of water, occasionally lifting the upper and lower eyelids. Check four and remove any contact lenses. Continue to rinse for at least 10 minutes. Get medical attention.
Skin Contact: Flush contaminated skin with plenty of water. Remove contaminated clothing and shoes. Continue to rinse for at least 10 minutes. Get medical attention. Wash clothing before reuse. Clean shoes thoroughly before reuse.
Inhalation: Remove victim to fresh air and keep at rest in a position comfortable for breathing. If not breathing, if breathing is irregular or if respiratory arrest occurs, provide artificial respiration or oxygen by a trained professional. May be dangerous to the person providing aid to give mouth to mouth resuscitation. Get medical attention if adverse health effects persist or are severe. If unconscious, place in recovery position and get medical attention immediately. Maintain an open airway. Loosen tight clothing such as a collar, tie, belt or waistband.
Ingestion: Wash out mouth with water. Remove dentures if any. Remove victim to fresh air and keep at rest in a position comfortable for breathing. If material has been swallowed and the exposed person is conscious, give small quantities of water to drink. Stop if the exposed person feel sick as vomiting may be dangerous. Do not induce vomiting unless directed to do so by medical personnel. If vomiting occurs, the head should be kept low so that the vomit does not enter the lungs. Get medical attention if adverse health effects persist or are severe. Never give anything by mouth to an unconscious person. If unconscious, place in recovery position and get medical attention immediately. Maintain an open airway. Loosen tight clothing such as a collar, tie, belt or waistband.

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The Safety Data Sheet for Febreze Air Freshener noted the following:
4. First Aid Measures:
Eye Contact: Rinse with plenty of water. Get medical attention immediately if irritation persists.
Skin Contact: Rinse with plenty of water. Get medical attention if irritation develops and persists.
Inhalation: Move to fresh air. If symptoms persist, call a physician.
Ingestion: Drink one or two glasses of water. Do not induce vomiting. Get medical attention immediately if symptoms occur.

The Safety Data Sheet for Purell Hand Sanitizer noted the following:
4. First Aid Measures:
Eye Contact: In case of contact, immediately flush eyes with plenty of water for at least 15 minutes. If easy to do, remove contact lenses, if worn. Seek medical advice.
Skin Contact: Wash with water and soap as a precaution. Get medical attention if irritation develops and persists.
Inhalation: If inhaled, remove to fresh air. If symptoms persist, call a physician.
Ingestion: If swallowed, do not induce vomiting. Rinse mouth with water. Obtain medical attention.

On 4/14/25 at 10:50 a.m., in an interview, the Clinical Lead of Maine confirmed that the chemicals were not secured on the administrative wing and the resident had access to them.

On 4/14/25 at 3:15 p.m.in an interview, a surveyor discussed the findings with the Clinical Market Advisor.

2. On 4/14/25, from 9:45 a.m. to 10:23 a.m., a

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F 689	Continued From page 20 surveyor observed the following on the North Wind Unit > The hallway closet door across from soiled utility room had chipped/splintered laminate by the handle and down the edge that was sharp, creating a hazardous and unsafe environment. > Resident Room 2 - The bathroom door had chipped/splintered laminate along the edge and front that was sharp, creating a hazardous and unsafe environment. Additionally, the toilet was loose and not secured to the floor. > Resident Room 3 - The bathroom door had chipped/splintered laminate that was sharp, creating a hazardous and unsafe environment. > > Resident Room 4 - The bathroom door, inside, has chipped/splintered laminate that was sharp, creating hazardous and unsafe environment. > Room 5- The bathroom had a 32.5-ounce container of Oxi Clean Plus laundry detergent stored on the floor, creating a hazardous and unsafe environment. The Safety Data Sheet for Arm & Hammer Oxi Clean Plus laundry detergent noted the following: 4. First Aid Measures: Eye Contact: immediately rinsed with water for at least 15 minutes. Remove contact lenses, if present and easy to do. Continue rinsing. Obtain medical attention. Skin Contact: Remove contaminated clothing. Wash affected area with soap and water for at least 15 minutes. Obtain medical attention if irritation/rash develops or persists. Inhalation: When symptoms occur: go into open air and ventilate suspected area. Obtain medical attention if breathing difficulty persists. Ingestion: Rinse mouth. Do not induce vomiting. Obtain medical attention.	F 689		

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> Resident Room 8 - The bathroom door had chipped/splinter laminate that was sharp, creating a hazardous and unsafe environment.

> Resident Room 12 - The bathroom door had chipped/splintered laminate that was sharp, creating a hazardous and unsafe environment.

On 4/14/25 at 10:25 a.m., in an interview, the Administrator and the Senior Maintenance Director confirmed these findings created hazardous and unsafe environments and were accident hazards.

3. Windward Center
> On 4/16/25 at 11:00 a.m., a surveyor observed in Resident Room 205 that the room entrance door and the bathroom door had chipped/splintered laminate that was sharp and created a hazardous and unsafe environment.
On 4/16/25 at 11:05 a.m., in an interview and observation, the Administrator confirmed the findings.
4. On 4/14/25 at 9:05 a.m., Resident #53 was observed seated in his/her wheelchair at a table in the Windham Center Unit dining room, and Licensed Practical Nurse (LPN) was observed removing Resident #53's oxygen tank from the holder located on the back of his/her wheelchair and then placed the unsecured oxygen tank (not in a portable cart) on the floor behind Resident #53's wheelchair and instructed him/her to not forget that the oxygen tank was behind him/her.

5. On 4/14/25 at 9:47 a.m., during an observation of Room 205, an unsecured oxygen tank was observed standing upright against the wall next to the closet.

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F 689	Continued From page 22 On 4/14/25 at 9:50 a.m., during an interview, LPN stated oxygen tanks should not be left unsecured and that empty oxygen tanks should be stored in the storage closet. At this time, the Assistant Director of Nursing was observed removing the oxygen tank from Room 205. On 4/14/25 at 10:50 a.m. the above findings were discussed with the Clinical Lead.	F 689		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725	All residents have the potential to be affected by this practice. The facility ensures that they have staffing patterns in place, based on census and acuity, identified in the facility assessment, that are sufficient to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient. This includes the ability to meet the plan of care of each resident, including care needs. Nursing leadership staff will be re-educated to this process. NHA/ Designee will validate that the facility has sufficient nursing staff to meet the needs of the facility based on acuity and facility assessment and DNS/designee will complete random resident interviews regarding care needs to validate sufficient staffing is in place to meet the needs of the residents. These audits will be weekly x4weeks, then monthly x 3 months.	5/30/2025

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F 725	Continued From page 23 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, interview and Payroll Based Journal Report (PPJ), the facility failed to ensure it was sufficiently staffed on weekends for 1 of 1 quarter reviewed (10/1/24 through 12/31/24/ [39 days]). Findings: Review of Center for Medicare & Medicaid (CMS)PPJ Report revealed the facility triggered for low weekend staffing during the first quarter (10/1/24 through 12/31/24). During a review of first quarter weekend staffing with Administrator and Scheduler on 4/17/25 at 12:27 p.m., the Administrator confirmed the facility was not adequately staffed for 32 of 39 days reviewed.	F 725	Results of these audits will be discussed at QAPI for further review and recommendation.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732	Scheduler educated regarding posting the daily nurse staffing information in a prominent place, readily accessible and visible to all residents and visitors. Administrator or designee will perform audits to ensure daily nurse staffing information is posted in a prominent place, readily accessible and visible to all residents and visitors. These audits will be conducted weekly x4 weeks, then monthly x 3 months. The results of these audits will be discussed at QAPI for further review/ recommendations.	5/30/2025

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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
F 732	Continued From page 24 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the nurse staffing information in a prominent place, readily accessible and visible to all residents, for 3 days.(4/12/25 , 4/13/25 and 4/14/25). Finding: On 4/14/25 at 8:00 a.m., 3 surveyors observed that the nurse staffing information posted in an area visible to residents and visitors was dated 4/11/25 (Friday). On 4/15/25 at 2:46 p.m., in an interview, the	F 732		

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F 732	Continued From page 25 Market Clinical Advisor confirmed that the nurse staffing information was not posted on (Saturday-4/12/25 , Sunday-4/13/25 and Monday-4/14/25).	F 732		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of the Food Storage policy (dated 2013), the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a hood system, a fan, ceiling lights, ceiling tiles, ceiling vents, floors, a chemical hose, a food slicer and an exit door. Additionally, the facility failed to ensure that foods in the walk-in freezer were sealed, dated and labeled. Findings:	F 812	Environmental issues in the kitchen addressed specific to the washing machine hood, ceiling fan and vent system, ceiling lights, ceiling tiles, kitchen floor, and food slicer. Food that was not properly sealed, dated, and labeled was removed. Education will be provided to dietary staff regarding labeling, dating, and storing, preparing, and distributing, and serving food in accordance with professional standards for food service safety. Administrator/ designee will perform audit of kitchen and food storage areas to ensure food is labeled, dated, stored, prepared, distributed, and served in accordance with professional standards for food service safety. These audits will be conducted weekly x4 weeks, then monthly x 3 months. The results of these audits will be discussed at QAPI for further review/ recommendation.	5/30/2025

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On 4/14/25 from 8:15 a.m. to 9:00 a.m., during an initial kitchen tour, the following findings were observed and discussed with the Head Cook and Kitchen aide:
> The hood over the dish washing machine was dusty and had rust build-up in it.
> The dish room had a wall mounted fan, a ceiling vent and an entire ceiling grid system that was dusty/dirty.
> There were 2 ceiling lights in the dish room that had dirt/debris in the lenses.
> The floor in front of the dish machine had an approximately 2-foot by 2-foot section of laminate missing which exposed untreated cement.
> The 3-bay pot sink had a long chemical hose hanging down inside the center bay.
> The kitchen hallway had 2 ceiling tiles that had brown stains on them.
> There were 2 kitchen ceiling vents that were heavily soiled with dust/dirt.
> The food slicer had dried food particles on the blade and the shroud.
> The cement floor in front of the stove had chipped/missing paint creating an uncleanable surface.
> The walk-in freezer had a package of fish patties and a previously opened and unsecured/open bag of pizza crusts that were not labeled and dated. Additionally, there was trash and debris all over the floor.
> One kitchen exit door had chipped/missing paint creating an uncleanable surface.
> The kitchen office was missing 9 ceiling tiles.

On 4/14/25 at 9:00 a.m., in an interview, the Head Cook and the Kitchen aide confirmed the findings.
On 4/16/25 at 9:08 a.m., in an interview, the

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F 812	Continued From page 27 surveyor discussed the findings with the Food Service Director.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842	The events for resident 308, 258, and 37 happened in the past and therefore cannot be corrected. An audit was completed to ensure the medical records contains complete and accurate information regarding palliative care/hospice, falls, weights, catheter care and ADL documentation. Nursing staff and Medical records staff educated regarding maintaining complete and accurate information regarding palliative care/ hospice, falls, weights, catheter care and ADL documentation. DON/ designee will perform audit to ensure medical records contain complete information regarding palliative care/hospice, falls, weights, catheter care and ADL documentation. These audits will be conducted weekly x4 weeks, then monthly x3 months. Results of these audits will be discussed at QAPI for further review and recommendations.	5/30/2025

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law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 2 residents reviewed for palliative care/hospice (Resident #308), falls for 1 of 1 (Resident #258), and weights/catheter care and Activities of Daily Living (ADL) documentation

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for 1 of 9 resident's reviewed for a complaint (Resident #37).

Findings:

1. Resident #308 was recently admitted with diagnoses to include severe protein calorie malnutrition and adult failure to thrive.

Review of Resident #308's hospital discharge summary revealed, "...Specialist appointment ...Palliative care in 2 weeks..."

Review of Resident #308's clinical record revealed the following physician progress notes:

-progress note, dated 3/27/25 states, "... has been having weight loss and decreased appetite...A palliative care consult was obtained...determined with [his/her] son that [he/she] would be evaluated for possible Hospice therapy...Long conversation with family and will proceed with hospice consult."

-progress note, dated 4/3/25, states, "...Failure to thrive--been progressive. Goals of care was discussed by admitting physician with son ...Agreement that quality of life is poor. hospice consult pending ..."

-progress note, dated 4/8/25, states, "...Goals of care-- was discussed ...upon admission with son. Agreement that quality of life is poor. hospice consult pending will f/u [follow up] on this today ..."

Review of Social Services progress note, dated 4/9/25 revealed, "Spoke with [son] and updated on the care plan meeting and progress ... We

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discussed Palliative Care referral and he agreed with this..."

Further review of Resident #308's clinical record lacked evidence that a palliative consult had been obtained or that a hospice consult had been ordered/obtained.

On 4/15/25 at 9:41 a.m., during an interview, the Director of Social Services stated Resident #308 was receiving skilled services since admission and could not receive skilled services and hospice at the same time and that the hospital mentioned palliative in the discharge summary, but she is not sure if the referral was made. The Director of Social Services then stated she wanted to make the referral to palliative and hospice services but that Resident #308's condition changed quickly yesterday and he/she died yesterday afternoon, so the referral was not made.

On 4/15/25 at approximately 10:15 a.m. during an interview, the Nurse Practitioner (NP) stated when she refers a resident for a palliative or hospice services, the decision is a team effort and that Resident #308 was still participating in physical therapy, so she intended to order the hospice evaluation once Resident #308 completed skilled services and that "palliative consult obtained" and "hospice consult pending" in her progress note meant that Resident #308 would be referred to palliative and hospice once skilled services were complete. At this time, the NP stated she should have worded her progress note to indicate this.

On 4/15/25 at 10:45 a.m., the above finding was discussed with the Market Clinical Advisor.

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2. Resident #258 was admitted 1/2025 with diagnoses to include severe vascular dementia, protein calorie malnutrition, and had a history of frequent falls.

Review of "Provider note "dated 2/13/25 states: " ....ASSESSMENT/PLAN:
Sepsis/Encephalopathy- pt is poorly responsive? behavioral. Not eating and drinking some. Will ...discuss goals of care with family. ..." Further review of Resident #258's clinical record lacked evidence the family was contacted to discuss goals of care.

During an interview on 4/16/25 at 5:15 p.m., discussed with Administrator and Market Director there was no evidence provider contacted family after 2/13/25 visit.

Review of Resident #258's clinical record revealed "progress note" dated 2/10/25 at 9:58 a.m., states " CNA found resident lying on the floor mat near [his/her] bed ...neuros [neurological] initiated ..." Further review of R258's clinical record lacked evidence that neuro checks were done after this fall.

During an interview on 4/16/25 at 2:35 p.m., Clinical Marketing Director (CMD) stated that after every unwitnessed fall, neuro checks have to be completed and documented in the clinical record. At this time CMD confirmed there was no evidence that neuro checks were completed after Resident #258's fall.

3. Resident #37 was admitted 3/2025 and has diagnoses to include congestive heart failure

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F 842	Continued From page 32 (CHF) with fluid overload, and tinea cruis (imbedded penis) requirring an indwelling foley cathether. Review of Resident #37 provider orders revealed order with start date of 3/11/25 for "Weight in the morning for CHF. Notify the provider if gain>2 lbs in 1 day, or 5 lb in a week." Review of Resident #37's clinical record lacked evidence weights were obtained/offered and refused on: 4/7/25, 4/5/25, 3/29/25, 3/26/25, 3/23/25, 3/22/25, 3/21/25, 3/19/25, 3/17/25, 3/16/25, 3/15/25, 3/14/25, 3/13/25 or 3/12/25. Review of Resident #37's "After Hours Telehealth Consult" dated 3/7/25 states Chief complaitn: fluid overload..Currently on 2L (Liter) fluid restriction... Assessment/Plan: 1. Fluid overload: Daily weights ordered for monitoring. ..3. Congestive heart failure: Continue fluid restriction to 2L Daily weights for monitoring. .." Review of Resident #37's care plan updated 3/18/25 states: Resident requires indwelling foley catheter due to Tinea Cruis: imbedded penis: Goal: Resient will have no signs and symptoms of urinary tract infection x 30 days. Interventions: Record output.. Catheter care twice a day and PRN, monitor urine for sediment, cloudy, odor, blood and amount..." Review of Resident #37's clinical record lacked evidence this was done. Review of Resident #37's "output measured" lacked evidence this was completed on the evening shift on 3/22/25, 3/26/25, 4/4/25, 4/5/25, 4/7/25, 4/9/25, or 4/11/25. During the day shift on 3/26/25, 3/27/25, 3/28/25, 3/29/25, 3/31/25, 4/7/25, 4/9/25, or 4/11/25. and during the overnight shift on 3/22/25, 3/26/25, 4/4/25, 4/9/25,	F 842		

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

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F 842	Continued From page 33 or 4/11/25. During an interview on 4/17/25 at 9:10 a.m., Nurse Practitioner stated Resident #37 was on daily weights and she had to tell staff to do them often. During an interview on 4/17/25 at 9:30 a.m., Clinical Market Advisor confirmed daily weights were not completed for Resident #37.	F 842		