

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2025
NAME OF PROVIDER OR SUPPLIER Woodlawn Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 West Front Street Skowhegan, ME 04976	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure that emergency cart equipment and supplies were maintained in a clean, safe and ready-to-use condition for 1 of 1 emergency cart reviewed. Findings:On [DATE] at 3:30 pm, during an observation of the facility's emergency cart with the Director of Nursing (DON), the following concerns were identified: The adult manual resuscitator (Ambu bag) stored in a torn, cloudy plastic bag with the attached reservoir bag that was worn, discolored and consistent with prior use. The plastic resuscitation mask and oxygen tubing was discolored, yellow, and visibly dirty. A package of oxygen tubing had an expiration date of [DATE]. The suction machine on the cart was dusty, and the inspection sticker indicated the last inspection was completed on [DATE]. During an interview on [DATE] at 3:30 p.m., the DON stated that night shift staff were responsible for ensuring the emergency cart equipment and supplies were maintained in clean, functional and ready to use condition. She acknowledged that the suction machines inspection was overdue and that emergency respiratory equipment should not have been discolored, dirty or expired.</p>

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.

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

TITLE

(X6) DATE