STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205154	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlawn Rehabilitation & Nursing Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to follow their standing orders for bowel management for 1 of 3 residents reviewed for bowel management resulting in the resident having to be transferred to the hospital. (Resident #1)Findings:On 1/29/29 the Division of Licensing and Certification received a complaint regarding Resident #1. The complaint stated that Resident #1 was screaming in pain, when the complainant was able to figure out what was causing the pain, it was determined that Resident #1 had not had a bowel movement in 14 days. Resident #1 was then taken to the emergency room (ER) via ambulance.A review of the facilities standing orders for their bowel routine indicated that nursing staff had the ability to give Resident #1 a Bisacodyl laxative Rectal Suppository 10 milligrams: insert 1 suppository rectally as needed for bowel management every 3 days as needed, MiraLAX oral powder 17grams: give 17 grams by mouth as needed for bowel management once per day as needed, Senna 8.6 milligram tablet: Give 2 tablets by mouth as needed for bowel management at bedtime, Milk of Magnesia oral suspension 7.75%: give 30 milliliters by mouth as needed for constipation, and a Fleet oil rectal enema: insert 1 applicator rectally as needed for constipation every 3 days as needed.A review of Resident #1's clinical record showed he/she had a bowel movement on 1/9/26. On 1/16/26 (day 7 without a bowel movement) Senna (oral laxative) was given. On 1/24/26 (day 15 without a bowel movement) a Bisacodyl Suppository was given. On 1/24/26 at 11:56 a.m., a nursing progress note indicated that the suppository was ineffective. This note also stated that Resident #1's bowel sounds were hypoactive (slowed intestinal activity), and his/her abdomen was firm and tender. At this time, an order was obtained to transfer the resident to the ER. Further review of the clinical record shows a nursing note on 1/24/26 at 7 p.m., stating the resident returned from the ER and his/her constipation issue was rectified with an enema.Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of 14 of 15, indicating he/she is cognitively intact.On 2/3/26 at 11:00 a.m., in an interview with Resident #1, he/she remembers going 2 weeks without a bowel movement. Stating he/she had bad pain. He/she informed the surveyor that they alerted multiple staff of his/her pain and discomfort.A review of Resident #1's medical administration record and treatment administration record under the column Pain monitoring- Assess for pain every shift from the dates 1/10/26 through 1/24/26 shows he/she experienced pain 2 times on day shift and 6 times on evening shift. On 2/3/26 at 11:30 a.m., during an interview with a Licensed Practical Nurse (LPN), a surveyor asked what process is in place to inform staff when residents go extended periods of time without a bowel movement. She stated that night shift prints off a list of all residents, which shows how long a resident has gone without a bowel movement. When follow up questions were asked, it was determined that the facility initiates bowel protocol after 3 days after no bowel movement. She states that first they start with prune juice, then go to senna, then milk of magnesia, then a suppository, and if none of that works, they do a fleet enema.On 2/3/26 at 11:45 a.m., during an interview with a (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Tech who discussed the facilities bowel protocol starting after 3 days of no bowel movement. She states they start with the least invasive medication and work the way up to a fleet's enema, or until they get a bowel movement.On 2/3/26 at 12:30 p.m., during an interview with the Director of Nursing and Facility Administrator, they confirmed that bowel protocol starts after 3 days of no bowel movement. Furthermore, they confirmed that Resident #1's constipation was not appropriately managed.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interviews, the facility failed to obtain lab services in a timely manner for 1 of 1 resident reviewed for lab orders. In turn, this led to the resident needing to obtain treatment and receive care in the emergency room (ER). (Resident #1).Findings:A review of Resident #1's medical record shows an resident had ER visit on 1/24/26 for constipation, at the time labs were drawn. A review of the ER discharge summary stated resident had a moderately low sodium level of 125. The ER discharge summary indicated to redraw Resident #1's sodium level Monday 1/26/26. Resident #1's record lacked evidence of a lab draw occurring on 1/26/26. On 1/29/26 a nursing progress note stated he/she had a critical sodium level of 121 the on-call provider was notified, and the resident was transferred to the ER.On 2/3/26 at 12:30 p.m., during an interview with the Director of Nursing (DON) and Facility Administrator, the DON discussed how she spoke on the phone with the facility provider on 1/27/26 (no documentation in Resident #1 clinical record to show this conversation), and the sodium level was ordered to be drawn on Thursday 1/29/26, as Thursdays are the day lab is scheduled to come into the facility. During the interview the DON stated she could have drawn the lab herself when she became aware of it but didn't. The DON then confirms that the lab should have been drawn on 1/26/26 as indicated by the ER provider.