

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 02/25/2026
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure the confidentiality of protected resident health information when a resident's electronic medication profile and residents' written medication information was left unattended on a medication (med) cart and a nursing assignment sheet containing resident health information was left unattended on the nurses' station countertop, leaving the residents' health information visible and accessible to residents and visitors on 1 of 2 units (West Unit). Findings: 1. On 2/25/26 at 9:43 a.m., a surveyor observed an unattended med cart located outside of room [ROOM NUMBER] on the [NAME] Unit with an open laptop computer affixed to the cart and the electronic Medication Administration Record (eMAR) for Resident #4 visible on the computer screen. The visible information on the eMAR included but was not limited to Resident #4's name, photograph, date of birth, vital signs, and medication orders. The surveyor also observed a white sheet of paper, face-up on top of the med cart, listing 3 resident names with a medication name and strength under each resident's name. At 9:50 a.m., Certified Nursing Assistant-Medication Tech (CNA-M) #1 returned to the med cart. At this time, during an interview, the surveyor discussed the above observation, and CNA-M #1 stated that she should have closed her laptop and turned the resident info upside down before leaving the med cart unattended. On 2/25/26 at 10:08 a.m., the surveyor discussed the above finding during an interview with the Director of Nursing (DON). 2. On 2/25/26 at 12:36 p.m., the surveyor observed a clipboard face-up on the countertop of the [NAME] Unit nurse's station. The assignment sheet on the clipboard included the names of 17 residents and their room numbers, meal intakes, and bathing information. A small sheet of paper also attached to the clipboard contained the names of 2 residents and listed their vital signs. There were no staff nearby at the time of the observation. On 2/25/26 at 12:37 p.m., the surveyor discussed the finding during an interview with the DON. At this time, the DON stated that she has previously educated the nursing staff that they cannot leave the clipboard on the countertop and that she will re-educate the staff. On 2/25/26 at 2:10 p.m., during a repeat observation, the unattended clipboard remained face-up and accessible to residents and visitors.</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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that the resident's environment remains free of accident hazards by failing to clean up spilled liquids on an ambulatory resident's floor on 1 of 2 units observed during a complaint investigation (West Unit). Additionally, the facility failed to ensure that a metal threshold plate at an entrance used by residents was properly secured, creating a tripping hazard with the potential to affect multiple residents. Findings: 1. Resident #2 was recently admitted with diagnoses to include legal blindness and syncope and collapse. On 2/25/26 at 8:36 a.m., a surveyor observed Resident #2 lying in bed and liquid on the floor next to his/her bed. During an interview at this time, Resident #2 stated that he/she had spilled his/her coffee and notified a staff member and that the staff member said she would clean it up but has not been back yet. On 2/25/26 at 8:55 a.m., during a repeat observation, Resident #2 was seated in his/her chair located next to his/her bed. During an interview at this time, Resident #2 stated that he/she transferred him/herself and ambulated to the chair using his/her walker. The surveyor observed that the floor remained wet with coffee. At this time, the surveyor discussed the above observations with the Director of Nursing (DON), and she stated that she will have housekeeping clean the floor now. 2. On 2/11/26, the Division of Licensing received a complaint stating, "the threshold is broken at the first entrance and the client could not exit with [his/her] wheelchair in an emergency situation. On 2/25/26 at 1:40 p.m., a surveyor and the Maintenance Director observed a metal transition plate located at the main front entrance threshold. The outer edges of the threshold plate were not properly secured, creating gaps between the plate and the floor/ground, causing the plate to shift when weight was applied. During an interview at this time, the Maintenance Director confirmed that residents do exit and enter through this entrance when leaving with family or staff. The Maintenance Director then stated that he would repair the threshold immediately. On 2/25/26 at 4:00 p.m., the surveyor observed that the threshold plate was properly secured to the floor.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and facility policy, the facility failed to ensure medications were stored properly on 1 of 2 units (West unit). Finding: On 2/25/26 at 9:43 a.m., a surveyor observed an unattended medication (med) cart located outside of room [ROOM NUMBER] on the [NAME] Unit. A medication cup containing an unknown red liquid was on top of the med cart. Additionally, a clear plastic cup containing plastic sleeves used for crushing medications, with medication residue inside the plastic sleeves, was located on top of the med cart. At this time, the surveyor observed Resident #3 foot-propelling in his/her wheelchair in the hall by the med cart. At 9:50 a.m., Certified Nursing Assistant-Medication Tech (CNA-M) #1 returned to the med cart. At this time, during an interview, the surveyor discussed the above observation, and CNA-M #1 stated that the medication sleeves are trash and contain residue from meds she had crushed for a resident and that the red liquid in the med cup is Robitussin that she had poured for a resident, and that she should have placed the med in a locked drawer before leaving the med cart unattended. Facility policy Medication Labeling and Storage, revised 3/2025 states, The facility stores all medications and biologicals in locked compartments. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including but not limited to, drawers, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. On 2/25/26 at 10:08 a.m., the surveyor discussed the above finding during an interview with the Director of Nursing (DON).</p>		