STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305097	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlawn Healthcare Center LLC	84 Pine Street Newport, NH 03773

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview, observation, and record review, the facility's water management plan failed to have an assessment documenting where Legionella or other opportunistic waterborne pathogens could grow and spread or to include interventions for when control limits were not met. This deficiency has the potential to affect the facility's census of 51 residents. Findings include:Review on 2/18/26 of facility policy titled Woodlawn Care Center Legionella Management Plan Policy and Procedure, revealed that there was no assessment identifying areas within the facility where Legionella or other opportunistic waterborne pathogens could grow and spread. Further review revealed that there were no established interventions for situations in which control limits were not met. The review also revealed under control measures, hot water temperatures were required to be maintained at a level high enough to discourage the growth of Legionella, between 116-120 degrees Fahrenheit. Interview on 2/19/26 at approximately 2:20 p.m. with Staff B (Director of Maintenance) confirmed the above findings. Review on 2/18/26 of the CDC's Controlling Legionella dated January 3, 2025 revealed Store hot water above 140 F (60 C). Maintain circulating hot water above 120 F (49 C). Review on 2/18/26 of the CDC's Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings dated September 30, 2025 revealed, .3. Identify Areas Where Legionella Could Grow & Spread .Once you have developed your process flow diagram, identify where potentially hazardous conditions could occur in you building water systems . Each potentially hazardous condition should be addressed individually with a control point, measure, and limit . 5. Establish Ways to Intervene When Control Limits Are Not Met . You should plan for your monitoring results to vary over time and be prepared to apply corrective actions. Corrective actions are taken in response to systems performing outside of control limits .

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide notifications of the Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) for 2 of 3 residents reviewed for Beneficiary Notification (Resident identifiers are #4 and #14).Findings include: Resident #4Review on 2/18/26 of the SNF Beneficiary Notification for residents who received Medicare Part A services (Form CMS-20052) revealed that the facility/provider initiated a discharge from Medicare Part A services for Resident #4 before the resident's benefit days were exhausted. Further review revealed that Resident #4 remained in the facility and that the last covered skilled services was 10/10/25. Resident #4 or Resident #4's representative was not provided the SNF ABN. Resident #14Review on 2/18/26 of SNF Beneficiary Notification for residents who received Medicare Part A Services (FORM CMS-20052) revealed that the facility/provider initiated a discharge from Medicare Part A services for Resident #14 before the resident's benefit days were exhausted. Further review revealed that Resident #14 remained at the facility and that his/her last covered skilled services was 10/16/25. Resident #14 or Resident #14's representative was not provided the SNF ABN.Interview on 2/18/2026 at approximately 9:00 a.m. with Staff D (Business Office Manager) confirmed the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to ensure that residents have the appropriate equipment to prevent a decrease in Range of Motion (ROM) for 1 of 1 resident reviewed for limited range of motion in a final sample of 13 residents (Resident identifier is #21).Findings include:Review on 2/18/26 of Resident #21's physician's orders revealed an order for OT [Occupational Therapy] Recommendation: B palm protectors [orthotic device] should be worn daily as tolerated to reduce contractures and skin breakdown. B palms should be cleaned and thoroughly dried before donning. The order had a start date of 12/30/25, and an end date of 3/24/26. Observation on 2/17/26 at 2:06 p.m. of Resident #21 revealed Resident #21 was sleeping in bed, both hands clenched. Resident #21 was not wearing palm protectors. Further observation revealed that the palm protectors were stored in the drawer of the resident's bedside table.Interview on 2/17/26 at 2:07 p.m. with Staff C (Licensed Nursing Assistant (LNA)) confirmed the above findings. Staff C stated that he/she was Resident #21's assigned LNA and had not applied the palm protectors for Resident #21.Observation on 2/18/26 at 8:30 a.m. and 12:29 p.m. revealed Resident #21 was in the main dining room being assisted with his/her meal. Resident #21's hands were resting on his/her lap and were clenched shut. Resident #21 was not wearing palm protectors on either hand.Review of 2/18/26 of Resident #21's Treatment Administration Records for January 2026 and February 2026 revealed that there was no documentation that the palm protectors were being applied daily.Interview on 2/18/26 at 1:06 p.m. with Staff A (Assistant Director of Nursing) confirmed the above findings.