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AUG 11 2025
BY:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205154	A. BUILDING B. WING	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN REHABILITATION & NURSING CENTER	59 WEST FRONT ST , SKOWHEGAN, Maine, 04976

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E0000	Initial Comments Federal Recertification Survey Survey Date: 07/29/2025 Woodlawn Rehab and Nursing Center, a long-term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73, Requirement for Emergency Preparedness in a Long-Term Care Facility.	E0000	This Plan of Correction constitutes my written allegation of compliance for deficiencies during the recent survey on 7/29/25 and 7/30/25. However, submission of this Plan of Correction is not the admission that a deficiency exists or that it was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal Law.	
K0000	INITIAL COMMENTS Federal Recertification Survey 07/29/2025 Woodlawn Rehabilitation and Nursing Center was surveyed pursuant to the National Fire Protection Association 101, Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) - Physical Environment and is not in substantial compliance.	K0000		
K0211 SS = D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the exit corridors free of storage obstructions per NFPA 101, Life Safety Code, 2012 Edition, Sections 7.1.10.1, 7.1.10.2.1, and 19.2.1.	K0211	All residents have the potential to be affected by this practice. No residents were affected by this practice. Facility designee will conduct routine rounds to ensure hallways are clear of obstructions that represent violations of the life safety codes. Re-education was provided by Maintenance to all staff regarding the Means of Egress must be contiguously maintained, free of all obstructions in case of emergency. The temperature and blood pressure combination machine was removed from the hallway at time of survey and moved to area where it could be safely stored while not in use. Blood pressure machine will be charged in an approved location.	8/8/25

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 reverse for further 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
Veronica Hopkins	Administrator	8/11/2025

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K0211 SS = D	Continued from page 1 Finding: On 07/29/2025, between 09:00 AM and 12:00 PM, a surveyor, with the Administrator and Maintenance Director present, observed the following:A temperature and blood pressure combination was plugged in and being stored in West wing exit corridor by room 211. Interview with the Administrator and the Maintenance director revealed that the units are not stored there regularly. The surveyor confirmed this finding with the Administrator and Maintenance Director at the time of the observation, and during the exit interview on 07/29/2025.	K0211		
K0223 SS = D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation, the facility failed to ensure that doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position in accordance with NFPA 101, Life Safety Code, 2012 edition Section19.2.2.2.7. Findings: On 07/29/2025 between hours of 09:00 AM and 12:00 PM, this surveyor accompanied by the Administrator, and the Maintenance Director observed the following:	K0223	No residents were affected by this practice. All residents have the potential to affected by this practice. The self closing door located at the top of the stairs by the office was repaired by maintenance. A new self closing device was applied on 7/29/25. The self closing door located on the soiled entry to the laundry room was repaired by maintenance. A new self closing device was applied on 7/29/25 The Maintenance Director completed training on July 31st 2025 through ASHE for fire door inspections. Monthly audits on all doors, including fire doors will be conducted by facility designee to ensure all doors close and function as per life safety regulations. QAPI will review monthly door audits times 3 months to ensure compliance.	7/31/25

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K0223 SS = D	Continued from page 2 1. The self closing door at the top of the stairs by the office did not self close and latch. Three attempts were made, but the closer was malfunctioning at the joint in the arm. The Maintenance Director and the Administrator were shown the defective closer, and he observed it not working properly under his control. 2. The self closing door on the soiled entry to the laundry room did not self close and latch. Three attempts were made, but the closer was malfunctioning by not putting enough pressure on the door. The Maintenance Director and the Administrator were shown the defective door, and he observed it not working properly under his control. The surveyor confirmed these findings with the Maintenance Director and the Administrator at the time of the observation and during the exit interview on 07/29/2025.	K0223		
K0355 SS = D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation, the long-term care facility failed to properly install portable fire extinguishers in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, Section 6.1.3.8, as referenced by NFPA 101, Life Safety Code 2012 edition, Sections 19.3.5.12, and 9.7.4.1. Finding: On 07/29/2025 between hours of 09:00 AM and 12:00 PM, this surveyor accompanied with Maintenance Director observed the following: 1. The Class ABC portable fire extinguisher was setting on the concrete floor of the Boiler room in the basement level of the facility. There was no bracket found in the area to show where the fire extinguisher may have been located previously. Interview with the Maintenance Director revealed that this is where the	K0355	No residents were affected by this practice. All residents have the potential to be affected by this practice. The Class ABC portable extinguisher located in the Boiler room was installed properly and bracket to hold fire extinguisher was installed on 8/5/2025. Facility Designee will conduct monthly audits of all fire extinguishers to ensure all are selected, installed, inspected, and maintained according to Life Safety Code. Re-education was provided to Maintenance Director regarding the proper selection, installation, inspecting and maintenance of all fire extinguishers through TELS on An inspection of all current fire extinguishers was conducted by maintenance to ensure all fire extinguishers meet the Life Safety Code for installation QAPI will review monthly audits of fire extinguishers to ensure compliance.	8/7 /25

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K0355 SS = D	Continued from page 3 extinguisher has always been, and has never had a bracket. The surveyor informed the Maintenance Director that all portable fire extinguishers shall be at least 4 inches above the floor and no higher that 5 feet from the floor to the top of the extinguisher. The surveyor confirmed this finding with the Maintenance Director at the time of the observation and both the Administrator and the Maintenance Director at the time of the exit interview.	K0355		
K0761 SS = E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on interview and documentation review, the long-term care facility failed to conduct an annual fire door inspection that ensures that all fire rated doors and hardware are inspected, tested, and maintained by individuals performing the door inspections that possess knowledge, training or experience that demonstrates ability in accordance with NFPA 80, Standard for Fire Door and Other Opening Protectives, 2010 edition Section 5.2 as referenced by NFPA 101, Life Safety Code, 2012 Edition, Sections 19.7.6, and 8.3.3.1 Finding: Documentation review and interview during a facility tour with the Administrator and Maintenance Director	K0761	No residents were affected by this practice. All residents have the potential to affected by this practice. The Maintenance Director completed the Fire door inspection training on July 31st 2025 through ASHE. All doors, including fire doors were inspected on 8/7/25 to ensure all doors meet the life safety regulations Monthly audits on all doors, including fire doors will be conducted by facility designee to ensure all doors close and function as per life safety regulations. QAPI will review monthly door audits times 3 months to ensure compliance.	7/31/25

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K0761 SS = E	Continued from page 4 present on 07/29/2025, between 09:00 AM and 12:00 PM identified: 1. The facility had no documentation that the doors had been inspected by a trained person. Interview with the Maintenance Director revealed that he has not completed any fire door inspection training and he verified that he is the one that completed the annual fire door inspection in June. We discussed how some door inspection and fire stopping companies offer training, as well as various websites that offer the approved training for fire door inspections. The surveyor confirmed this finding with the Maintenance Director and the Administrator at the time of the observation and during the exit interview on 07/29/2025, between 09:00 AM and 12:00 PM.	K0761		
K0911 SS = D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observations, the facility failed to meet the requirements of NFPA 70, National Electrical Code, 2011 edition, Section 310.2, as referenced by NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.3.2.1. Finding: On 07/30/2025, between 1:00 PM and 2:00 PM a surveyor, with the Maintenance Director present, observed the following: 1. The power cord to the left hand washing machine has separated from the plug exposing the individual insulated wires at the end of the cord. This finding was acknowledged by the Maintenance Director at the time of observation, and acknowledged by the Administrator at the time of the exit interview.	K0911	No residents were affected by this practice. All residents have the potential to be affected by this practice. The power cord to the left hand washing machine that was separated from the plug exposing the individual insulated wires at the end of the cord was repaired by maintenance and wires are no longer exposed or loose. Maintenance conducts monthly audits of washing machines through the TELS system. Monthly audits will continue,to ensure all washing machines are free from loose/exposed wires. K0911 was reviewed by Maintenance Director to ensure electrical systems requirements are met regarding loose/exposed wires. QAPI will review monthly audits of washing machines to ensure compliance.	8/5/25

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K0911 SS = D		K0911		

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The American Society for Health Care Engineering (ASHE)
would like to thank you for your participation.

This is to certify that

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has successfully attended

ASHE Quick Training: Fire Door Inspections

The program awarded the following credits (1 CEC = 1 contact hour)

CEC: 0.50. Sub Types: CHFM Compliance,CHFM M&Op.

Date

07/31/2025

Gordon Howie. MSPM, CHFM, CHC
ASHE 2023 President