Department of Health and Human Services

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 _____	C 04/23/2024

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

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T 001	Initial Comments On 4/23/24, an unannounced on-site investigation was conducted at Woodlawn Rehabilitation & Living Center for the purpose of investigating complaints #ME00047117. It was determined that Woodlawn Rehabilitation & Living Center is not in compliance with 10-144 CMR 110 State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.	T 001	This Plan of Correction consititutes my written allegation of compliance for deficiencies during the recent complaint survey on April 23, 2024. 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.	
T 222	9.A.4. Minimum Staffing Rules The nursing staff-to-resident ratio is the number of nursing staff to the number of occupied beds. Nursing assistants in training shall not be counted in the ratios. The minimum nursing staff-to-resident ratio shall not be less than the following: a. On the day shift, one direct-care provider for every 5 residents; b. On the evening shift, one direct-care provider for every 10 residents; and c. On the night shift, one direct-care provider for every 15 residents The definition of direct care providers and direct care is found in Chapter 1 of these Regulations. This Regulation is not met as evidenced by:	T 222	All residents have the potential to be affected by this practice. Re-education was provided by the Administrator to all licensed nursing staff and Scheduler on minimum staffing regulations and call back policy. Audits of daily staffing sheets will be conducted by the Scheduler and Director of Nursing to ensure minimum staffing requirments are being met. QAPI will review monthly for three months to ensure compliance.	4/24/24 ongoing 7/24/24

Department of Health and Human Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Veronica Hopkins — Administrator — 5/17/24

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T 222	Continued From page 1 Based on review of staffing schedules, the resident census, and interview, the facility failed to assure staffing minimums were met on all units in between 4/7/24 through 4/20/24 for 7 of 14 days reviewed for staffing. Findings: The "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., indicates the minimum nursing staff-to-resident ratio shall not be less than one direct care provider for every 5 residents on the day shift; not be less than one direct care provider for every 10 residents on the evening shift, and not be less than one direct care provider for every 15 residents on the night shift. "Direct Care" means hands-on care provided to residents, including, but not limited to feeding, bathing, toileting, dressing, lifting, moving residents, treatments, and medication administration per the definition in Chapter 1 of the regulations. On 4/8/24, the facility had a census of 39 residents, which required 8 direct care staff to be on duty on the day shift. The nursing schedule indicated that there were 7 direct care staff on duty during the day shift. On 4/11/24, the facility had a census of 37 residents, which required 8 direct care staff to be on duty on the day shift. The nursing schedule indicated that there were 7 direct care staff on duty staff on duty from 7:00 a.m. to 11:00 a.m. during the day shift. On 4/12/24, the facility had a census of 38 residents, which required 8 direct care staff to be	T 222		

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T 222	Continued From page 2 on duty on the day shift. The nursing schedule indicated that there were 7 direct care staff on duty staff on duty from 7:00 a.m. to 11:00 a.m. during the day shift. On 4/13/24, the facility had a census of 38 residents, which required 8 direct care staff to be on duty on the day shift. The nursing schedule indicated that there were 7 direct care staff on duty during the day shift. On 4/16/24, the facility had a census of 39 residents, which required 8 direct care staff to be on duty on the day shift. The nursing schedule indicated that there were 7 direct care staff on duty during the day shift. On 4/19/24, the facility had a census of 39 residents, which required 8 direct care staff to be on duty on the day shift. The nursing schedule indicated that there were 7 direct care staff on duty during the day shift. On 4/20/24, the facility had a census of 40 residents, which required 8 direct care staff to be on duty on the day shift. The nursing schedule indicated that there were 7 direct care staff on duty during the day shift. On 4/23/24 at 12:35 p.m., a surveyor confirmed the above findings with the Administrator, that certain shifts on 7 out of 14 days were not staffed correctly to meet state minimum staffing ratios.	T 222		
T 379	13.A.10.a-b Accidents Accidents The facility must ensure that:	T 379	One resident was affected by this practice. All residents have the potential to be affected by this practice.	

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T 379	Continued From page 3 a. The resident environment remains as free of accident hazards as is possible; and b. Each resident receives adequate supervision and assistance devices to prevent accidents. This Regulation is not met as evidenced by: Based on review of the Nursing Facility Reportable Incident Form, the facility's internal investigation, the facility transfers policy and procedure, and interviews, the facility failed to ensure a resident's safety during a Hoyer lift transfer which caused harm to the resident. The facility failed to follow their Hoyer lift policy and procedure which resulted in the resident falling to the floor from the Hoyer lift. From this fall, the resident sustained a closed head injury for 1 of 1 resident. Finding: On 4/12/24, The Division of Licensing and Certification received a facility Reportable Incident Form indicating that on 4/9/24 at 10:30 a.m. Certified Nursing Assistant #1 (CNA) transferred Resident #1 alone in the Hoyer lift. (mechanical lift) Resident #1 became restless during the transfer and slipped out of the Hoyer pad onto the floor and hit his/her head. Resident #1 sustained swelling in the back of his/her head. A review of the Incident Report dated 4/9/24 at 11:17 a.m. indicates that Resident #1 had a fall and hit his/her head while the CNA was transferring the resident with a Hoyer lift. In addition, the Incident Report also indicates that the CNA was transferring the resident with a	T 379	One on One training was provided with C.N.A involved in policy violation and return demonstration on use of mechanical lift transfers. Mandatory re-education of Hoyer Safety provided to all clincial staff. Newly hired C.N.As will demostrate competency with Hoyer lift transfers. Newly hired C.N.As will review Hoyer Lift policy upon hire. Director of Nursing will conduct random audits of Hoyer lift transfers to ensure compliance with policy x's 2 months. Hoyer lift Audits will be reviewed in monthly QAPI to ensure compliance x's two months	4/12/24 4/23/24 ongoing ongoing 6/23/24 6/23/24

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T 379	Continued From page 4 Hoyer lift without the assistance of a second CNA. Emergency Department notes, dated 4/9/24, indicate Resident #1 bumped the back of his/her head after falling during a Hoyer lift transfer. Resident #1 was diagnosed with a closed head injury and sent back to the facility the same day. Resident #1's Care plan, dated 3/2/24, indicates that the resident requires extensive assists with bathing, dressing, grooming, personal hygiene and bed mobility. The care plan instructs staff to assist the resident with transfers using a mechanical lift and two people. A review of the facility's 'Lifting Machine-Using a Portable' stated: Under General Guidelines," Page 1, number 1, stated, "At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift." On 4/23/24 at 11:00 a.m., during an interview with a surveyor, CNA #1 states that she was unable to find another CNA to assist her with transferring Resident #1 from the chair to the bed using a Hoyer lift. CNA #1 stated that Resident #1 became restless and his/her shoulders slipped out of the Hoyer pad during the transfer. Resident #1 hit the back of his/her head. CNA #1 acknowledged that the facility policy indicates "At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift." The Root Cause Analysis indicates under Contributing Factors "lift policy not followed". On 4/23/24 at 3:00 p.m., a surveyor confirmed with the Administrator that the facility failed to follow their Hoyer lift policy and procedure which	T 379		

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T 379	Continued From page 5 resulted in the resident falling to the floor from the Hoyer lift. As a result of this isolated incident, the following corrective actions were initiated with a completion date of 4/12/24 - One on One training with CNA #1 on the "Lifting Machine" policy and procedure that indicates "At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. CNA #1 demonstrated competence. - Mandatory re-education on "Hoyer Safety" was initiated with all nursing staff. - Newly hired CNA's will demonstrate competency with Hoyer lift transfers.	T 379		