STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255148	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE CENTER	**102 WOODCHASE PARK DRIVE CLINTON, MS 39056**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #25089) at the facility on 6/06/24. CI MS#25089 was investigated for Quality of Care/Treatment related to resident left wet for extended periods and Resident Neglect. During the survey, the AS determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F580 for physician notification and F697 for ensuring pain was managed timely. The facility held a license for 145 beds, with a census of 141 residents.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		6/19/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/14/2024

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F 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, and facility policy review the facility failed to notify the physician of a resident's severe pain rated initially at a ten (10) on a pain scale of (0-10) with 10 being the most severe for one (1) of four (4) sampled residents. Resident #2. Findings include: Record review of the facility policy titled "Medication Policies," revised 10/1/19, revealed, "	F 580	1. Resident #2 was discharged from the facility on 5/9/2024. Registered Nurse (RN) #1 was in serviced by the Director of Nursing on 6/6/24 on requirement to contact the attending physician regarding a change in condition for any resident where it is likely the physician will order a medication; the nurse is to inform the physician of the availability of remote medications in the facility to ensure this will facilitate timely drug administration to	

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F 580	Continued From page 2 ...Procedure ...12. When contacting the attending physician regarding a change in condition where it is likely the physician will order a medication, the nurse is to inform the physician of the availability of remote medications in the facility (i.e. the contents of the remote drug supply). This will facilitate timely drug administration ..." During a telephone interview on 6/6/24 at 12:20 PM, Resident #2 revealed that upon arrival/admission at the facility, she reported severe pain in her right hip. She reported that she did not receive any medication for pain until later in the evening. The resident was unable to recall the exact time but reported that it was hours after her arrival. She stated that the nursing staff was not responsive to her reports of pain. Record review of the "Progress Notes" dated 5/8/24 at 5:05 PM, revealed "Resident transferred to facility ...at 3:00 PM ...due to right hip fracture ...Resident is alert ...oriented x (times) 4 ...Resident reports pain 9 out of 10 on pain scale during assessment ...Narcotic script ...faxed to pharmacy ... standing order for Acetaminophen 325 MG (milligrams) two (2) tablets every six (6) hours as needed ..." Record review of the Baseline Care Plan-V-2 revealed " ...B. Communication: 1. Can the resident communicate easily with staff?... Yes ...2. Cognitive status: Cognitively intact ...E. Pain: 5/08/24 at 4:58 PM ...Most recent pain level: 10 ... Resident admitted to facility for skilled services...aftercare following joint replacement surgery ..." Record review of the facility's electronic Medication Administration Record (eMAR)	F 580	the resident. 2. The facility has determined that 141 residents had the potential to be affected. 3. To prevent from re-occurring, beginning 6/6/24, the Director of Nursing began in-servicing licensed staff, and all staff on monitoring for pain, and providing interventions as needed when residents voice pain, displace non-verbal indicators of pain, to include notification to physician related to change of condition. On 6/13/24, an in-service was conducted by the Regional Case Mix Registered Nurse via Teams with MDS Nurses on requirements to accurately develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 4. Beginning on 6/7/2024, an audit will be conducted weekly for twelve (12) weeks by the Director of Nursing, that will be submitted to the Administrator and the Corporate Clinical Specialist Nurse, then	

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F 580	Continued From page 3 revealed Resident #2 received (1) tablet of Oxycodone-Acetaminophen 7.5-325 MG on 5/8/24 at 8:35 PM, (2) tablets of Acetaminophen 325 MG on 5/9/24 at 12:47 AM, (1) tablet of Oxycodone-Acetaminophen 7.5-325 MG on 5/9/24 at 2:55 AM and again at 8:56 AM. During an interview on 6/6/24 at 3:40 PM, Registered Nurse (RN) #1 confirmed that on 5/08/24 she had been on duty from 7:00 AM to approximately 5:15 PM. The nurse stated that at approximately 3:00 PM, Resident #2 had arrived at the facility, and she had conducted a pain assessment. RN #1 confirmed that Resident #2 had reported pain rated 9 on a 0-10 pain scale during her initial admission assessment. RN #1 confirmed that she had not administered any pain medication to Resident #2 on 5/08/24. She confirmed that the facility had a policy and procedure in place that addressed pain management which included reporting to the resident's primary healthcare provider for direction and informing the physician of the availability of remote medications in the facility. She confirmed that she had not notified the resident's primary healthcare provider regarding the resident's pain. During an interview on 6/6/24 at 6:11 PM, the Director of Nurses (DON) confirmed that in case pain was unrelieved by a resident's current pain regimen, the resident's nurse could notify the primary healthcare provider and report the resident's description of pain and make the provider aware of pain medications readily available. She confirmed that there was no documentation or indication of any report of unrelieved pain to the primary healthcare provider.	F 580	monthly for three months for all new admissions into the facility. This audit will determine the completion of notification to physician of any condition of change with utilization of the SBAR (Situation, Background, Assessment, and Recommendations) of a resident related to pain. A Quality Assurance meeting was held on 6/6/2024 with the Medical Director, Director of Nursing, Assistant Director of Nursing, Risk Manager, Administrator, Assistant Administrator, Corporate Clinical Specialist, Staff Development Coordinator, and the Registered Nurse Minimum Data Set Coordinator to review findings and current plan of corrections put in place. A report of audit findings beginning on 6/19/2024 will be submitted by the Director of Nursing to the Quality Assurance Performance Improvement committee monthly for three (3) months for further review and recommendations. The facility Director of Nursing is responsible for compliance.	

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F 580	Continued From page 4 During an interview on 6/06/24 at 6:20 PM, the Administrator confirmed that according to the documentation the resident complained of unrelieved pain not reported to the resident's primary healthcare provider on 5/08/24. Record review of the Admission Record for Resident #2 revealed the facility admitted the resident on 5/08/24, with diagnoses that included Aftercare Following Joint Replacement, Pain in right Hip, and Presence of Right Artificial Hip Joint.	F 580		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review and facility policy review, the facility failed to respond and administer pain medication timely for a resident's complaint of severe pain rated initially at a ten (10) on a pain scale of (0-10) with 10 being the most severe for one (1) of four (4) sampled residents. Resident #2. Findings Include: Record review of the facility policy titled, "Pain Management Program Policy," revised 10/22, revealed, "The facility will ensure that residents receive the treatment and care in accordance	F 697	1. Resident #2 was discharged from the facility on 5/9/2024. Registered Nurse (RN)#1 and Licensed Practical Nurse (LPN) #1 was in serviced by the Director of Nursing on 6/6/24 on the pain management program policy to include identification of individuals with or at risk for pain with timely administration of pain medication following the professional standards of practice, development of comprehensive care plans and patient choices and alternatives, the follow up on effectiveness, along with any revisions needed related to pain management.	6/19/24

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F 697	Continued From page 5 with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management ... Monitoring ... 5. If a resident is experiencing pain during that shift, then pain medication and or alternative therapies should be administered as ordered ... Additional Guidance ... If pain has not been adequately controlled, it may be necessary to reconsider the current approaches and revise or supplement them as indicated ..." Record review of the facility policy titled "Medication Policies," revised 10/1/19, revealed, "Subsection: Ordering and Receiving Medications from Pharmacy Subject: Remote Medication Kits (Emergency Kits) and Controlled (Narcotic) Kits or Safe," ..."An initial or STAT supply of medications for first dose and continued doses until next regular, scheduled delivery, is maintained in the facility in limited quantities by the provider pharmacy in a portable, sealed containers per state and federal regulations. Procedure ...12. When contacting the attending physician regarding a change in condition where it is likely the physician will order a medication, the nurse is to inform the physician of the availability of remote medications in the facility (i.e. the contents of the remote drug supply). This will facilitate timely drug administration ..." On 6/6/24 at 12:20 PM, a telephone interview with Resident #2 revealed that upon arrival/admission at the facility, she reported severe pain in her right hip. She reported that she did not receive any medication for pain until later in the evening. The resident was unable to recall the exact time but reported that it was hours after her arrival. She stated that the nursing staff was not responsive to her reports of pain.	F 697	2. The facility has determined that 141 residents had the potential to be affected. 3. To prevent from re-occurring, beginning 6/6/24, the Director of Nursing began in-servicing licensed staff, and all staff on monitoring for pain, and providing interventions as needed when residents voice pain, displace non-verbal indicators of pain, to include notification to physician related to change of condition. On 6/7/2024, pain evaluations were completed for all 141 residents by the Registered Nurses/Licensed Practical Nurses to evaluate pain level over the last five days. All findings of the audit resulted in no concerns related to pain management. On 6/11/2024, an audit was conducted by the Registered Nurse/Licensed Practical Nurse Minimum Data Set (MDS) of all pain care plans. The audit reviewed six (6) residents that determined a care plan to be entered related to the resident's medical condition or risk of, with measurable goals and interventions. On 6/13/24, an in-service was conducted by the Regional Case Mix Registered Nurse via Teams with MDS Nurses on requirements to accurately develop and implement a comprehensive person- centered care plan for each resident, consistent with the resident rights and that includes measurable objectives and timeframes to meet a	

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F 697	Continued From page 6 Record review of the "New Admit/Readmits Hospital Report Sheet," dated 5/8/24 regarding a "Nurse-to-Nurse Phone Report", revealed the facility was made aware that Resident #2 had "Pain issues" prior to admission to the facility. The nursing staff was made aware that the last pain medication Resident #2 received prior to admission to the facility was on 5/8/24 at 12:15 PM. Record review of the hospital History and Physical dated 5/07/24 revealed that Resident #2 had right total hip arthroplasty (hip replacement) on 5/06/24. Record review of the "Progress Notes" dated 5/8/24 at 5:05 PM, revealed "Resident transferred to facility ...at 3:00 PM ...due to right hip fracture ...Resident is alert ...oriented x (times) 4 ...Resident reports pain 9 out of 10 on pain scale during assessment ...Narcotic script ...faxed to pharmacy ... standing order for Acetaminophen 325 MG (milligrams) two (2) tablets every six (6) hours as needed ..." Record review of the Baseline Care Plan-V-2 revealed " ...B. Communication: 1. Can the resident communicate easily with staff?... Yes ...2. Cognitive status: Cognitively intact ...E. Pain: 5/08/24 at 4:58 PM ...Most recent pain level: 10 ... Resident admitted to facility for skilled services ...aftercare following joint replacement surgery ..." Record review of the "Order Summary Report," with active orders as of 5/8/24, revealed an order dated 5/8/24 "Oxycodone-Acetaminophen Tablet 7.5-325 MG Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain for 7 (seven)	F 697	resident's medical, nursing, and mental and psychosocial needs to include pain management that are identified in the comprehensive assessment. 4. Beginning on 6/7/2024, an audit will be conducted weekly for twelve (12) weeks by the Director of Nursing, that will be submitted to the Administrator and the Corporate Clinical Specialist Nurse, then monthly for three months for all new admissions into the facility. This audit will include identification of individuals with pain through assessment, administration of pain medication and the effectiveness of the pain management program. A Quality Assurance meeting was held on 6/6/2024 with the Medical Director, Director of Nursing, Assistant Director of Nursing, Risk Manager, Administrator, Assistant Administrator, Corporate Clinical Specialist, Staff Development Coordinator, and the Registered Nurse Minimum Data Set Coordinator to review findings and current plan of corrections put in place. A report of audit findings beginning on 6/19/2024 will be submitted by the Director of Nursing to the Quality Assurance Performance Improvement committee monthly for three (3) months for further review and recommendations. The facility Director of Nursing is responsible for compliance.	

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F 697	Continued From page 7	F 697		

days." An additional order dated 5/8/24 revealed "Acetaminophen Oral Tablet 325 MG ... Give 2 (two) tablet by mouth every 6 hours as needed for pain."

Record review of the facility's electronic Medication Administration Record (eMAR) revealed Resident #2 received (1) tablet of Oxycodone-Acetaminophen 7.5-325 MG on 5/8/24 at 8:35 PM, (2) tablets of Acetaminophen 325 MG on 5/9/24 at 12:47 AM, (1) tablet of Oxycodone-Acetaminophen 7.5-325 MG on 5/9/24 at 2:55 AM and again at 8:56 AM.

On 6/6/24 at 3:15 PM, during an interview with Licensed Practical Nurse (LPN) #1 she confirmed that she was on duty on 5/08/24, when Resident #2 was admitted by the facility. She confirmed that she had not administered any pain medication to Resident #2 during her shift on 5/08/24. LPN #1 stated that she did not remember the resident's report of pain or an assessment regarding the resident's pain. LPN #1 revealed that pharmacy deliveries were usually made after 7:00 PM each evening.

On 6/6/24 at 3:40 PM, an interview with Registered Nurse (RN) #1 confirmed that on 5/08/24 she had been on duty from 7:00 AM to approximately 5:15 PM. The nurse stated that at approximately 3:00 PM, Resident #2 had arrived at the facility, and she had conducted a pain assessment. She confirmed that the resident had a written physician's prescription with her upon arrival for Oxycodone/Acetaminophen 7.5-325 MG one (1) tablet by mouth every 6 hours as needed for pain and she had faxed the prescription to the facility pharmacy. RN #1 confirmed that Resident #2 had reported pain

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F 697	Continued From page 8	F 697		

rated 9 on a 0-10 pain scale during her initial admission assessment. She stated that Resident #2 also had physician orders for Acetaminophen 325 MG two (2) tablets by mouth every six (6) hours as needed for pain. RN #1 confirmed that she had not administered any pain medication to Resident #2 on 5/08/24, as she was the RN Supervisor, not the resident's medication nurse. She confirmed that the facility had a policy and procedure in place that addressed pain management which included reporting to the resident's primary healthcare provider for direction and informing the physician of the availability of remote medications in the facility, although she said she was not sure which medications were in the emergency medication kit. She confirmed that she had not notified the resident's primary healthcare provider regarding the resident's pain.

On 6/6/24 at 6:11 PM, an interview with the Director of Nurses (DON) and record review of the "New Admit/Readmits Hospital Report Sheet," for Resident #2 revealed that the DON had taken the telephone report from a nurse at the hospital regarding discharge and history and physical for Resident #2. She indicated that she had recorded that the hospital nurse had reported the last pain medication (medication name not included) administration at the hospital was at 12:15 PM on 5/08/24. The DON confirmed that based on her notes the resident could have Oxycodone-Acetaminophen 7.5-325 MG at 6:30 PM on 5/08/24. She confirmed that in case pain was unrelieved by a resident's current pain regimen, the resident's nurse could notify the primary healthcare provider and report the resident's description of pain and make the provider aware of pain medications readily

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F 697	Continued From page 9	F 697		

available. She confirmed that there was no documentation or indication of any report of unrelieved pain to the primary healthcare provider. The DON confirmed that the resident had a total hip replacement surgery on 5/06/24. She confirmed that there was documentation of a report of pain rated 9 on a 0-10 pain scale during initial assessment and no documentation of administration of pharmacological or non-pharmacological pain management interventions for Resident #2 from 3:00 PM until 8:35 PM on 5/08/24. She confirmed that the facility had a policy and procedure for pain management which included notification of the resident's primary healthcare provider who could call in a prescription in accordance with the provider's determination of need and if available the medication could be retrieved from the emergency medication kit or delivered to the facility by the pharmacy.

On 6/06/24 at 6:20 PM, an interview with the Administrator revealed that nurses were responsible for pain assessments for new and existing residents. She said she was not aware that Resident #2's physician orders for Oxycodone-Acetaminophen 7.5-325 MG was not administered per orders at 6:15 PM on 5/08/24. She confirmed that the facility had procedures in place to obtain medications for new residents to be administered in a timely manner according to physician's orders. She confirmed that according to the documentation the resident complained of unrelieved pain not reported to the resident's primary healthcare provider on 5/08/24.

Record review of the contents of the facility's EDK (Emergency Drug Kit) revealed the kit contained Oxycodone-Acetaminophen 5-325 mg and

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F 697	Continued From page 10 Oxycodone-Acetaminophen 10-325 mg. Record review of the Admission Record for Resident #2 revealed the facility admitted the resident on 5/08/24, with diagnoses that included Aftercare Following Joint Replacement, Pain in right Hip, and Presence of Right Artificial Hip Joint.	F 697		