MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #27490 and CI MS #27491 at the facility on 1/23/25. The SA returned to the facility on 2/3/25 to extend the survey. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. This was based on the facility's implementation of corrective actions on 12/31/24 and was Past Non-Compliance (PNC). CI MS # 27490 was investigated regarding infection control, equipment not being maintained, and physical environment and there were no citations related to that complaint. CI MS # 27491 was a facility reported incident (FRI) and was investigated regarding resident abuse, safety, and quality of care. The facility failed to protect a resident's right to be free from physical and emotional abuse. The SA cited M500 related to this FRI. The facility's failure to protect Resident #1 when Certified Nursing Aide (CNA) #1 physically and emotionally abused Resident #1 on 12/25/24 by handling the resident roughly, spraying cold water on the resident's face, shaking the shower bed, and turning off the lights in the shower room while laughing, resulted in the resident reporting that he felt "sad, taken advantage of, and a little afraid" and the facility did not immediately remove the abuser from the facility. The facility's failure to report the abuse within the required timeframe when Licensed Practical Nurse (LPN) #1 witnessed the physical and emotional abuse of Resident #1 on 12/25/24 but the facility did not report it to the State Agency until 12/30/24, delayed the facility's ability to protect this resident from further harm.	M 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 000	Continued From page 1 During the investigation of the FRI, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 12/25/24 existed at Rule 45.17.2 Residents' Rights (M500) - Level IV The abuser was not immediately removed from the facility which left Resident #1 and other residents in a situation that was likely to result in ongoing serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 2/3/24 at 2:40 PM. Based on the facility's implementation of corrective actions on 12/31/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 1/1/25, prior to the SA's entrance on 1/23/25.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility,	M 500		2/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 2	M 500		

and of related charges including any charges for services covered by the facility's basic per diem rate;

3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 3	M 500		

established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 4 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 5 personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV Based on interviews, record review, and facility policy review, the facility failed to protect the residents' right to be free from physical abuse from a staff member for one (1) of five (5) sampled residents. Resident #1 Resident #1 was physically and emotionally abused on 12/25/24 when Certified Nursing Aide (CNA) #1 handled him roughly, sprayed cold water on his face, and turned out the lights in the shower room, while laughing. The facility's failure to protect resulted in Resident #1 reporting he felt "sad, taken advantage of, and a little afraid." Additionally, the facility's failure to immediately remove CNA #1 from the facility placed this resident and other residents at risk for similar abuse. The situation was determined to be Immediate jeopardy (IJ) and Substandard Quality of Care (SQC). The State Agency (SA) notified the Administrator of the IJ and SQC on 2/3/25 at 2:40 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 12/31/24, the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 1/1/25 prior to the SA's entrance on 1/23/25. Findings include:	M 500	No Plan. Past non compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 6 A review of the facility's, "Abuse Prohibition Policy" dated 5/17/24, revealed, "Intent: This protocol was intended to assist in the prevention of abuse ...Policy:1. The facility will prohibit neglect, mental or physical abuse ..." A record review of the "Admission Record" revealed the facility admitted Resident #1 on 8/22/24 with diagnoses including Hypertension and Depression. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. A record review of the facility's investigation, dated 1/2/25, revealed that on 12/30/24, the Director of Nursing (DON) received notification that a CNA had handled a resident roughly during activities of daily living (ADL) care, which included spraying a resident in the face with cold water and turning the light off in the shower room prior to exiting the room, leaving another employee and the resident in darkness. The incident occurred on 12/25/24. A review of the corrective actions revealed the facility put immediate actions in place including suspending and terminating the perpetrator and the facility's Administrator. The resident was provided support and reassurance, a body audit was conducted, and the allegation was reported, and appropriate notifications, including law enforcement were made. Life Satisfactions Rounds and Peer reviews were initiated, and Trauma Assessment was performed on Resident #1. A Quality Assurance Performance Improvement (QAPI) committee meeting was held on 12/31/24. In-services were	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 7	M 500		

completed on abuse, resident rights, and vulnerable the adult act.

A record review of the "Witness Statement", completed by Licensed Practical Nurse (LPN) #1 and signed on 12/26/24, revealed, "I, (Proper Name of LPN #1), witnessed CNA (name not provided) cause emotional abuse to resident (Proper Name of Resident #1). While giving the resident a shower, CNA turned on the shower and sprayed the resident in the face with the water. Resident hollered out loudly, telling CNA to stop. Writer also told CNA not to do it anymore. CNA roughly wiped the resident's body parts. Resident started crying for CNA to stop and please let her (writer) do my shower. Writer told CNA she would take over with the shower. Writer asked CNA to just spray the soap off. CNA then turned the water from warm to cold and began spraying the resident. Resident began to scream, telling CNA the water is too cold. CNA only laughed and told the resident he will be ok. CNA began to shake the resident's bed side to side roughly. Resident began to scream 'stop.' Writer also told CNA to stop and that the resident could fall off the shower bed. CNA replied, 'it's your wheels screeching.' Also, while writer was drying the resident off, CNA went and turned the lights off, causing darkness. Both writer and the resident screamed, telling CNA to stop. CNA just laughed it off. When writer got done dressing the resident, I asked CNA how he would transfer the resident back to bed without a sling because he wet the previously one up, he replied, 'watch this, he's going to roll and go for a ride.' CNA put the shower bed beside the resident's bed and told resident, 'your about to roll on your stomach then to your back' and proceeded to push the resident from the shower bed to his bed. Writer walked out."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 8 A record review of the timecard for CNA #1 revealed he worked at the facility from 6:30 AM to 7:00 PM on 12/25/24 and 12/26/24. He also worked from 6:30 AM to 4:45 PM on 12/30/24, which was after the abuse occurred on 12/25/24. On 1/23/25 at 9:46 AM, during an interview with Resident #1, he recalled the incident in the shower and explained CNA #1 roughly handled him roughly and sprayed cold water on his face. He stated that he told CNA #1 it was cold, and CNA #1 laughed in response. Later, when CNA #1 began drying him off, it hurt and at that point, the nurse intervened and took over, which felt much better to him. He expressed that he was not afraid or upset, but the incident did make him feel sad that he was taken advantage of. CNA #1 did not take care of him anymore after that. At 11:18 AM on 1/23/25, during a phone interview with LPN #1, she recalled the incident involving CNA #1, where she witnessed as he began to get the resident from the bed. As he did so, he placed both his hands on the sides of the bed and shook it from side to side. She told him to stop because the resident could fall off the bed. He complied, but in response, CNA #1 thought it was funny and stated, "He will be alright." After that, CNA #1 wheeled the resident out to the shower room and into the stall and she was there to assist as well. At that time, he took off the resident's gown, turned on the water, and sprayed the resident in the face with the shower sprayer. LPN#1 yelled, "What are you doing? The water is still cold!" She observed Resident #1's face grimace as if he was in pain, and he then stated, "It's cold, it's cold." She asked CNA #1 why he did that, but he shrugged her off and waited until the water warmed up. LPN#1 began to lather the resident's	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 9	M 500		

body with body wash while CNA #1 sprayed him down with warm water. After CNA #1 finished, he grabbed a towel and began to wipe the resident down roughly. The resident said, "It hurts," so she commanded CNA#1 to stop, and let her handle it. She then took the towel and began to wipe the resident gently. She indicated that CNA #1 continued to laugh it off, and turned the lights off, she and the resident screamed, and he turned them back on.

On 1/23/25 at 12:02 PM in an interview with the current Administrator, she revealed the incident occurred with the previous Administrator, but she was aware of the situation. During the investigation, the facility determined that the event occurred and terminated CNA #1 and the Administrator.

On 1/23/25 at 1:12 PM, during a phone interview, CNA #1 revealed that he has worked at the facility for the past two years. He explained that he is aware but does not know the source of the allegations regarding Resident #1. He confirmed that a nurse he does not know and claims to have never seen before assisted him while he was showering the resident. He stated that he does not recall spraying cold water on the resident's face, adding that all he remembers is the resident saying the water was too hot. He reiterated, "I did not do anything to the resident." CNA #1 further explains that the Administrator never spoke with him about anything. All he knows is that on 12/30/24, he was told to go home because an investigation had been opened regarding him. He stated that he did not ask what it was about nor was he informed, and a few days later, someone from Human Resources called him and told him he was fired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 10 On 1/23/25, at 1:36 PM, during an interview with the DON, she revealed that the incident occurred on 12/25/24, however, she did not learn about it until Monday, 12/30/24. She immediately suspended CNA#1 and began inservicing staff as the they were not allowed to work until in serviced on abuse and neglect. The Administrator was on vacation at the time. She indicated that she could not readily remember if CNA #1 had been written up for similar actions and was surprised that he would be accused of such behavior. She noted that he had been working with the same group of men for at least three (3) or four (4) months and that during her interviews after the event, the men spoke fondly of him, although she did add that he "plays a lot." On 1/23/25 at 2:57 PM, in a phone interview with the previous Administrator, she explained that she worked on 12/26/24 and 12/27/24, which were on Thursday and Friday, and then she was off for vacation. During that time, LPN #1 came to talk with her and informed her about the incident with CNA #1 and Resident #1, mentioning that the CNA had the water set too cold during the shower. The former Administrator explained that was all LPN #1 said about the situation, so she instructed the nurse to write a statement and put it in her box. Afterward, she went to interview Resident #1 while he was sitting outside his door, and he denied that anything had happened to him other than the shower being cold. She asked him if someone had hurt him, and he specifically said "No." She then told the resident that she would speak with the CNA anyway, and the resident seemed concerned, asking, "What are you going to talk with him about?" She reassured the resident that there was nothing to worry about. The Administrator stated she then attempted to interview CNA #1 by	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 11	M 500		

calling him on the phone, but he did not answer and was not scheduled to work that day. She noted that the written statement by LPN #1 was completely different from what she had verbally reported. She stated she was surprised to be suspended and later terminated regarding this event.

On 2/3/25 at 10:00 AM, in a follow up interview with Resident #1, he recalled being a "little afraid" when CNA #1 was shaking the shower bed because he could have fallen. He acknowledged that he was sprayed in the face but was most upset about being wiped and handled roughly. Resident #1 confirmed that he did cry out during the shower for CNA #1 to stop and that it was several days before anyone at the facility asked him any questions about it.

On 2/3/25 at 10:18 AM in a follow-up interview with LPN #1, she stated that the event occurred on 12/25/24 in the afternoon, and she thought it may have been after 3:00 PM. She explained both she and CNA #1 were working a 12 hour shift that day. She stated that CNA #1's behavior in the shower room scared her because it seemed odd to her. LPN #1 could not recall if CNA#1 was in the resident's room after the shower when she left the room, but she immediately reported what had happened to Registered Nurse (RN) #1 who was the charge nurse. She explained RN #1 was at the nurses station when she reported the abuse and there were other staff members that were there and may have heard her report. She reported everything that happened in the shower room to the charge nurse. LPN #1 further explained that on the following day, 12/26/24, she was working at the facility and the Administrator was there. She reported the CNA's abusive behavior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 12 Administrator at that time, who instructed her to write a statement. She wrote the statement and handed it directly to the Administrator and did not put it in a box. She said the Administrator did not ask her any questions about it. On 2/3/25 at 10:53 AM, in a phone interview with LPN #2, she stated that on 12/25/24, she walked up on RN #1 and LPN #1 as they were discussing the incident that occurred in the shower room with Resident #1 and CNA #1. She explained that LPN #1 was upset, but she was not sure of everything that was said because she was passing by and just heard part of the conversation. LPN #2 was unsure of how many days CNA #1 worked after 12/25/24. On 2/3/25 at 11:33 AM, in a phone interview with CNA #2, she stated that she was working on 12/25/24. She explained that she worked close to the shower room and recalled hearing noises and hollering from the shower room. She described it as "kind of unusual" but that CNA #1 always talked loudly. She stated that she saw LPN #1 and RN #1 talking but did not hear much of the conversation. She said that LPN #1 was upset and was saying she "couldn't believe" what was happening. On 2/3/25 at 11:45 AM, in an interview with RN #1, she stated that she left the facility on 12/25/24 around 1:30 PM to 2:00 PM and denied being at the facility when the event occurred. She stated she did not hear about it until the next day (12/26/24) when LPN #1 told her about it and said she was going to report it to the Administrator. She said that the nurse did not go in detail, but said she was uncomfortable with what had happened.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE (	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) COMPLETE DATE
M 500	Continued From page 13 On 2/3/25 at 1:00 PM, in an interview with the current Administrator and the DON, they confirmed the CNA continued to work his shift on 12/25/24 and he also worked on 12/26/24 and until around 4:00 PM on 12/30/24. The DON stated she received the call from corporate around 4:00 PM inquiring if the allegation was reported to the SA. She was unaware of the incident because she was off the week of Christmas. The DON and Administrator stated that as part of their investigation they conducted interviews regarding the nurse's inaction. The nurse (LPN #1) said that she reported the incident immediately, but when they interviewed the charge nurse, she denied this. They felt like it was a "she said, she said" situation and was unable to find out where the breakdown occurred. They said they interviewed the staff that worked on 12/25/24, but none of them stated they heard LPN #1 telling the charge nurse about the abuse. Based on the implementation of the facility's corrective actions on 12/31/2024, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 1/1/25. Validation: The SA validated on 1/23/2025, through interview and record review that all corrective actions had been implemented as of 12/31/24, and the facility was in compliance as of 1/1/25, prior to the SA's entrance on 1/23/2025.	M 500		