Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE CENTER	**102 WOODCHASE PARK DRIVE , CLINTON, Mississippi, 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
M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs), MS #2580436, CI MS #2576119, CI MS #476635, and CI MS #476638 at the facility from 8/11/25 through 8/15/25. CI MS #2580436 was investigated for resident not turned/repositioned, environment, resident left wet and soiled, and resident not treated with respect and dignity. CI MS #2576119 was investigated for resident not dressed properly, resident not groomed, environment, and odors in the facility. CI MS #476635 was investigated for neglect, misappropriation, and resident left soiled. CI MS #476638 was investigated for accidents and Resident Representative (RR) not notified of changes. There were no citations regarding the CIs. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M640, M715, and M1570.	M0000		
M0500	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, and of related charges including any charges for services covered by the facility's basic per diem rate;	M0500		

Office of Primary Care and Health Systems Management

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

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M0500	Continued from page 1 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 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	M0500		

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M0500	Continued from page 2 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; 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);	M0500		

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M0500	Continued from page 3 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 personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure that a resident was informed of their right to formulate an advance directive (AD) and was provided assistance to do so for one (1) of (26) sampled residents (Resident #22). Findings Include: A review of the facility's policy, "Resident Rights," undated, revealed, "…Facility must protect and promote the rights of each resident, including each of the following rights … 5. Advance Directives …a… Facility will inform and provide written information to Resident concerning the right to accept or refuse medical or surgical treatment and, at the Resident's option, formulate an advance directive…" A record review of Resident #22's clinical record revealed there was no documentation indicating whether the resident had been informed of ADs or was offered assistance by the facility in formulating one. On 8/12/25 at 8:00 AM, during an interview and concurrent observation of the electronic health record (EHR), Licensed Practical Nurse (LPN) #1 in Medical Records confirmed that Resident #22 had no documentation indicating the resident had been informed or was offered assistance in formulating an AD. LPN #1 explained that if it was not scanned into the system, then it was not present in the building, and verified that the resident's entire chart had been scanned into the new system. On 8/12/25 at 1:26 PM, during an interview with the Administrator, she confirmed that Resident #22's AD had	M0500		

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M0500	Continued from page 4 lived in the facility for several years. She acknowledged that a care plan conference was held on 8/6/25 with the resident, at which time it was identified that the resident had no Power of Attorney (POA) or AD in place. However, the Administrator confirmed that, since that time, the facility had taken no steps to ensure the resident was informed of their right to formulate an AD or offered assistance in doing so. A record review of the “Admission Record” revealed Resident #22 was initially admitted by the facility on 6/17/16 with diagnoses including Unspecified Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/25 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A record review of the Care Plan Conference document, dated 8/6/25, revealed interdisciplinary team (IDT) discussion that Resident #22 did not have an AD plan.	M0500		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident #140) received supervision and assistance during activities of daily living (ADL) bathing to prevent accidents or injury. The facility failed to ensure staff followed the resident's functional status, used appropriate transfer assistance, and sought help when the resident displayed signs of weakness during a shower transfer. Findings included: On 08/13/2025 at 11:44 AM, during an observation, Certified Nursing Assistant (CNA)# 3 was observed providing shower care to Resident #140. The resident was seated on a rolling shower chair and required transfer back to his wheelchair. CNA #3 instructed Resident #140 to stand twice to be dried and dressed. The resident was visibly weak and unsafe while standing	M0640		

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M0640	Continued from page 5 both times. During the second attempt, the resident's arms were noted to shake while holding himself upright. No other staff were present during the bathing process, and CNA#3 did not request assistance. On 08/13/2025 at 2:01 PM, during an interview CNA #3, explained it was their first time caring for Resident #140. When asked how a CNA would know how to safely transfer a resident, they stated, "It's usually in the care plan, but I can usually look in a room at a resident and decide if they can walk... I can tell if they need two people or not if I see a lift pad or other things in the room." CNA #3 reported they had assistance transferring the resident to the wheelchair earlier but did not think help was needed in the bathroom because "he had done so well in the room." When asked why assistance was not sought during the observed episode of weakness, CNA#3 stated they did not want to leave the resident alone and chose not to call using the call light because they "didn't think anyone would answer it" and the surveyor was present. CNA #3 acknowledged the resident's arms were visibly shaking but stated they did not want to place the resident back in the shower chair because it had been soiled with stool. They admitted in hindsight that it would have been safer. When asked whether it was within a CNA's scope to determine transfer needs by observation alone, they responded, "No," and acknowledged that improper transferring could lead to resident falls and injury. On 08/13/2025 at 5:10 PM, during an interview the Director of Nursing (DON), explained the resident was listed as a one-person assist upon admission assessment. The DON stated that CNA #3 should have sought help or sat the resident back down when he became visibly unstable. The DON confirmed that both the care plan and CNA Point of Care Kardex contain transfer status guidance. The DON stated that failure to follow proper transfer protocols or making assumptions about resident ability based solely on appearance, places the resident and staff at risk for injury. A review of the Admission Record revealed Resident #140 was admitted on 08/06/2025 with a diagnosis of Syncope and Collapse, a condition that may contribute to weakness or fainting.	M0640		
M0715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements.	M0715		

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M0715	Continued from page 6 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure medications were securely stored and monitored to maintain safety and integrity for one (1) of five (5) residents reviewed for medication administration and storage, Resident #62. Findings included: Record review of facility storage and medication policy dated July 2024 review 6/24/2025 reveal the facility stores all drugs and biologicals in a safe secure and orderly manner. On 08/13/2025 at 11:32 AM, during an observation, a medication prescribed to Resident #62 was noted sitting unattended on the bedside table. The medication was Dulera Inhalation Aerosol 100-5 MCG/ACT (Mometasone Furoate–Formoterol Fumarate Dihydrate). The label included resident-identifying information and dosage instructions: “2 puffs orally, twice daily”. The medication was not secured in a medication cart or locked storage area, and no staff were present in the room. Record review of the “Order Details” revealed a physician order dated 8/8/25 for “Dulera Inhalation Aerosol…related to Acute and Chronic Respiratory failure with hypoxia.” A review of the resident’s August 2025 Medication Administration Record (MAR) revealed Dulera was ordered for treatment of acute and chronic respiratory failure with hypoxia. A review of the Admission Record revealed Resident #62 was admitted to the facility on 7/23/25 with diagnoses that included acute and chronic respiratory failure with hypoxia. A review of the resident’s most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/28/2025 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. On 08/13/2025 at 11:32 AM, during an interview, the Director of Nursing (DON) stated that nurses were not supposed to leave medications in residents’ rooms. She stated that Resident #62 would not be able to self-administer the inhaler. The DON removed the medication from the room.	M0715		

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M0715 M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to maintain an infection prevention and control program to help prevent the possible development and transmission of communicable diseases and infections for three (3) of 26 sampled residents, as evidenced by failing to conduct hand hygiene between glove changes (Resident #5 and Resident #115) and failing to adhere to Enhanced Barrier Precautions (EBP) during care (Resident #32). Findings Include: Review of the facility's policy, "Infection Prevention and Control Program" with a revision date of 6/30/25 revealed "Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection…" Review of the facility's "Non-Sterile Dressing Change Skills Checklist", dated 6/27/25, revealed, "…Step 10 Remove gloves, place in plastic bag Step 11 Wash hands	M0715 M1570		

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M1570	Continued from page 8 (or hand sanitizer) & put on gloves…" Review of the facility's "Handwashing/Hand Hygiene Residents" with a revision date of 6/30/25 revealed "Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections…" Review of the facility's "Enhanced Barrier Precaution" dated 6/30/25 revealed, "… EBP refer to infection control interventions designed to reduce transmission of multidrug-resistant organism that employ targeted gown, and gloves use during high contact residents care activities…" Resident # 5 On 8/13/25 at 1:03 PM, during an observation of wound care for Resident #5's left foot, Registered Nurse (RN) #3 removed and changed gloves a total of five (5) times throughout the procedure without performing hand hygiene between glove changes. On 8/13/25 at 1:23 PM, during an interview with Registered Nurse (RN) #3, he explained that he was not aware hand hygiene should be performed between glove changes. He acknowledged that failing to do so was an infection control issue with the potential to spread infection to Resident #5's wound. He further stated that he had previously received training on infection control. On 8/13/25 at 5:10 PM, during an interview with the Director of Nursing (DON), she explained that Registered Nurse (RN) #3 should have performed hand hygiene with either soap and water or hand sanitizer between each glove change. She stated that by not doing so, RN #3 placed the resident at risk for infection during wound care. A record review of the "Admission Record" revealed the facility admitted Resident #5 on 5/30/23 with current diagnoses including Pressure Ulcers. A record review of the "Order Summary Report" revealed Resident #5 had a Physician's Order, dated 8/7/25, for wound care to the 5th toe on the left foot. A record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/4/25 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Resident # 115	M1570		

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M1570	Continued from page 9 On 08/13/2025 at 1:58 PM, in an observation of Resident #115 receiving perineal care by Certified Nursing Assistant (CNA) #2, the CNA applied gloves but did not place a gown on. She removed the front of the resident's brief, which was heavily soiled, and then used pre moistened perineal wipes from a package, pulling out two to three wipes at a time while continuing to wear dirty gloves. Throughout the care, she removed soiled gloves and applied clean gloves a total of four times but never performed hand hygiene with soap and water or hand sanitizer between glove changes. There was signage on the resident's door indicating Enhanced Barrier Precautions. On 08/13/2025 at 2:16 PM, in an interview with Certified Nursing Assistant (CNA) #2, she confirmed she did not wear a gown while providing perineal care and did not perform hand hygiene during the care for Resident #115. She stated she was supposed to apply a gown before starting perineal care. She acknowledged she forgot to wash her hands and apply a gown. She explained she had received training on hand hygiene and Enhanced Barrier Precautions. She stated she also forgot to place a barrier on the table and to remove all needed wipes from the package before starting care. She acknowledged she was not supposed to pull wipes out of the package with dirty gloves on. She stated Resident #115 was placed at risk for infection due to her not following Enhanced Barrier Precautions, not performing hand hygiene, and pulling wipes out of the package with contaminated gloves. On 08/13/2025 at 5:13 PM, in an interview with the Director of Nursing (DON), she explained that CNA #2 should have placed a barrier on the table and gathered all needed supplies, including pulling wipes out of package, before beginning care for Resident #115. She stated the CNA should have washed her hands and donned (put on) a gown prior to starting perineal care. She further stated that CNA #2 placed the residents at risk of infection by not following the facility's Enhanced Barrier Precautions policy during care. Record review of the "Admission Record" revealed the facility admitted Resident #115 on 9/29/20 with diagnosis including of Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease. Record review of the Comprehensive Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/24/25 revealed Resident #115 had a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive impairment.	M1570		

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M1570	Continued from page 10 Resident #32 On 8/13/2025 at 9:00 AM, during an observation of Percutaneous Endoscopic Gastrostomy (PEG) site care performed by Licensed Practical Nurse (LPN) #2, a protective gown was not worn during the procedure. On 8/13/2025 at 3:15 PM, during an interview with the Director of Nursing (DON) with the Administrator present, the DON confirmed that a gown should be worn during care identified for EBP and stated she would conduct additional staff training. On 8/13/2025 at 4:02 PM, during an interview, LPN #2 acknowledged that she did not wear a gown during the procedures and agreed this was an infection control issue. A record review of the “Admission Record” revealed the facility admitted Resident #32 on 3/13/20 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 5/11/25, revealed Resident #32 had a BIMS of 00, which indicated severe cognitive impairment. A record review of the “Order Details” revealed a physician’s order, dated 7/29/24, for PEG site care.	M1570		