STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255148	(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
F0000	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 requirements of participation in Medicare and Medicaid and cited F578, F656, F689, F698, F759, F761, F842, F867, and F880. The facility had a census of 128 and was licensed for 145 beds.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or	F0578		

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

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F0578 SS = D	Continued from page 1 surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This 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	F0578		

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F0578 SS = D	Continued from page 2 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 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.	F0578		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), 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. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F0656		

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F0656 SS = D	Continued from page 3 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, facility policy review, and interview, the facility failed to implement care plan interventions related to Enhanced Barrier Precautions for one (1) of 26 sampled residents (Resident #115). Findings included: Review of the facility's policy "Care Plans Comprehensive Person-Centered", with a review date of 6/2/25, revealed, "A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical psychological and functional needs is developed and implemented for each resident…" Record review of the "Care Plan Report" for Resident	F0656		

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F0656 SS = D	Continued from page 4 #115 revealed a “Focus” of “Resident requires Enhanced Barrier Precautions r/t (related to) Feeding tube” with “Interventions/Tasks” including “EBP…used during high-contact resident care activities as applicable such as…Changing briefs…” On 08/13/2025 at 1:58 PM, in an observation of Resident #115 receiving perineal revealed Certified Nursing Assistant (CNA) #2 did not wear a protective gown. On 08/13/2025 at 2:16 PM, in an interview with CNA #2 confirmed that she did not wear a gown doing peri care or washing hands doing care. She stated she was supposed to put on a gown before starting peri care. She stated she forgot to put on the gown. She stated she has had training on Enhanced Barrier Precautions. (EBP). On 08/14/25 at 11:36 AM, in an interview with Registered Nurse (RN)/Minimum Data Set (MDS)/Care plan nurse stated CNA #2 did not follow the comprehensive care plan. She stated the purpose of the care plan is to help staff take care of the Resident. She stated she expects the staff to follow the care plan. She stated CNA #2 should have worn a gown while providing 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.	F0656		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This 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	F0689		

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F0689 SS = D	Continued from page 5 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 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	F0689		

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F0689 SS = D	Continued from page 6 appearance, places the resident and staff at risk for injury. A record review of the Admission Assessment – Functional Abilities, dated 08/08/2025, section GG of the Minimum Data Set (MDS), revealed the resident was coded as “01 – Dependent,” meaning the helper does all of the effort, or that two or more helpers are required to complete the activity. 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.	F0689		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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 interview and record review, the facility failed to ensure that one (1) of (26) sampled residents (Resident #46) receiving dialysis treatment was transported in a timely manner to receive the full duration of the prescribed treatment. This resulted in multiple shortened dialysis sessions over the previous month and placed the resident at risk for adverse health outcomes, including hyperkalemia, gastrointestinal distress, and other dialysis-related complications. Findings included: On 08/12/2025 at 10:58 AM, during an interview, Resident #46 reported that she had been consistently arriving late to her scheduled dialysis appointments and stated, “I’m supposed to be there by 11:00, but I’ve been getting there around 12:00.” She further stated that her dialysis sessions had been shortened as a result. On 08/14/2025 at 11:46 AM, during an interview with the dialysis Nurse Manager, they explained that Resident #46 had arrived more than 15 minutes late to her appointments on five separate occasions in the last	F0698		

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F0698 SS = D	Continued from page 7 month: 07/25/2025, 07/28/2025, 08/08/2025, 08/11/2025, and 08/13/2025. The dialysis Nurse Manager stated that the resident's scheduled "chair time" was 11:30 AM to 3:00 PM, and her average arrival time had been 12:16 PM. She stated the resident's late arrivals had caused the clinic to reschedule her chair time to 11:55 AM to 3:25 PM effective 08/15/2025, making her the last patient of the day and resulting in early removal from dialysis on late arrival days because the clinic closes at 5:00 PM. The dialysis Nurse Manager reported that shortened dialysis sessions result in incomplete treatment, and complications associated with inadequate dialysis include hyperkalemia (high potassium), nausea, vomiting, and itching. On 08/14/2025 at 12:05 PM, during an interview Director of Nursing (DON), explained that they had contacted the dialysis clinic and were told the resident had only been late "a few times" and only by about ten minutes. The DON stated that the chair time had been adjusted effective 08/12/2025, which may have contributed to the resident's tardiness on that date. On 08/14/2025 at 2:29 PM, during an interview with Driver# 1, explained that the dialysis clinic had informed him of a chair time of 11:50 AM, which was later changed to 11:55 AM effective 08/12/2025. He stated the resident was only late on 08/13/2025 due to that change. He acknowledged that the dialysis clinic had made multiple chair time changes without clearly communicating them and that one of the facility's vans was currently out of service, causing occasional delays in transportation. However, he confirmed that dialysis patients were treated as a transport priority. A review of the dialysis attendance log and interview documentation confirmed that the resident had repeatedly arrived late, leading to shortened treatment durations and increasing the risk of adverse medical outcomes due to incomplete dialysis sessions. On 8/14/25 at 5:30 PM, in an interview with Resident #46, she stated that it is frustrating and inconvenient the fact that her chair time is being changed to later in the day because her body is used to the time already. She doesn't understand why the facility can't just take her early and drop her off at the dialysis facility so she doesn't miss getting her whole treatment she started and wondered why the facility can't get her there on time. On 08/15/2025 at 1:00 PM, In an interview with the Administrator, she stated that the company had two vans go down one due to the air conditioning being out on one and the other due to car wreck damage. This led to the facility using the only	F0698		

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F0698 SS = D	Continued from page 8 service for transport in town to cover more appointments, however this provider had a past history of being late for dialysis, so the facility van drivers are responsible for getting residents to and from dialysis and it is her expectation that residents be transported in a timely manner to their appointment and follow policy and doctor's orders.Record review of the “Admission Record” revealed Resident #46 was admitted on 7/23/25 with diagnoses that included End Stage Renal Disease. Record review of the “Order Summary Report” with active orders as of 8/14/25 revealed a physician order dated 7/25/25 “Resident to receive hemodialysis three (3) days a week on M/W/F (Monday, Wednesday, Friday) at (Proper name of dialysis center) …Chair Time: 11:30 AM.”	F0698		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to maintain a medication error rate below five (5) percent (%), for two (2) of 31 medication opportunities observed, resulting in a 6.45 % medication error rate. Included was Resident #3, who was not instructed to rinse with water following administration of a steroid inhaler, and Resident #141, for whom the nurse prepared an incorrect dosage of Thiamine. Findings include: Record review of facility “Medication Administration” policy, reviewed and revised June 2025, revealed “Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation… 10. The individual administering the medication checks the label THREE (3) times to verify the right resident right, right medication, right dosage, right time and right method (route) of administration before giving the medication…"	F0759		

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F0759 SS = E	Continued from page 9 Resident #3 On 8/13/2025 at 8:33 AM, during an observation of medication administration, Licensed Practical Nurse (LPN) # 5 administered Symbicort Inhalation Aerosol to Resident #3. LPN #5 did not rinse Resident #3's mouth after administering the inhalation medication. LPN# 5 explained that she forgot and acknowledged that mouth rinsing should occur because "it can cause thrush," and reported she would go back and do it. On 8/12/2025 at 11:30 AM, during an interview with the Director of Nursing (DON), explained that a resident's mouth should be rinsed with water following administration of an inhaled corticosteroid, such as Symbicort, to prevent oral thrush. A record review of "Order Summary Report" with active orders as of 8/14/25 revealed an order dated 7/18/25 "Symbicort Inhalation Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate), two (2) puffs inhaled orally every morning and at bedtime for wheezing…" A record review of the "Admission Record" for Resident #3 revealed the facility admitted the resident on 7/18/2025 with diagnoses that included Toxic Encephalopathy. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/2025 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of (14), indicating the resident was cognitively intact. A record review of the "Quick Guide to Using Your Symbicort Inhaler", dated 2018, revealed, "…After you finish taking Symbicort…rinse your mouth with water. Spit out the water…" Resident #141 On 8/12/2025 at 8:14 AM, during an observation of medication administration, LPN #6 prepared medications for Resident #141. She prepared Thiamine 100 mg and placed it in the medication cup with the resident's other medications to be administered. The resident's physician orders indicated the correct dosage as Thiamine 50 mg. On 8/12/2025 at 8:30 AM, during an interview with LPN #6, she confirmed she intended to administer the medications to Resident #141, however, when she reviewed the Thiamine medication label, she confirmed	F0759		

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F0759 SS = E	Continued from page 10 the dosage was listed as Thiamine 100 milligrams (mg). She removed the 100 mg tablet and explained that it was what they had available. On 8/12/2025 at 10:15 AM, during an interview the DON, explained that administering an incorrect dose could result in negative outcomes and that medications must be administered in accordance with physician orders. A record review of the “Admission Record” revealed the facility admitted Resident #141 on 8/5/2025 with diagnoses including Fracture of Shaft of Humerus. A record review of the Medication Administration Record (MAR) for August 2025 revealed Resident #141 had a Physician’s Order, dated 8/12/25, for Thiamine HCl Oral Tablet 50 mg to be given by mouth every morning as a supplement.	F0759		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and	F0761		

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WOODLANDS REHABILITATION AND HEALTHCARE CENTER	102 WOODCHASE PARK DRIVE , CLINTON, Mississippi, 39056

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F0761 SS = D	Continued from page 11 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.	F0761		
F0842 SS = D	Resident Records - Identifiable Information	F0842		

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F0842 SS = D	Continued from page 12 CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F0842		

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F0842 SS = D	Continued from page 13 §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to maintain a complete and accurate medical record by not documenting whether a resident had an advance directive (AD) in place, declined to complete one, or was offered assistance to formulate one for one (1) of (26) sampled residents (Resident #22). Findings Include: A record review of Resident #22's clinical record revealed there was no documentation indicating whether the resident had an AD in place, declined to complete one, or had been offered assistance by the facility in formulating one. During an interview and concurrent observation of the	F0842		

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F0842 SS = D	Continued from page 14 electronic health record (EHR), on 8/12/25 at 8:00 AM, Licensed Practical Nurse (LPN) #1 in Medical Records confirmed that Resident #22 had no documentation indicating the resident did or did not have an AD. The LPN verified Resident #22's entire chart had been scanned into the new system and commented that if the information was not scanned into the system, then it was not present in the building. During an interview on 8/12/25 at 1:26 PM, the Administrator, confirmed that Resident #22's information regarding an AD was not readily available in the medical record. The Administrator reported that the resident had lived for several years in the facility and 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 documentation of the resident's AD status in the medical record. 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.	F0842		
F0867 SS = D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident	F0867		

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F0867 SS = D	Continued from page 15 representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F0867		

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F0867 SS = D	Continued from page 16 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F0867		

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F0867 SS = D	Continued from page 17 This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to maintain a medication error rate below 5 percent (%) during an annual recertification survey on 4/11/24 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of nine (9) deficiencies cited. (F759) Findings Include: Review of the facility's policy "Quality Assurance Performance Improvement" (QAPI) Program, reviewed 6/25, revealed, "…The purpose of Quality Assurance Performance Improvement committee is to create a system for improving the care for our residents…" Record review of the "Provider History Profile" revealed the facility received a citation for F759 – Free of Medication Error Rates 5 Percent or More. Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 4/11/24, revealed the facility received a citation for F759, "…Based on observations, interviews, record review, and facility policy review, the facility failed to maintain less than a 5% medication error administration rate for two (2) errors of 25 medication administration opportunities. This observation resulted in an 8% medication error rate…" During the current recertification survey, the facility failed to maintain a medication error rate below five (5) percent (%), for two (2) of 31 medication opportunities observed, resulting in a 6.45 % medication error rate. This included Resident #2, who was not instructed to rinse with water following administration of a steroid inhaler, and Resident #141, for whom the nurse prepared an incorrect dosage of Thiamine. On 8/15/25 at 2:20 PM, during an interview with the Nursing Home Administrator (NHA), she explained the Quality Assurance Committee meets quarterly and all members attend. She acknowledged awareness of previous citations and reported that the facility plans to	F0867		

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F0867 SS = D	Continued from page 18 increase education and provide one-on-one training. She explained that additional monitoring will be implemented by the Assistant Director of Nursing (ADON) and Director of Nursing (DON). She stated spot checks will be conducted, and pharmacy staff will provide additional oversight.	F0867		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880		

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F0880 SS = E	Continued from page 19 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This 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	F0880		

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F0880 SS = E	Continued from page 20 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 (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	F0880		

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F0880 SS = E	Continued from page 21 Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Resident # 115 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.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255148	(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
F0880 SS = E	Continued from page 22 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. 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. 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. 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.	F0880		