STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255148	A. BUILDING _____ B. WING _____	C 01/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and Complaint Investigations (CI) MS #17099, CI MS #17168, CI MS #16807, CI MS #16818, CI MS #16690, and CI MS # 16784 were conducted by the State Agency (SA) from 01/26/2021 through 01/28/2021. The facility was found to be in compliance with infection control regulations and has implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. CI MS #17099 was not substantiated for Quality of Care and Resident Rights, CI MS #17168 was not substantiated for Quality of Care and Resident Neglect, CI MS #16807 was not substantiated for Infection Control and Quality of Care, CI MS #16818 was not substantiated for Quality of Care, CI MS #16690 was not substantiated for Resident Abuse and Quality of Care. CI MS #16784 was substantiated for failure to maintain accurate medical records. The facility was cited F842 at a "D" level for failure to maintain accurate and up to date medical records regarding Certified Nurse Aide (CNA) documentation of bed mobility and turning and repositioning every shift for 4 of 4 residents reviewed, Resident #1, Resident #2, Resident #3, and Resident #4. The census at the time of the survey was 116.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(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	F 842		2/28/21

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

Electronically Signed | 03/04/2021

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F 842	Continued From page 1	F 842		

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(i) Medical records.
§483.70(i)(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(i)(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.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 2 §483.70(i)(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(i)(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 record review and staff interview, the facility failed to, in accordance with accepted and professional standards and practices, maintain accurately documented medical records for four (4) of four (4) resident's records reviewed out of a total of 116 residents in the facility with potential for adverse outcome. Resident #1, Resident #2, Resident #3, and Resident #4. Findings include: The facility was not able to provide a policy for maintaining accurate medical records with specifics to Certified Nurse Aide documentation. Resident #1	F 842	1.Initiated education on 1/28/2021, by the Director of Nursing, for all Certified Nursing Assistants staff including staff for Residents #3, & #4. Resident #1 and Resident #2 were discharged from the facility. The Education included proper documentation by entering bed mobility along with repositioning and turning into the electronic record and requirement to complete all documentation each shift. This with completion date on 2/1/2021. 2.One hundred and sixteen (116) Residents residing in facility on 1/28/2021, had the potential to be affected by this alleged deficient practice. 3.On 1/28/2021 Education was completed	

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F 842	Continued From page 3 Review of Resident #1's medical record revealed, he was admitted to the facility on 07/01/2019, and was discharged from the facility on 07/20/2020 to the hospital where he expired. He was admitted with diagnoses of Severe protein calorie Malnutrition, Diabetes Type 2, End Stage Renal Disease with dialysis, Dementia without Behavioral Disturbance, Atherosclerotic Heart Disease, and Epilepsy. Review of Resident #1's "Documentation Survey Report" for nurse aide task completion for the month of March 2020 revealed eight (8) days in which bed mobility assistance every shift was not documented. There was no documentation for all three shifts for one day reviewed, and for seven (7) days there was missing documentation for one of three shifts for bed mobility. There were also 8 days in which turning and repositioning assistance documentation was not complete. For 1 day there was no documentation present for all three shifts, and for 7 days there was missing documentation for one of three shifts for turning and repositioning. Review of Resident #1's "Documentation Survey Report" for nurse aide task completion for the month of April 2020 revealed, 7 days in which documentation for bed mobility was not complete. There was no documentation for all three shifts for one day reviewed, and for six (6) days there was missing documentation for one of three shifts for bed mobility. There were also 7 days in which turning and repositioning assistance documentation was not complete. For 1 day there was no documentation present for all three shifts, and for 6 days there was missing documentation for one of three shifts for turning	F 842	by the Staff Development Coordinator for Licensed Nurses to monitor point of care documentation in Resident's electronic health record each shift to ensure completion and accuracy regarding Activities of daily living (ADL) care by the Certified Nursing Assistants. On the week of 2/1/2021 Licensed Nurses began monitoring each shift for point of care documentation in Resident's electronic health record to ensure completion and accuracy regarding Activities of daily living (ADL) care by the Certified Nursing Assistants. Beginning the week of 2/1/2021, Licensed Nurses will turn in a end of shift report involving any concerns noted related to activities of daily living (ADL) care by the Certified Nursing Assistants. Any findings will be addressed immediately. 4.Beginning on the week of 2/1/2021, Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator conducted audits of point of care documentation within electronic health record with use of Residents electronic dashboard to ensure completion and accuracy of bed mobility, turning and repositioning documentation each shift. Any findings were addressed immediately. Audits will be conducted by the Director of Nursing and Assistant Director of Nursing weekly on 2/26/2021 for twenty-five (25) Residents for four (4) weeks and then fifteen (15) Residents monthly for three (3) months regarding activities of daily living (ADL) care by the Certified Nursing Assistants. Beginning 2/26/2021, the Director of Nursing will	

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F 842	Continued From page 4 and repositioning. Resident #2 Review of Resident #2's medical record revealed he was admitted to the facility on 01-08-2021 with diagnoses of a Fractured Left Femur. Review of Resident #2's "Documentation Survey Report" for January 2021 revealed 19 shifts in which bed mobility was not documented as done every shift. Of those 19 days, 2 days had no documentation for all three shifts, 5 days had documentation for one shift of three shifts, and 12 days had documentation for 2 of 3 shifts completed. Further review revealed 19 shifts in which turning, and repositioning was not documented as completed every shift. Of those 19 days, 2 days had no documentation for all three shifts, 5 days had documentation for one shift of three shifts, and 12 days had documentation for 2 of 3 shifts completed. Resident #3 Review of Resident #3's medical record revealed he was admitted to the facility on 5/4/2018 with diagnoses of Stroke, Aphasia, and Diabetes. Review of Resident #3's "Documentation Survey Report" for January 2021 showed 22 days in which bed mobility was not documented as completed. Of those 22 days, one day had no documentation for all three shifts, nine (9) days had documentation for one of three shifts, and 12 days had documentation for 2 of 3 shifts. Further review for turning and repositioning revealed 22 days in which documentation was not completed that the resident had been turned and	F 842	report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	

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repositioned every shift. Of those 22 days, one day had no documentation for all three shifts, nine (9) days had documentation for one of three shifts, and 12 days had documentation for 2 of 3 shifts.

Resident #4

Review of Resident #4's medical record revealed he was admitted to the facility on 10/01/2019 with a Stage III pressure ulcer to his right lateral malleolus, Aphasia, and Diabetes.

Review of Resident #4's "Documentation Survey Report" for January 2021, showed 17 days in which bed mobility was not documented as completed every shift. Of those 17 days, 2 days had documentation for 1 of 3 shifts, and 15 days had documentation for two of three shifts completed. Further review revealed 17 days in which turning, and repositioning was not documented as completed every shift. Of those 17 days, 2 days had documentation for 1 of 3 shifts, and 15 days had documentation for two of three shifts completed.

On 01/28/2021 at 2:30 PM during an interview with the Director of Nursing (DON), she agreed there was missing documentation for his bed mobility and turning and repositioning and stated those items should be documented every shift by the aides so that there was proof of Residents #1, #2, #3, and #4 being turned and repositioned and being assisted with bed mobility. She agreed that failure to chart the care given would make it impossible to prove the facility had provided the care.