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 **04/29/2026**

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 Complaint Investigations (CIs) at the facility from 4/28/26 through 4/29/26. CI MS# 2974863 was investigated related to physical environment. CI MS# 2964081 was investigated regarding staffing, call lights, physical environment, resident rights and feeding assistance. 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 and M620 related to CI MS# 2964081.	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; 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	M0500		

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

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M0500	Continued from page 1 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 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	M0500		

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M0500	Continued from page 2 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); 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.	M0500		

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M0500	Continued from page 3 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, facility policy review and skills checklist review, the facility failed to ensure a call light was maintained within reach and privacy was provided for Resident #2 during care and ensure residents were treated with respect and dignity during feeding assistance for Resident #3 for one (2) of three (3) sampled residents. Findings Included: Dignity: Record review of the facility policy, “Nursing Facility Resident Rights” dated 3/06/26 revealed, “The following rights are guaranteed to residents…To be treated with dignity, courtesy and respect…To privacy during personal care, visits, and phone calls...” Record review of the facility document titled, “Skills Checklist: Feeding a Resident” (undated) revealed Procedure Step 11. Stated, “Sits facing resident. Sits at resident’s eye level. Sits on the stronger side if resident has one-sided weakness.” Record review of the facility document titled, “Peri Care-Incontinent Care” revised 1-2023 revealed the procedure indicated “…Provide privacy (draw curtain from foot of bed to side up to wall, pull window curtain) …” Resident #2 On 4/28/26 at 12:55 PM, during an observation Certified Nursing Assistant (CNA) #1 provided incontinent care for Resident #2 without closing the door to the resident’s room and with the privacy curtain partially drawn. The State Agency (SA) was at the bottom right corner of the resident’s bed and able to see out into the hallway and watch the procedure during which the resident was uncovered and exposed. On 4/29/26 at 2:15 PM, during an interview CNA#1 confirmed that she was aware that assistance with incontinence care required provision of privacy and that she had received training from the facility and passed a competency check-off for incontinent care that included provision of privacy. She confirmed that in-service training included provision of privacy for respectful care and dignity which was each resident’s right.	M0500		

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M0500	Continued from page 4 Resident #3 On 4/29/26 at 12:15 PM, during an observation CNA #3 assisted Resident #3 to eat lunch while standing over the resident. The Director of Nursing (DON) instructed CNA #3 that staff were to sit next to residents while assisting with eating. On 4/29/26 at 12:20 PM, during an interview CNA #3 revealed that she forgot to sit beside the resident while assisting with eating. On 4/29/26 at 2:15 PM, during an interview CNA#1 confirmed that she was aware that assistance with incontinence care required provision of privacy and that she had received training from the facility and passed a competency check-off for incontinence care that included provision of privacy. She confirmed that in-service training included provision of privacy for respectful care and dignity which was each resident's right. On 4/29/26 at 3:00 PM, during an interview CNA #2 revealed that she was the CNA Supervisor and Scheduler and provided orientation and competency checks-offs for new CNAs and would observe the new CNA s to complete the skills check offs ensure competency during orientation and at least annually using the "Skills Checklist: Feeding a Resident" and the "Peri care-Incontinent Care" Skills Checklist. She confirmed that nursing staff (nurses and CNAs) received in-service training on residents' rights and treating residents and providing care in a respectful and dignified manner at least monthly. CNA#2 confirmed that provided training included provision of privacy for incontinent care and that staff were to sit beside residents while assisting with eating to provide respectful and dignified care. On 4/29/26 at 2:45 PM, during an interview with Licensed Practical Nurse (LPN)#1, revealed she confirmed that nursing staff (nurses and CNA s) received in-service training on residents rights and treating residents and providing care in a respectful and dignified manner at least monthly and that CNAs competency was assessed through competency checks during orientation upon hire and annually using the "Skills Checklist: Feeding a Resident" and the "Peri care-Incontinent Care" Skills Checklist (among others that addressed specific skills/procedures). She confirmed that in-service training, resident rights and competency check offs included ensuring respectful care during each procedure and resident interaction, which included provision of privacy, especially for any procedure that involved exposure of residents and sitting	M0500		

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M0500	Continued from page 5 beside residents while assisting them to eat. On 4/29/26 at 3:12 PM, during an interview the Director of Nursing (DON) stated the facility provided in-service training that included provision of privacy for all procedures that involved exposure of residents and sitting next to residents while assisting with eating to ensure respectful and dignified care in accordance with Residents' Rights. She confirmed that she observed CNA #2 standing over Resident #3 while assisting her to eat lunch on 4/29/26. On 4/29/26 at 4:10 PM, during an interview with the Administrator revealed that she expected call lights to be left within reach of residents and answered in a timely manner. She confirmed that she expected residents' rights to be protected and promoted for all residents as instructed through monthly facility provided in-service training. She confirmed that the Residents' Rights to dignified and respectful treatment included staff be seated while assisting residents to eat and provision of privacy for incontinence care. Record review of the "Admission Record" revealed Resident #2 was admitted to the facility on 12/11/23 with diagnoses that included epilepsy, infection of the skin and subcutaneous tissue, open wound of left upper arm, and gastrostomy status. Record review of the Admission Record for Resident #2 revealed the facility admitted him on 12/11/23 and he had diagnoses of epilepsy, infection of the skin and subcutaneous tissue, open wound of left upper arm, and gastrostomy status. Record review of the Quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 3/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 11, which revealed moderate cognitive impairment. Section GG revealed the facility assessed Resident #2 was dependent for toilet hygiene. Record review of the "Admission Record" for Resident #3 revealed the facility admitted the resident on 4/27/26 and she had diagnoses of cerebral infarction (stroke), anemia, hemiplegia and hemiparesis affecting right dominant side. Record review of the "Baseline Care Plan" for Resident #3 revealed "…A.1. Eating…01 Dependent…" Accommodations of Needs: Record review of the facility policy document titled,	M0500		

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M0500	Continued from page 6 “Skills Checklist: Feeding a Resident” (undated) revealed Procedure Step 21 “Leaves call light within resident’s reach..." The facility was unable to provide a call light policy. On 4/28/26 at 2:15 PM, observation and interview revealed Resident #2 was awake and resting in bed with his lunch tray on the over the bed table in front of him. The resident’s call light was lying on the floor under the head of his bed. He stated that he could use his call light but did not know where it was. On 4/29/26 at 12:00 PM, observation revealed that Resident #2 was resting in bed with his lunch tray on the over the bed table in front of him. The resident’s call light was behind the head of his bed, hanging behind the mattress and out of the resident’s sight and reach. He stated that he could use her call light but did not know where it was. The Director of Nurses (DON) retrieved the call light and placed it within reach of the resident. On 4/29/26 at 2:15 PM, during an interview Certified Nursing Assistant (CNA) #1 said that call lights were to be within the reach of residents. She confirmed that she had received in-service training and passed competency checked off on regarding feeding/serving resident meals and leaving their call lights within reach. On 4/29/26 at 3:00 PM, an interview with CNA #2 confirmed that call lights were to be within the reach of residents and that the facility provided in-service training on resident rights and call lights at least monthly. During an interview on 4/29/26 at 3:15 PM, Licensed Practical Nurse (LPN) #1 stated nurses make rounds throughout the day and use direct observation to ensure call lights are answered in a timely manner, which requires call lights to be within the reach of residents. On 4/29/26 at 3:12 PM, an interview with the DON revealed that she expected call lights to be left within reach of residents and answered in a timely manner. She confirmed that Resident #2 was unable to find or reach his call light at 12:00 PM on 4/29/26. During an interview on 4/29/26 at 4:10 PM, the Administrator stated she expects call lights to be left within the reach of residents and answered in a timely manner. She confirmed the facility does not have a specific policy regarding call light placement.	M0500		

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M0500	Continued from page 7 Record review of the “Admission Record” revealed Resident #2 was admitted to the facility on 12/11/23 with diagnoses that included epilepsy, infection of the skin and subcutaneous tissue, open wound of left upper arm, and gastrostomy status. Record review of the Quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 3/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 11, which revealed moderate cognitive impairment.	M0500		
M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, facility policy review, and interviews the facility failed to provide treatment and care in accordance with professional standards of practice to prevent urinary tract infections for one (1) of three (3) sampled residents who required incontinent care. Resident #2. Findings Included: Record review of the facility policy/procedure titled, “Peri Care-Incontinent Care” with revision Date 1-2023 (January 2023) revealed the procedure stated, “FOR MALE RESIDENTS: For a male resident: a. Wet washcloth/cleaning wipes and apply soap or skin cleansing agent. b. Wash perineal area starting with urethra and working outward…c. Retract foreskin of the uncircumcised male. d. Wash and rinse urethral area using a circular motion. e. Continue to wash the perineal area including the penis, scrotum, and inner thighs. F. Thoroughly rinse perineal area in same order, using fresh water and clean washcloth/cleaning wipes. G. Gently dry perineum following same sequence….” On 4/28/26 at 12:55 PM, observation revealed that Certified Nursing Assistant (CNA) #1 provided incontinent care for Resident #2. CNA #1 removed Resident #2’s wet brief, assisted the resident to turn onto his right side, loosened the fitted sheet, tucked the sheet under the resident, replaced the fitted	M0620		

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M0620	Continued from page 8 sheet with a clean one on the left side of his bed, walked to the right side of the bed, assisted him to turn onto his left side and adjusted and secured the fitted sheet and replaced his incontinent brief with a clean, dry brief without cleansing the resident's perineal area front or back. On 4/29/26 at 2:15 PM, during an interview CNA #1 confirmed that she was aware and had completed in-service training and competency check offs for perineal cleansing during incontinent care. She confirmed that on 4/28/26 at 12:55 PM she provided incontinent care for Resident #2, whose incontinence brief was wet with urine, without cleansing his perineal area. She stated that she was nervous but had received training and knew that she was supposed to cleanse the resident's perineal area in addition to replacing his wet brief with a dry one. On 4/29/26 at 3:00 PM, during an interview CNA#2, (the CNA Supervisor and Schedular) revealed she provided in-service training upon hire and during orientation and competency checks-offs for new CNAs and employees during orientation and then annually to ensure skills competency using the "Peri- care/ Incontinent Care" Skills Checklist. She confirmed that the procedure for incontinent care included cleansing the perineal area, front and back in addition to removal of wet briefs and replacement with a clean dry brief. On 4/29/26 at 2:45 PM, an interview with Licensed Practical Nurse (LPN) #1 confirmed that nursing staff received in-service training using the "Peri Care-Incontinent Care" Skills Checklist. She confirmed that incontinent care included cleansing the perineal area, front and back. On 4/29/26 at 3:12 PM, during an interview the Director of Nursing (DON) stated the facility provided in-service training that included provision of incontinent care and toileting hygiene for all incontinent residents as needed with orientation and annual competency check offs for CNA s. She confirmed that incontinent care included cleansing the perineal area, front and back. On 4/29/26 at 4:10 PM, an interview with the Administrator revealed that she expected CNA s to provide cleansing the perineal area, front and back along with brief changes for incontinent care. Record review of the "Admission Record" revealed Resident #2 was admitted to the facility on 12/11/23 with diagnoses that included epilepsy, infection of the skin and subcutaneous tissue, open wound of	M0620		

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M0620	Continued from page 9 left upper arm, and gastrostomy status. Record review of the Quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 3/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 11, which revealed moderate cognitive impairment. Section GG revealed the facility assessed Resident #2 was dependent for toilet hygiene.	M0620		