

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/28/2021
NAME OF PROVIDER OR SUPPLIER WOODLANDS REHABILITATION AND HEALTHCARE C		STREET ADDRESS, CITY, STATE, ZIP CODE 102 WOODCHASE PARK DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, CI MS# 17928, on 7/28/21 related to allegations of resident negligence, residents left for extended times wet, soiled, and unturned/repositioned, with medications not given or not given in a timely manner, and nursing services. During the survey, the SA determined the facility was in compliance with the requirements with Minimum Standards for Institutions for the Aged or Infirm. The SA was not able to substantiate the complaint. At the time of the survey the facility had a census of 128 residents and was licensed for 145 residents.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE