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 _____	04/25/2019

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 The State Agency (SA) conducted an annual survey along with a complaint investigation MS#15856 from 4/22/19 to 4/25/19. The result of the complaint investigation revealed one (1) of three (3) areas of concern was substantiated, for not honoring the resident's preference of a shower/tub bath with a related deficiency cited at F 561. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA also cited deficiencies at F 580, F 623, F 655, F 656, F 657, F 677, F 679, F 688, and F 806. The census at the time of survey was 136 and the facility held a license for 145 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		5/31/19

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

Electronically Signed | 05/31/2019

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 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.

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F 561	Continued From page 1 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review, and facility policy review the facility failed to provide the resident with a shower, as preferred, for one (1) of 26 residents reviewed, Resident #95. Findings include: Review of a signed document by the Administrator, on facility letterhead, revealed the facility did not have a specific policy regarding resident choice; however, they did follow the "Patient Self Determination Act". On 04/24/19 at 08:30 AM, an interview with Resident #95 revealed she would love to have a tub bath or a shower. Resident #95 stated she had told the staff lots of times that she wanted a shower. Registered Nurse (RN) #6 was present in the room and stated the facility did not have a tub. RN #6 confirmed the facility had a shower for resident use. Review of the most recent Brief Interview for Mental Status (BIMS) evaluation, revealed Resident #95 scored 14 of 15, which indicated no cognitive impairment.	F 561	F561 Self Determination 1. On 4/24/19, Resident #95 refused shower offered by Certified Nursing Assistant (C.N.A.) #5 and Director of Nursing (DON). On 4/25/19 Resident #95 consented to and received shower. On 4/29/19, Resident #95 was interviewed by Social Service for bath preferences and care plan updated. 2. Beginning on 4/29/19, current residents with BIMs of twelve (12) or greater, were interviewed for bath preferences by Social Services/Administrator in Training (AIT). On 5/30/19, Minimum Data Set (MDS) nurses completed review and update of care plans and Kardexes of active residents to reflect resident preference; no updates needed. Current residents were updated in the Kardex to reflect bath/shower preferences. 3. On 5/23/19, Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) implemented a new form for Admission Coordinator to obtain resident shower/bath preferences at time of admit. Form will be turned over to MDS nurses to	

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F 561	Continued From page 2 During an interview on 04/24/19 at 08:35 AM, Certified Nurses Assistant (CNA) #5 stated she had offered Resident #95 a shower, but the Resident refused. CNA #5 stated Resident #95 said her daughter was coming to give her a shower. On 04/24/19 at 08:40 AM, during an interview, CNA #6, Staff Coordinator, stated Resident #95 required total care. CNA #6 stated shower days for the residents by the window are Tuesday, Thursday, and Saturday. On 04/24/19 at 08:45 AM, during an observation and interview with Resident #95 and the Director of Nursing (DON), the DON asked Resident #95 if she wanted to take a shower and Resident #95 stated she wanted about a tablespoon of bleach on a towel to wash with. The DON instructed her that they could not use bleach. The DON asked the resident if she wanted to get a shower and Resident #95 would not answer. On 04/24/19 at 9:55 AM, an interview with Resident #95 revealed her preference is a tub bath, but she would also take a shower. Resident #95 confirmed she had asked to take a shower, but was told it was not her day. On 04/24/19 at 09:59 AM, an interview with the DON revealed that resident who reside on the window side of the room were scheduled showers on Tuesday, Thursday, and Saturday, and Resident #95 had been scheduled for the afternoon, because she seemed to do better then. An interview with Resident #95, on 04/25/19 at	F 561	ensure preference is reflected on care plan and information is loaded into Kardex. On 5/23/19, Admissions team was educated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on new form for obtaining resident shower/bath preferences at the time admit and to distribute form to MDS nurses. On 5/23/19, MDS nurses were educated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on new shower/bath preferences form and ensuring care plan/Kardex reflects preference. On 5/24/19, staff in-services were initiated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on resident's self-determination with a focus on resident bath preferences. 4. Starting 5/31/19, resident bath choices will be monitored by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT). Residents will be interviewed, along with review of care plan and Activity of Daily Living (ADL) record. Four (4) residents will be audited weekly for four (4) weeks, monthly for three (3) months and then quarterly. The ADM will report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendation. The ADM is responsible for on-going monitoring and compliance.	

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F 561	Continued From page 3 10:45 AM, revealed Resident #95 was taken to the shower on this date. Resident #95 stated that she enjoyed her shower. Record review of the Activities of Daily Living Task form revealed Resident #95 had received only bed baths from 04/12/19 to 4/24/19. An interview, on 4-25-19 at 11:20 AM, with the DON, confirmed she had no documentation to support staff had offered Resident #95 a shower, or that Resident #95 had refused a shower at anytime.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		5/31/19

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F 580	Continued From page 4 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review the facility failed to notify the Responsible Party (RP) of results of a test ordered for one (1) of three (3) resident records reviewed and family interviews for notifications, Resident #95. Findings include: Record review revealed a Physician order for Resident #95, dated 04/16/19 MD for a KUB (Kidney Ureter and Bladder) X-ray. The order was transcribed by Registered Nurse (RN) #1.	F 580	F580 Notify of Changes 1. On 4/16/19, Resident #95 received a KUB X-Ray. On 4/17/19, results revealed no evidence of acute disease in the abdomen. On 4/24/19, Registered Nurse (RN) #1 notified family of the KUB results. 2. On 4/29/19, an audit was conducted of ordered X-rays within the past thirty (30) days to ensure resident/Resident Representative was notified of results. Sixty-three (63) resident had orders for x-rays and residents/resident	

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F 580	Continued From page 5 Review of the X-ray report (KUB) dated 4/17/19, revealed no evidence of acute disease in the abdomen for Resident #95. Review of Resident #95's medical record revealed no documented evidence that the RP was notified of Resident #95's X-ray order and/or results. In an interview, on 04/24/19 at 10:20 AM, RN #1 confirmed a family member expressed concern about Resident #95's abdomen being larger than normal. RN #1 stated she notified the doctor and an x-ray was ordered. RN #1 confirmed she failed to call the family to notify them of the new order and the results of the KUB. RN #1 stated she should have called the Responsible Party, but she guessed she forgot.	F 580	representative were notified of results; no negative findings. 3. On 5/1/19, a new x-ray tracking log was created and implemented to help licensed nurses track x-rays and notifications to Resident Representatives. On 5/1/19, in-services were initiated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) with nursing supervisors on new x-ray tracking log, along with notifying Resident Representative of results and documenting in a progress note. On 5/24/19 staff in-services were initiated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on notification of resident changes to the Resident Representative. 4. Starting 5/31/19, notification of changes are being monitored by DON to ensure results were obtained and Resident Representative Notification documented via the new x-ray tracking log. Four (4) residents will be audited weekly for four (4) weeks, then monthly for three (3) months and then quarterly thereafter. The DON will report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months. The DON is responsible for on-going monitoring and compliance.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		5/31/19

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F 623	Continued From page 6 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section	F 623		

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F 623	Continued From page 7 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 8 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the Responsible Party (RP), in a written form, of a transfer to the hospital for three (3) of three (3) residents records reviewed for transfer notice. Residents #6, #48, and #128. Findings include: The facility did not provide a specific policy for the written notification for resident transfers. Resident #48 A review of Resident #48's medical record revealed a physician's order to transfer the resident to the hospital Emergency Room (ER) on 3/16/19, along with a hospital transfer form completed on the same date. There was no documentation of a written discharge/transfer notice to the RP. An interview on 04/24/19 at 04:58 PM with the Director of Nursing (DON) confirmed there was not a written notification given to Resident #48's family about the transfer to the hospital on 3/16/19. The DON stated she verbally told the family, because they were present at the time of	F 623	F623 Notice of Requirements before Discharge/Transfer 1. On 3/16/19, Resident #48 transferred to the emergency room, notice of discharge/ transfer was mailed by Social Services on 5/24/19. On 2/13/19, Resident #6 transferred to the emergency room, notice of discharge/transfer was mailed by Social Services on 5/24/19. On 1/18/19, Resident #128 was transferred to the emergency, notice of discharge/ transfer was mailed by Social Services on 5/24/19. 2. On 5/1/19 and 5/30/10 an audit was completed by Social Services on transfers that occurred within the last thirty (30) days. Thirty-three (33) residents transferred/discharged to the hospital during that time frame and Social Services mailed a copy of the discharge/transfer notice to thirty-three (33) Residents/Resident Representatives. 3. On 4/24/19, Administrator (ADM) created a new notification form to be sent to Resident/Resident Representative regarding discharge/transfer. The form contains the reason for transfer, a copy of	

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F 623	Continued From page 9 transfer. The DON confirmed the facility did not have a specific policy for the written notification for resident transfers. Resident #6 Record review revealed on 2/13/19, the Nurse Practitioner (NP) gave an order to send Resident #6 to the Emergency Room (ER) for evaluation. There was no documented evidence the resident/RP was provided a written transfer notice. Resident #128 Record review of Resident #128's Physician's orders revealed an order written for 1/18/19, to transfer the resident to the hospital. Record review of Resident #128's Minimum Data Set Assessments, revealed a Discharge assessment dated 1/18/19, and a Return assessment dated on 1/21/19. There was no documented evidence of a written notice of discharge/transfer to the RP. On 04/24/19 at 04:56 PM, an interview with the Director of Nursing (DON) confirmed the facility has not notified the residents or resident's responsible party of transfers and discharges to the emergency room or hospital. 04/24/19 at 05:19 PM, interview with the DON confirmed the facility is not mailing or handing a transfer notification to the responsible party and/or the resident explaining in layman's terms the reason for the transfer. The DON revealed they do not have a form developed for this purpose and have not been properly notifying the RP of transfers. On 04/25/19 at 08:23 AM, an interview with the	F 623	the facility bed-hold policy along with state Ombudsman information. On 4/24/19, Administrator (ADM) created a new tracking form that will be utilized by Services to keep a log of notifications that are sent. On 4/24/19, Social Services staff was in-serviced by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on the new discharge/transfer notification form, discharge/transfer tracking log and the responsibility of sending the notifications within a reasonable timeframe. On 5/24/19, staff in-services were initiated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on Notice Requirements before Transfer/Discharge. 4. Starting 5/31/19, notification of discharge/transfer will be monitored by ADM by comparing census report for discharges/transfer to the transfer letter tracking form. Four residents will be audited weekly for four (4) weeks, monthly for three (3) months and then quarterly thereafter. The ADM will report findings of the audit monthly for three (3) to the Quality Assurance Performance Improvement committee for review and further recommendation. The ADM is responsible for on-going monitoring and compliance.	

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F 623	Continued From page 10 Administrator (ADM) confirmed the facility was not sending written notification, to the RP, of transfer or discharge to the hospital.	F 623		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655		5/31/19

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F 655	Continued From page 11 of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, and record review, the facility failed to develop a base line care plan on admission for one (1) of 26 resident records reviews, Resident #378 Findings include: A review of a facility statement on letterhead, signed by the Director of Nursing (DON), revealed the facility should initiate an Interim care plan as part of the admission process and the interim care plan is to be completed within 48 hours. A review of Resident #378's medical record revealed the resident did not have any nursing care plans related to the resident's current status. A review of the form titled, "ICP-Interim Care Plan", for Resident #378, dated 4/16/19, revealed instructions to answer each question and navigate to the care plan to view the triggered items to start building the interim care plan. An observation on 4/22/19 at 11:20 AM, revealed Resident #378 in his room with a stiff back and neck brace on his upper torso. Resident #378	F 655	F655 Baseline Care Plan 1. Resident #378 admitted to facility on 4/16/19 and baseline care plan was completed on 4/24/19 by the interdisciplinary team. 2. On 5/29/19, Minimum Data Set (MDS) nurses conducted an audit on new admissions since 4/1/19 to ensure baseline care plans were completed within 48 hours. 3. On 5/23/19, Minimum Data Set (MDS) nurses were in-serviced by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) to audit new admits within 48 hours to ensure base line care plans are completed timely. On 5/24/19, staff in-services were initiated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on the completion of baseline care plans within 48 hours of admission. On 5/30/19, Administrator implemented a new Care Plan Attendance Record to indicate that the Baseline Care Plan was reviewed and distributed to Resident/Resident Representative and Social Services and Minimum Data Set	

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F 655	Continued From page 12 was sitting independently on the side of the bed, oriented to person, place and time with clear speech. An interview on 04/22/19 at 11:24 AM, with Resident #378, revealed he had been in the facility about a week. Resident # 378 said would be ready to go home when therapy released him. A review of Resident #378's physician orders revealed the resident was admitted on 4/16/19. On 04/24/19 04:30 PM, an interview with Registered Nurse (RN) #4, Minimum Data Set (MDS) Coordinator, revealed she was responsible for the comprehensive care plan, but the initial care plan should have been done by the nurse at admission from the triggers of the initial assessment. RN #4 confirmed the three (3) care plans that were completed were Social Services, and she was completing the other triggers at that moment of the the surveyor's interview. An interview on 04/24/19 at 05:02 PM, with Certified Nursing Assistant (CNA) #2, revealed she had not looked at the kiosk to review the resident's needs because she had other duties to complete. She stated she was not normally Resident #378's aide; she was an agency CNA. An interview on 04/24/19 at 05:04 PM, with the DON, revealed when she provided Resident #378's form titled "ICP-Interim Care Plan", dated 4/16/19, she stated that she was unaware of the procedure to use the form as an assessment and would review the policy. She confirmed they were using this form as the interim and admission care plan.	F 655	(MDS) nurses were in serviced by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT). 4. Starting 5/31/19, completion of baseline care plans are being monitored weekly by Administrator (ADM). Four (4) residents will be audited weekly for four (4) weeks, monthly for three (3) months and then quarterly thereafter. The ADM will report findings of audits to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and further recommendation. The ADM is responsible for on-going monitoring and compliance.	

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F 655	Continued From page 13 On 04/25/19 at 01:18 PM, an interview with RN #3, MDS/Care Plan Coordinator, revealed she had been with the facility since October 2018. RN #3 said the nurses that work in the MDS office were assigned residents at admission and were responsible for completing the base line care plan. RN #3 confirmed Resident # 378's baseline care plan was not completed within 48 hours of admission and was completed the prior day, by RN #4.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 (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	F 656		5/31/19

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F 656	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to follow the comprehensive care plan for three (3) of 26 resident care plans reviewed, Resident #104, #103, and #95. Findings include: Review of the facility's policy titled, "Care Plans-Comprehensive", with a revised date of August 2006, revealed that the facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Each resident's comprehensive care plan was designed to incorporate identified problem areas and reflect treatment goals and objectives. Resident #104	F 656	F656 Develop/Implement Comprehensive Care Plans 1. Resident #104 had nails trimmed and cleaned on 4/24/2019 by Treatment Nurse. On 5/8/19, Director of Nursing (DON), notified physician that betadine had been used in place of chloroprep for Resident #103 on 4/23/19; no new orders. On 5/8/19, DON notified Resident Representative of Resident #103 regarding change of treatment that occurred on 4/23/19. On 4/25/19, it was observed that resident #95 was not wearing a left knee splint per order. Order was for Resident #95 to have split put on after breakfast and removed before dinner. Director of Rehab completed screen on 4/25/19, no negative impact noted. Splint was applied to Resident #95 after lunch. Resident #95 tolerated well. 2. On 5/23/19, Director of Nurses (DON), Assistant Director of Nurses (ADON),	

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F 656	Continued From page 15 Review of Resident #104's care plan revealed, "The Resident has an Activity of Daily Living (ADL) self-care performance deficit related to Muscle Weakness", with an intervention that the resident requires physical assistance from staff for personal hygiene. An observation on 04/22/2019 at 12:09 PM, revealed that Resident #104 had long fingernails with a black substance under each nail on hands bilaterally. An interview with Resident #104 on 04/22/2019 at 12:10 PM, revealed that he wanted his nails trimmed and cleaned. Resident #104 stated, "My nails are long and dirty. They need to be cleaned." Resident #104 confirmed that he needed and wanted assistance with nail care. An interview with the Director of Nursing (DON) on 04/25/2019 at 11:30 AM, confirmed that the purpose of the care plan is to tell the staff how to take care of the resident and that Resident #104's Comprehensive Care plan had not been followed in relation to Resident#104's need for assistance with personal nail care. An interview with the Minimum Data Set (MDS) Coordinator/RN #3, on 04/25/2019 at 12:10 PM, revealed that it is the responsibility of the Assessment Nurse and the Interdisciplinary Team (IDT) to develop and update each resident's care plan as needed. The MDS Coordinator stated that the purpose of the care plan is for the staff to know how to take care of the resident. The MDS Coordinator confirmed that it is important for the care plan to be updated as needed and to be followed to ensure the residents get the care they need.	F 656	Treatment Nurses and other Licensed Nurses assessed current residents for nail care needs. Audit showed twenty-five (25) residents needed nail care; nail care was completed on 5/24/19. Beginning on 5/23/19, Minimum Data Set (MDS) nurses reviewed Activity of Daily Living (ADL) care plans for current residents for accuracy; no revisions indicated. Beginning on 5/23/19 DON initiated observations of treatment nurses performing treatments to validate orders were being followed. Beginning on 5/23/19, DON/MDS nurses reviewed care plans/Kardexes of current residents for accuracy in regards to splints; fourteen (14) current resident have orders for splints, fourteen (14) care plans were reviewed and eight (8) updated. Fourteen (14) are accurately flowing to Kardex. 3. On 5/2/19, DON in-serviced treatment and licensed nurses on following physician treatment orders, notifying physician for wound care changes and obtaining new orders. Beginning on 5/24/19 staff in-services were initiated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on following care plans specifically related to nail care, splints, and following physician treatment orders. 4. Beginning 5/31/19, care plan implementation will be monitored through direct care observations by the DON/Assistant DON, to validate: Four (4) residents will be audited weekly for nail care, then monthly for three (3) months, then quarterly thereafter, Four (4) residents will be audited weekly	

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F 656	Continued From page 16 Resident #103 A review of Resident # 103's comprehensive care plan revealed the resident's wound careplan stated to administer treatments as ordered. An observation on 04/23/19 at 04:26 PM, revealed Resident #103 had an orange colored stripe on top of a right scalp incision. Resident #103 was resting quietly in bed, with her head resting on blue pad draped over the pillow. An interview on 04/23/19 at 04:28 PM, with Registered Nurse (RN) #2/Treatment Nurse, revealed she used betadine and sometimes bacitracin ointment for a small open area to scalp for "the last couple of weeks" for Resident #103. RN #2 confirmed she had completed the treatment on Resident #103 today, 4/23/19. An interview on 4/23/19 at 4:40 PM, with Resident #103, revealed the nurse just put water on her head, when questioned about the orange color stripe on her scalp. A review of Resident #103's physician's orders for wound care revealed an order for ChloroPrep to right scalp incision twice a day, dated 4/1/19. A review of Resident # 103's treatment record revealed the treatment for ChloroPrep was signed off on 4/23/19. An interview and observation on 04/24/19 at 3:30 PM with RN #2 said she used betadine today for Resident # 103's scalp incision. RN #2 said ChloroPrep was the same as betadine and showed me a bottle of generic providone iodine she had been using on the Resident #103's wound.	F 656	for splints weekly for four (4) weeks, then monthly for three (3) months and then quarterly thereafter, Four (4) residents will be audited weekly for four (4) weeks to ensure treatment orders are being followed by DON/Assistant Director of nursing observing treatment per treatment nurse, then monthly for three (3) months, then quarterly thereafter. The DON will report findings of audits/observations to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and further recommendations. The DON is responsible on-going monitoring and compliance.	

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F 656	Continued From page 17 An interview on 04/25/19 at 11:07 AM, with Director of Nursing (DON), revealed when the Treatment Nurse used betadine on Resident #103's wound, she did not follow physician orders for the ChloroPrep. DON said that ChloroPrep was not the same as providone iodine. She confirmed the resident's careplan said to follow the resident orders. An interview on 04/25/19 at 01:22 PM, with RN #3, Minimum Data Set (MDS) Coordinator, revealed the purpose of the care plan was to direct staff on how to care for the resident. She said the expectation of the staff would be to follow physician orders according to standards of practice. Review of the ingredients for ChloraPrep, revealed Chlorhexidine and isopropyl alcohol, not Betadine. Resident #95 Record review revealed a care plan focus that indicated Resident #95 had a Cerebrovascular Accident (CVA/Stroke) affecting the left extremities related to hemiparesis/ hemiplegia, and contractures to the left knee. The intervention revealed the use of a left knee splint, put on after breakfast, take off before dinner, and check skin as ordered. Observation on 04/25/19 at 8:30 AM, revealed Resident #95 did not have a splint on her left leg. Observation with the DON, on 04/25/19 at 11:30 AM, revealed Resident #95 did not have a splint on her left knee.	F 656		

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F 656	Continued From page 18 Interview with the DON, on 04/25/19 at 11:35 AM, confirmed Resident #95 had an order for a splint for her left knee and the splint was not on the resident as it should be. An interview, on 04/25/19 at 1:14 PM, with Certified Nurses Assistant (CNA) #4, confirmed she was not aware Resident #95 was supposed to have a splint. An interview, on 04/25/19 at 2:30 PM, with CNA #3, revealed she thought she remembered doing a check off a long time ago for putting a splint on Resident #95, but cannot recall ever putting a splint on her knee until today. Interview, with the DON on 04/25/19 at 2:55 PM, confirmed the care plan was not followed for applying a splint to Resident #95's left knee.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		5/31/19

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F 657	Continued From page 19 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review, and facility policy review, the facility failed to revise the comprehensive care plan related to activities for Resident #51 and #101, and for Dialysis care for Resident #82, for three (3) of 26 resident care plans reviewed. Findings include: A review of the facility policy titled "Care Plans - Comprehensive", revised August 2006, revealed care plans were to be revised as changes in the resident's condition dictate. Record review of the Facility policy titled "Documentation, Activities", revised on June 2018, revealed that individualized activities care plan or activities portion of the Comprehensive Care Plan: should be documented. Resident #82 A review of Resident #82's comprehensive care plan revealed to monitor the dialysis access site to left upper arm with no mention of the central line on the resident's chest wall.	F 657	F657 Care Plan Timing and Revision 1. On 4/23/19, for Resident #82, a new order was obtained to monitor the central line on the chest wall by Assistant Director of Nursing (ADON) and care plan updated by Minimum Data Set (MDS) Coordinator. On 4/29/19, Resident #101 was evaluated by Activity Director and care plan was revised to reflect current preferences. On 4/29/19, Resident #51 was evaluated by Activity Director and care plan was revised to reflect current preferences. 2. Beginning on 4/29/19, Activities Director initiated updates of activity evaluations for current residents and reviewed/updated activity care plan. Beginning on 5/23/19, Director of Nursing (DON) conducted audit on the ten (10) residents who have physician orders for dialysis and Minimum Data Set (MDS) nurses initiated audit of the care plans of ten (10) residents who require dialysis to ensure that care plans accurately reflected dialysis access sites; two (2) care plans were updated. 3. On 4/26/19, Administrator (ADM)	

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F 657	Continued From page 20 An observation on 04/23/19 at 8:38 AM, revealed an arteriovenous fistula (AV fistula) noted to Resident #82's upper left arm. A dry dressing over a central line was was also observed to be on Resident #82's top right chest. In an interview on 4/23/19 at 8:40 AM, Resident #82 stated the AV fistula was not used anymore at dialysis and that the central line on her chest was used during dialysis. Resident #82 said she didn't know what had happened to the AV fistula. An interview on 04/23/19 at 5:30 PM, with Registered Nurse (RN) #1/Assistant Director of Nursing, confirmed that the central line on Resident #82's chest was used for dialysis. In an interview on 04/24/19 3:15 PM, RN #5 stated he had already taken Resident #82's vital signs in her right arm and checked the central line dressing on her chest. RN #5 said he didn't check the AV fistula, because it was not being used at dialysis. During an interview on 04/25/19 at 1:26 PM, RN #3/Minimum Data Sheet (MDS) Nurse, said the only way for the care plan to be revised would be through physician orders or notification in morning meetings. She confirmed the changes for Resident #82's care plan should have been changed immediately upon MDS office notification. She stated that she was unaware of these changes. In an interview on 04/25/19 at 2:30 PM, the Director of Nursing (DON) stated both the central line and the AV fistula were present on admission, and she believed the admission nurse was not sure at the time which was one was being used at	F 657	educated Activities Director on accuracy of care plans related to resident choices identified on activity evaluations. On 5/23/19, MDS nurses were educated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) to ensure care plans reflect accurate dialysis site per physician's order. On 5/24/19, staff in-services were initiated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on care plan timing and revisions to specifically include accuracy related to dialysis access sites and current activity preferences. 4. Beginning on 5/31/19 residents will be by the DON/ADON monitored weekly to ensure that care plans and orders are accurate related to dialysis access site. Four (4) residents will be reviewed for four (4) weeks, then monthly for three (3) months then quarterly thereafter. Beginning on 5/31/19, four (4) residents will be interviewed by ADM/Social Services in regards to their activities preferences being met per activity evaluation and care plan weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter. The ADM will report audit findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The ADM is responsible for on-going monitoring and compliance.	

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F 657	Continued From page 21 dialysis. DON said she had called the dialysis clinic and they told her the AV fistula had not been used since Resident #82's admission to the nursing home. A review of Resident # 82's physician's orders, dated 3/23/2019, revealed to monitor the shunt in the left upper arm. A review of the admission note, dated 3/23/19, revealed the nurse documented both the right chest wall central line and the left upper arm AV fistula. Resident #101 Record review of the current Comprehensive Care Plan for Activities for Resident #101, revealed an intervention to offer seek and find puzzle books. The care plan was not revised by removing the activity of offering puzzle books when the resident could no longer see to do them. On 04/22/19 at 11:34 AM, an interview with Resident #101 revealed there is not nearly enough activities, she gets bored with what they offer and she had discussed this with the Activity Director more then once. Resident #101 revealed she is limited on participation in some activities, due to her vision. The resident revealed she is blind in one (1) eye and can not do puzzle books any more. Resident #51 Record review revealed the current Comprehensive Care Plan for Resident #51 did not have any patient specific activities Resident #51 had voiced he would enjoy. The interventions included to allow the resident to	F 657		

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	255148	A. BUILDING _____ B. WING _____	04/25/2019

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

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F 657	Continued From page 22 choose own clothes to wear, invite on outings, offer snacks, special events, TV time, praise efforts and attendance, provide calendar in room and resident is a Protestant. On 4/23/19 at 05:45 PM, an interview with Resident #51 revealed "There is nothing to do here, I will go outside and water the plants some but there really is not any activities I attend, I wish there was more to do. I would get out of my room more if they had an activity I enjoyed." "I really enjoy beading and gardening. I would like to go to more activities, or have more visitors." On 4/23/19 at 5:12 PM an interview with the Activity Director (AD) revealed she should have listed on the care plan and revised the care plan for specific activities Resident #51 and #101 had voiced to her they would enjoy. On 4/25/19 at 1:15 PM, an interview with the Lead Minimum Data Set (MDS) Coordinator revealed the MDS staff is responsible for developing the Comprehensive Care Plan for new admits. She stated with a new order or a change in the Resident's condition or care, there should be a revision of the care plan.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, record review, and facility policy review,	F 677	F677 ADL Care Provided for Dependent Residents	5/31/19

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F 677	Continued From page 23 the facility failed to provide nail care for one (1) of 26 residents reviewed for nail care, Resident #104. Findings include: Review of the facility's policy"Activities of Daily Living (ADLs) Supporting", revised March 2018, revealed that residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. An observation on 04/22/2019 at 12:09 PM, revealed Resident #104 had long fingernails on both hands, with a black substance under each nail. An interview with Resident #104, on 04/22/2019 at 12:10 PM, revealed that he wanted his nails trimmed and cleaned. Resident #104 stated his nails were long and dirty and needed to be cleaned. The resident confirmed he needed and wanted assistance with nail care. An interview with the Director of Nursing (DON), on 04/24/2019 at 4:20 PM, confirmed that Resident #104's finger nails were dirty and long and the resident should have been provided nail care. The DON revealed that the Certified Nurse Aid (CNA) or Nurse assigned to Resident #104 should have noticed the long, dirty nail condition during care and should have made sure nail care was provided. The DON stated it is the Nurse's responsibility to provide finger nail care for diabetics and the CNA's responsibility to provide	F 677	1. On 4/24/19, Resident #104 received nail care by Treatment Nurse. 2. On 5/23/19, Director of Nurses (DON), Assistant Director of Nurses (ADON), Treatment Nurses and other Licensed Nurses assessed current residents for nail care needs. Audit showed twenty-five (25) residents needed nail care; nail care was completed on 5/24/19. Beginning on 5/23/19, Minimum Data Set (MDS) nurses reviewed Activity of Daily Living (ADL) care plans for current residents for accuracy; no revisions indicated. 3. On 5/24/19, staff in-services were initiated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on ADL care with a focus on nail care. 4. Beginning 5/31/19, ADL care will be monitored by DON/Assistant Director of Nursing through direct care observations for four (4) residents reviewed weekly for four (4) weeks, monthly for three (3) months and quarterly thereafter. The DON will report audit findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The DON is responsible for on-going monitoring and compliance.	

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F 677	Continued From page 24 finger nail care for residents who are not diabetics. An interview with Certified Nurse Assistant, (CNA) #1 on 04/25/2019 at 10:05 AM, revealed that she observes her residents daily for needed nail care during morning care. CNA #1 stated that she cleans the nails of her residents daily. CNA#1 stated that she notifies the Wound Nurse or Nurse Supervisor if nails need trimmed. An interview with the Assistant Director of Nursing (ADON)/RN#1 on 04/25/2019 at 10:10 AM, revealed that it is the responsibility of the CNA and Nurse assigned to the the resident to monitor the need for nail care during daily care. The ADON/RN#1 stated that if nail care is needed the Wound Care Nurse or Nurse Supervisor performs fingernail care on all diabetic residents and the CNA is instructed to perform fingernail care if the resident is not a diabetic.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview and	F 679	F679 Activities Meet the Needs of Each	5/31/19

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F 679	Continued From page 25 record review the Facility failed to provide resident centered activities for two (2) of 22 residents interviewed for activities, Resident #51 and #101. Findings include: (Was there an activity assessment) Resident #51 On 4/23/19 at 05:45 PM an interview with Resident #51 revealed, "There is nothing to do here". She stated, "I will go outside and water the plants some, but there really is not any activities I attend, I wish there was more to do. I used to go to Bingo, but got tired of doing the same thing. I would get out of my room more if they had an activity I enjoyed. I would enjoy doing beads more, but they only have that one (1) time a month, I would like to have more activities." On 04/22/19 at 11:34 AM, Resident #101 revealed there is not near enough activities and she gets bored with what they offer. She stated she had discussed this with the Activity Director (AD) more then once. Resident #101 revealed she is limited on participation in some activities, due to her vision. Resident #101 revealed she is blind in one (1) eye and can not do puzzle books any more. On 4/23/19 at 5:12 PM, an interview with the Activity Director (AD) revealed she did not have any documentation for actual activities the residents participated in, or who attended the activities. The AD confirmed that some activities she counted were not confirmed by any staff or by the resident. The AD revealed she counted watching TV in the resident's room and could not tell state what activities Resident #101 or	F 679	Resident 1. On 4/29/19, an Activity evaluation was updated for Resident #51 and care plan revised by the Activity Director to reflect current activity interest. On 4/29/19, an Activity evaluation was updated for Resident #101 and care plan revised by the Activity Director to reflect current activity interest. 2. Beginning on 4/29/19, Activity Director initiated updating activity evaluations and care plan revisions; residents of the facility had potential to be impacted. 3. On 4/26/19 Administrator (ADM) implemented new forms to capture attendance for group and individual activities attendance. On 4/26/19, ADM educated Activity Director on activities meeting the interest and needs of each resident and utilization of new attendance tracking forms. On 5/24/19, staff in-services were initiated Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on the importance of activities meeting the needs of each resident. 4. Beginning on 5/31/19, activity preferences will be monitored through resident interviews and activity care plan review by the ADM/Administrator in Training. Four (4) residents will be monitored weekly for four (4) weeks, then monthly for three (3) months then quarterly thereafter. The ADM will report finding to the Quality Assurance Performance Improvement committee for review and recommendation, monthly for three (3) months. The ADM is responsible for on-going monitoring and compliance.	

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F 679	Continued From page 26 Resident #51 had attended on any specific day. On 4/23/19 at 5:30 PM, an interview with the Administrator (ADM) confirmed the AD does not have adequate documentation to support Resident attendance to activities or to know which activity they attended on any given day. On 4/24/19 at 9:00 AM, an interview with Resident #101 revealed the facility just needed a bigger budget to be able to offer more outings, more crafts, and more games. Resident #101 stated they have dominoes, monopoly, and cards but when you lived her from now on, you would like a different game sometimes. On 4/25/19 at 9:28 AM, an interview with the Activities Director (AD) confirmed approximately five (5) to six (6) residents had approached her concerning adding more activities they are interested in. The AD revealed some of the activities mentioned were beads, crafts, and outings. The AD revealed she plans on going and getting more beads and crafts next week. The AD revealed Resident #101 has mentioned to her that she desired some new and different activities, including more outings. The AD revealed Resident #51 used to go to Bingo, but had stopped and she did not know why. The AD stated Resident #51 enjoyed beads and there is only one (1) activity for the month of April involving beads, but she could add more. Record review of the April 2019 Activity Calendar revealed on the 13th Bead Making was listed as an activity. No other day had the activity of bead making listed. Record review of the Minimum Data Set, Brief	F 679		

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F 679	Continued From page 27 Interview for Mental Status score for both Resident #51 and Resident #101 was 15, which indicated no cognitive impairment.	F 679		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review the facility failed to apply a splint as ordered for one (1) of four (4) residents investigated for Positioning and Range of Motion, Resident #95. Findings include: An observation, on 04/25/19 at 8:30 AM, revealed Resident #95 did not have a brace/splint on her left leg.	F 688	F688 Increase/Prevent Decrease In ROM/Mobility 1. On 4/25/19, it was observed that resident #95 was not wearing a left knee splint per order. Order was for Resident #95 to have split put on after breakfast and removed before dinner. Director of Rehab completed screen on 4/25/19, no negative impact noted. Splint was applied to Resident #95 after lunch. Resident #95 tolerated well. 2. Beginning on 5/23/19, DON/MDS	5/31/19

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F 688	Continued From page 28 Record review revealed an order dated 10/31/18, to discharge Resident #95 from skilled services due to plateau and refer to Restorative Nursing for splinting program. Record review revealed a Physician's order for Resident #95, dated 04/23/19, for a left knee splint, to don after breakfast and off before dinner, as tolerated, for contracture management. Nurses to remove every two (2) hours for skin check. An observation with the Director of Nursing (DON), on 04/25/19 at 11:30 AM, revealed Resident #95 did not have a brace/splint on her left knee. The DON found the splint in the Resident's closet. An interview with the DON, on 04/25/19 at 11:35 AM, confirmed Resident #95 had an order for a brace/splint for her left knee and the brace/splint was not on the resident as it should be. An interview, on 04/25/19 at 1:14 PM, with Certified Nursing Assistant (CNA) #3, who is a Restorative Aide, stated she did not know about an order for a splint for Resident #95's left knee. CNA #3 stated she found out about it today. CNA #3 stated the Therapy Director went to Resident #95's room with her and instructed her on how to put the splint on. CNA #3 stated the Restorative Aides are told by therapy about new orders. She stated she was not sure if Restorative or the regular CNA's are supposed to be putting the splint on. Interview on 04/25/19 at 1:14 PM, with CNA #4, a Restorative Aide, confirmed she was not aware of an order for a knee splint for Resident #95.	F 688	nurses reviewed care plans/Kardexes of current residents for accuracy in regards to splints; fourteen (14) current resident have orders for splints, fourteen (14) care plans were reviewed and eight (8) updated. Fourteen (14) are accurately flowing to Kardex. A review was initiated on 5/23/19 by Minimum Data Set (MDS) nurses of current resident care plans for range of motion; eighty (80) care plans were updated for active/passive range of motion. 3. On 5/24/19, staff in-services were initiated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on following care plans and physician orders specifically related to splints and providing active and/or passive range of motion per care plan/kardex to help reduce risk of contracture development. 4. Beginning on 5/31/19, residents with orders for splints will be monitored through direct care observations by the DON/Assistant DON to ensure splits are being donned and doffed and passive/active range of motion per orders/care plan and Kardex. Four (4) residents will be observed weekly for four (4) weeks, then monthly for three (3) months then quarterly thereafter. The DON will report observation findings to Quality Assurance Performance Improvement committee monthly for three (3) months. The DON is responsible for on-going monitoring and compliance.	

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F 688	Continued From page 29 Interview on 04/25/19 at 2:30 PM, with CNA #3, revealed she thought she remembered doing a check off a long time ago for putting a splint on Resident #95, but could not recall ever putting a splint on her knee until today. During an interview on 04/25/19 at 2:45 PM, the DON confirmed she would have to say that Resident #95 had not had the splint on as she should have. She stated she has no documentation to prove the resident has had the splint on.	F 688		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to provide resident's food preferences for two (2) of five (5) meals observed, Resident #82. Findings include: A review of the facility's policy titled "Dining and Food Preferences", revised 9/2017, revealed the	F 806	F806 Resident Allergies, Preferences, Substitutes 1. On 4/24/19, food preferences were updated for Resident #83 by Dietary Manager. 2. On 5/3/19, Dietary Manager initiated updating food preferences evaluations for current residents; tray card system was updated to reflect preferences; residents who receive PO diet were potentially	5/31/19

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F 806	Continued From page 30 Dining Services Director or designee will interview the resident or representative to complete a food preference interview within 48 hours of admission and enter into the medical record. The policy revealed one of the purposes of the interview was to identify the individual preferences for food and beverages. The preferences would be identified on the individual tray tickets. An observation on 04/23/19 at 8:33 AM, revealed Resident #82 had a breakfast tray set down on her overbed table. Resident #82 said she did not drink milk and told the nurse to take the milk back. During an interview on 4/23/19 at 8:33 AM, Resident #82 said she has told the staff over and over about the milk the last few weeks, and they still send it. Resident #82 also said she would love to have meat with her breakfast. She said the other meals she would be served meat, but on the breakfast tray she only gets eggs. A review of the Nutritional Therapy Evaluation, dated 3/27/19, did not list any preferences for Resident #82. A review of Resident #82's Dietary Note, dated 3/27/19, did not list any food preferences. A review the meal tray card for 4/24/19, revealed Resident #82 did not have her preferences listed and milk was on the card to be served. An observation on 4/24/19 at 8:15 AM, revealed milk served on the breakfast tray and no meat served. A review of the meal tray cards, for 04/24/19,	F 806	impacted. 3. On 4/26/19, contracted food services District Manager education the Dietary Manager on obtaining food preferences and ensuring resident choices are accurate on tray cards. Beginning on 4/26/19, District Manager and Dietary Manager educated dietary staff on obtaining food preferences and ensuring resident choices are accurate on tray cards. On 5/24/19, staff in-services were initiated by Administrator (ADM), Director of Nursing (DON), and Administrator in Training (AIT) on resident preferences as it relates to food choices. 4. Starting 5/31/19, resident meal preferences will be monitored through direct observations by District Manager/Dietary Manager. Four (4) residents will monitored weekly for four (4) weeks, monthly for three (3) months and then quarterly thereafter. The Administrator will report observation findings to the Quality Assurance Performance Improvement committee for review and recommendation, monthly for three (3) months. The Administrator is responsible for on-going monitoring and compliance.	

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F 806	Continued From page 31 revealed Resident #82 had milk listed for breakfast and dinner trays. An interview on 04/24/19 at 09:56 AM, with the Dietary Manager (DM), revealed the card lists the items to be served at meals and she confirmed the preferences should be listed on the tray cards. She confirmed that Resident #82's tray cards did not list milk as a dislike. The DM said the preferences would be listed in bold. The DM said the Renal diet at this facility did not include meat on the breakfast meal, but the resident could have meat if requested. The DM said she was not aware of the preferences and would talk to the resident today after she returns from dialysis. A review of the Resident #82's physician orders revealed an order for a Renal Diet.	F 806		

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	255148	A. BUILDING **02 - NEW MAIN BUILDING** B. WING _____	**04/24/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 05/31/2019

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 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.

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 _____	04/24/2019

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
E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 4/24/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 05/31/2019

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