MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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, MS #15856, along with a recertification survey from 4/22/19 through 4/25/19. The complaint was substantiated for not honoring a resident's preferences of bathing, for one (1) of three (3) areas of the complaint. The SA also determined during the annual recertification survey, that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M500, M610, M625, and M780. The census at the time of survey was 136 and the facility held a license for 145 beds.	M 000		
M 500	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	M 500		5/31/19

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

Electronically Signed | 05/31/19

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 500	Continued From page 1 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 500	Continued From page 2 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 500	Continued From page 3 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 500	Continued From page 4 the fullest exercise of these rights. This Statute is not met as evidenced by: Level II 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. 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.	M 500	M500 45.17.2 Resident Rights 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 500	Continued From page 5 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 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	M 500	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 500	Continued From page 6 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.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident interview, staff interview, record review, and facility policy review, 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,	M 610	M610 45.21.2 Activities of Daily Living 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	5/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 610	Continued From page 7 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 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.	M 610	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.	
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of	M 625		5/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 625	Continued From page 8 motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level II 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. 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	M 625	M625 Range of Motion 1. 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. 2. 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. 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. 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. 4. Beginning on 5/31/19, residents with orders for splints will be monitored through direct care observations by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 625	Continued From page 9 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. 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.	M 625	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.	
M 780	45.27.2 Activity Program Activity Program. Provisions shall be made for suitable recreational and entertainment activities for resident according to their needs and interests. These activities are an important adjunct to daily living and are to encourage	M 780		5/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 780	Continued From page 10 restoration to self-care and resumption of normal activities. Variety in planning shall include some outdoor activities in suitable weather. Level II Based on Resident interview, staff interview and 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	M 780	M45.27.2 Activity Program 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 780	Continued From page 11 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 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	M 780	three (3) months. The ADM is responsible for on-going monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CI	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTH(	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 780	Continued From page 12 an activity. No other day had the activity of bead making listed. Record review of the Minimum Data Set, Brief Interview for Mental Status score for both Resident #51 and Resident #101 was 15, which indicated no cognitive impairment.	M 780		