STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255148	A. BUILDING _____ B. WING _____	C 07/14/2022

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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to report an allegation of abuse for one (1) of three (3) residents reviewed for abuse. Resident #96. Findings Include:	F 609	1. Resident #95 was interviewed on 7/14/2022, by State Agency and Administrator regarding abuse/neglect concerns; On 7/14/2022, reporting of alleged abuse/neglect concerns notated by Resident #95 on behalf of Resident #96 with a BIMS (Brief Interview Mental	8/15/22

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

Electronically Signed | 07/26/2022

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F 609	Continued From page 1 A record review of the facility's "Abuse Prohibition Policy" with a revision date of 5/28/2021 revealed, " ...Policy ...2. The facility ...will provide notification of information to the proper authorities according to state and federal regulations ...Reporting/Response: 1. Any employee who becomes aware of an allegation of abuse ...shall report the incident to the Abuse Coordinator immediately. 2. The facility will report all allegations and substantial occurrences of abuse ...to the State Agency (SA) and to all other agencies as required by law ..." On 7/14/22 at 2:55 PM, in an interview with Resident #95, he stated that a little over a month ago, he saw and heard his previous roommate, Resident #96, getting "popped" by Registered Nurse (RN) #1, who is the wound care nurse. On 7/14/22 at 4:18 PM, in an interview with the Director of Nursing (DON), she stated she was aware of the incident and that the Administrator had the investigation in her office. She said she (the DON) did not report it to the SA. On 7/14/22 at 4:35 PM, in an interview with the DON, she stated she was on vacation when the incident occurred and when she returned on 6/13/22, the incident was reported to her as Resident #96 was having a behavior issue and not as an allegation of abuse. On 7/14/22 at 4:50 PM, in an interview with RN #1, she stated the event happened about a month ago. She stated she completed a statement that had another form attached to it and it may have been an incident report because she signed it and it had a comments section on it.	F 609	Status) of 0, was reported to the State Agency Abuse Hotline. Registered Nurse (RN) #1, was immediately suspended by the Administrator on 7/14/2022, pending investigation, which resulted her returning to the facility on 7/19/2022, receiving a written disciplinary action and education by the Administrator and Director of Nursing in regards to correct protocol and procedures for performing care for demented and combative residents. 2.Each of the 132 residents in the facility on July 15, 2022, had the potential to be affected. 3. On 7/14/2022, the Regional Vice President educated facility Administrator and Director of Nursing on requirements of abuse/neglect prohibition policy including reporting requirements. Beginning 7/14/2022 facility staff participated in abuse/neglect questionnaires to determine knowledge retention on abuse/neglect prohibition training; individuals who could not answer each question correctly were provided one-to-one additional training by the Staff Development Coordinator. The final report of the investigation was sent to the State Agency on 7/18/2022. Beginning on 7/14/2022, facility staff were in-serviced by Corporate Clinical Specialist/Director of Nursing regarding abuse and neglect prohibition policy, reporting concerns	

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F 609	Continued From page 2 A record review of a "Grievance Form" dated 6/13/22 revealed, "Nature of grievance: concern from resident care (Proper Name of Resident #95) stated he heard a popping sound during wound care to his roommate" and "Findings of Investigation: Resident (Proper Name of Resident #96) (roommate) was combative with wound care". The grievance form was signed by the Administrator on 6/14/22. On 7/14/22 at 6:27 PM, in an interview with Resident #95 and the Administrator in Resident #95's room, he stated he heard a popping sound and looked over and saw RN #1 popping Resident #96's hand. She popped his hands as you would scold a child and it was loud. He stated the DON never came to talk to him about what he had witnessed and today was the first time he had talked to the Administrator about it. On 7/14/22 at 6:39 PM, in an interview with the Administrator, she stated that before today's interview with Resident #95, she did not have the full picture of what occurred. She confirmed that based on what Resident #95 stated in the interview conducted with the SA and herself, she would have reported the incident as an allegation of abuse to the SA. She did not conduct an interview with Resident #95 on 6/14/22 when she reviewed the grievance even though it stated he reported he heard a "popping" sound. She thought it was a behavior issue and not an abuse issue. She stated she is guilty of not reporting the incident. A record review of Resident #95's "Admission Record" revealed the facility admitted him on 6/17/2019 with diagnoses including Quadriplegia and Unspecified Cord Compression.	F 609	regarding abuse and/or neglect immediately, two hour required reporting timeframe by the facility to the State Agency, protecting residents immediately following allegation of abuse/neglect. The Administrator in-serviced facility staff on Abuse and Neglect Prohibition program including but not limited to the requirement to protect residents, if a staff is involved, they will be suspended, facility is required to report to authorities within two (2) hour time frame, facility is required to conduct a thorough investigation and findings of investigation could lead to staff termination beginning on 7/14/2022. Residents with BIMs scores of 12 or higher were interviewed on 7/15/2022, by Director of Nursing/Risk Manager regarding concerns of abuse or neglect; no concerns noted. Facility staff were interviewed beginning on 7/15/2022 by Director of Nursing/Risk Manager, regarding concerns of abuse or neglect; no concerns noted. A Quality Assurance Performance Improvement committee meeting was held on 7/15/2022 with the Administrator, the Director of Nursing, and Medical Director to review the informed deficiencies and plan of correction; no further recommendations were made. 4. Beginning on 7/18/2022, facility department heads including social services, activities, nursing leadership, business office manager, Minimum Data Set nurses, lead Certified Nursing Assistant (C.N.A.), dietary manager,	

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F 609	Continued From page 3 A record review of Resident #95's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/30/22 revealed he had a Brief Interview of Mental Status (BIMS) score of 15 which indicated his is cognitively intact. A record review of Resident #96's "Admission Record" revealed the facility admitted him on 4/1/2019 with diagnoses including Pressure Ulcer of Sacral Region stage 4 and Cognitive Communication Deficit. A record review of Resident #96's MDS with an ARD of 7/6/22 revealed he had a BIMS score of 00. which indicated he has severe cognitive impairment.	F 609	admissions director, will interview (2) residents in their respective facility areas weekly for twelve (12) weeks, in regards to concerns related to care or treatment from staff related to abuse and/or neglect issues; any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. Beginning on 7/18/2022, the Administrator will review the incident log weekly to ensure reportable events have been investigated and reported as required. Beginning on 7/18/2022, the Administrator will review the grievance log weekly to ensure any allegations have been investigated and reported as required. A report will be submitted by the Administrator to the Quality Assurance Performance Improvement committee on 8/8/2022 and then monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring and compliance.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		8/15/22

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F 610	Continued From page 4 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to conduct a thorough investigation regarding an allegation of abuse for one (1) of three (3) residents reviewed for abuse. Resident #96 Findings Include: A record review of the facility's "Abuse Prohibition Policy" with a revision date of 5/28/2021 revealed, " ...Policy ...2. The facility ...will conduct an investigation of alleged or suspected abuse ...Investigation ...2. The facility will thoroughly investigate all alleged violations and take appropriate actions ...5. Investigations will be prompt, comprehensive and responsive to the situation and contain founded conclusions ..." During an interview on 7/14/22 at 2:55 PM, with Resident #95, he stated that a little over a month ago, he saw Resident #96 who was his previous roommate, Resident #96, getting "popped" by Registered Nurse (RN) #1, who is the wound care nurse. In an interview on 7/14/22 at 4:18 PM, with the Director of Nursing (DON), she stated she was aware of the incident and that the Administrator had the investigation in her office. The DON stated she did not report it to the State Agency.	F 610	1. Resident #95 was interviewed on 7/14/2022, by State Agency and Administrator regarding abuse/neglect concerns; On 7/14/2022, reporting of alleged abuse/neglect concerns notated by Resident #95 on behalf of Resident #96 with a BIMS (Brief Interview Mental Status) of 0, was reported to the State Agency Abuse Hotline. Registered Nurse (RN) #1, was immediately suspended by the Administrator on 7/14/2022, pending investigation, which resulted her returning to the facility on 7/19/2022, receiving a written disciplinary action and education by the Administrator and Director of Nursing in regards to correct protocol and procedures for performing care for demented and combative residents. 2.Each of the 132 residents in the facility on July 15, 2022, had the potential to be affected. 3. On 7/14/2022, the Regional Vice President educated facility Administrator and Director of Nursing on requirements of abuse/neglect prohibition policy	

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F 610	Continued From page 5 On 7/14/22 at 4:35 PM, in an interview with the DON, she stated she was on vacation when the incident occurred. She reported that when she returned on 6/13/22, the incident was reported to her as Resident #96 was having a behavior issue. It was not reported to her as an allegation of abuse. RN #1 reported during an interview on 7/14/22 at 4:50 PM, that the event happened about a month ago. She stated she completed a statement that had another form attached to it. She stated it may have been an incident report. She reported she signed it and it also had a comments section on it. She denied that she slapped the resident and stated that he was being combative during wound care. Record review of a "Grievance Form" dated 6/13/22 revealed, "Nature of grievance: concern from resident care (Proper Name of Resident #95) stated he heard a popping sound during wound care to his roommate" and "Findings of Investigation: Resident (Proper Name of Resident #96) (roommate) was combative with wound care". The grievance form was signed by the Administrator on 6/14/22. In an interview with Resident #95 in his room along with the Administrator, on 7/14/22 at 6:27 PM, Resident #95 stated he heard a popping sound and looked over and saw RN #1 popping Resident #96's hand. She popped his hands like you would scold a child. It was loud. He stated the DON never came to talk to him about what he had witnessed. He stated that today was the first time he had talked to the Administrator about the incident.	F 610	including reporting requirements. Beginning 7/14/2022 facility staff participated in abuse/neglect questionnaires to determine knowledge retention on abuse/neglect prohibition training; individuals who could not answer each question correctly were provided one-to-one additional training by the Staff Development Coordinator. The final report of the investigation was sent to the State Agency on 7/18/2022. Beginning on 7/14/2022, facility staff were in-serviced by Corporate Clinical Specialist/Director of Nursing regarding abuse and neglect prohibition policy, reporting concerns regarding abuse and/or neglect immediately, two hour required reporting timeframe by the facility to the State Agency, protecting residents immediately following allegation of abuse/neglect. The Administrator in-serviced facility staff on Abuse and Neglect Prohibition program including but not limited to the requirement to protect residents, if a staff is involved, they will be suspended, facility is required to report to authorities within two (2) hour time frame, facility is required to conduct a thorough investigation and findings of investigation could lead to staff termination beginning on 7/14/2022. Residents with BIMs scores of 12 or higher were interviewed on 7/15/2022, by Director of Nursing/Risk Manager regarding concerns of abuse or neglect; no concerns noted. Facility staff were interviewed beginning on 7/15/2022 by Director of Nursing/Risk Manager, regarding concerns of abuse or neglect; no concerns noted. A Quality Assurance	

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F 610	Continued From page 6 On 7/14/22 at 6:39 PM, in an interview with the Administrator, she stated that before today's interview with Resident #95, she did not have the full picture of what occurred and stated she is guilty of not completing a thorough investigation. She confirmed that based on what Resident #95 said in the interview conducted with the AS and herself today she would have conducted a thorough investigation which would have included an interview with Resident #95 when she reviewed the grievance. She reported that she had conducted interviews with staff and residents, but it was all verbal. She confirmed she did not document anything or have anything in writing. A record review of the Admission Record revealed Resident #95 was admitted to the facility on 6/17/2019 with diagnoses including Quadriplegia and Unspecified Cord Compression. A record review of Resident #95's Minimum Data Set (MD'S) with an Assessment Reference Date (AR) of 5/30/22 revealed he had a Brief Interview for Mental Status (BINS) score of 15 which indicated he is cognitively intact. Record review of Resident #96's Admission Record revealed the facility admitted him on 4/1/2019 with diagnoses including Pressure Ulcer of Sacral Region stage 4 and Cognitive Communication Deficit. Record review of Resident #96's MD'S with an AR of 7/6/22 revealed he had a BINS score of 00 which indicated he has severe cognitive impairment.	F 610	Performance Improvement committee meeting was held on 7/15/2022 with the Administrator, the Director of Nursing, and Medical Director to review the informed deficiencies and plan of correction; no further recommendations were made. 4. Beginning on 7/18/2022, facility department heads including social services, activities, nursing leadership, business office manager, Minimum Data Set nurses, lead Certified Nursing Assistant (C.N.A.), dietary manager, admissions director, will interview (2) residents in their respective facility areas weekly for twelve (12) weeks, in regards to concerns related to care or treatment from staff related to abuse and/or neglect issues; any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. Beginning on 7/18/2022, the Administrator will review the incident log weekly to ensure reportable events have been investigated and reported as required. Beginning on 7/18/2022, the Administrator will review the grievance log weekly to ensure any allegations have been investigated and reported as required. A report will be submitted by the Administrator to the Quality Assurance Performance Improvement committee on 8/8/2022 and then monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring and compliance.	