STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195482	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands Healthcare Center	144 Thad Bailes Rd Leesville, LA 71446

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment by failing to ensure residents received services necessary to maintain a sanitary, orderly, and comfortable interior for 2 (#R1 and #R6) of 10 Sampled Residents.Findings: #R1 Observation on 03/12/2026 at 4:29 a.m. of Resident # R1, in her room revealed a strong BM odor upon entrance. S6CNA revealed the 2 Y Hall CNAs had just changed Resident #R1. Observation with S6CNA revealed a large amount of smeared BM throughout the resident's bed linen. S6CNA revealed the 2 Y Hall CNAs should have changed Resident #R1's bed linen when they changed the brief during toileting care, but had not. #R6Observation on 03/12/2026 at 4:54 a.m. of Resident #R6, in her room revealed a strong urine and BM odor and uncontained soiled clothing near the door area of the room and pants on the floor with BM present. Resident #R6 revealed staff had not been by to check on her, and she was up and going to get coffee. Interview on 03/12/2026 at 5:03 a.m. with S10LPN confirmed residents who require assistance with ADLs should be assisted timely and Resident #R1 and Resident #R6's rooms should be free of soiled linen and BM on clothing.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review, the facility failed to identify a situation as an alleged violation involving abuse, and immediately report the alleged violation involving abuse to the administrator of the facility for 1 (Resident #1) of 10 sampled residents. Findings: Review of the facility's policy on 03/16/2026 at 1:22 p.m. titled Abuse and Neglect- Clinical Protocol dated 10/15/2022 read in part.Altercations between residents should be reviewed as a potential situation of abuse. Both residents having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. It is important to remember that abuse included the term willful which means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. Example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful, as defined in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal Abuse- the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. Physical Abuse - this includes but is not limited to hitting, slapping, pinching, and kicking. Interview on 03/12/2026 at 6:43 a.m. with Resident #1 revealed she had an altercation with Resident #2, on Saturday 03/07/2026. Resident #1 revealed she was in her room, in bed and heard a noise. Resident #1 revealed she heard someone in her bathroom, so she got up to check. Resident #1 revealed she saw Resident #2 in her bathroom, and stated He shoved the bathroom door open on me and screamed for me to get out of his room. Resident #1 revealed Resident #2 then shoved her against the wall. Resident #1 stated she fell, and Resident #2 was on top of her and began to pull her hair. Resident #1 stated Resident #2 called her a Stupid b*tch! Resident #1 revealed she yelled for help. Resident #1 stated S4LPN and S11CNA came to help her when she yelled for help, and got Resident #2 away from her. Resident #1 revealed she slapped Resident #2 when he called her a b*tch and she informed S4LPN of what happened regarding Resident #2 shoving her, pulling her hair, and calling her a b*tch. Record review of Resident #1's medical record on 03/12/2026 at 7:38 a.m. revealed no documentation of an incident, or abuse allegation between Resident #1 and Resident #2. Interview on 03/16/2026 at 9:45 a.m. with S1Administrator confirmed the facility had no SIMS reports since last survey on 02/19/2026 and there had been no recent resident to resident abuse allegations reported to her. Interview on 03/12/2026 at 10:35 a.m. with S2DON and S3ADON revealed staff had not made them aware of any abuse allegations regarding Resident #1 and Resident #2. S2DON acknowledged staff were to report abuse allegations. S2DON revealed staff had not reported any abuse allegations to administration regarding Resident #1 and Resident #2. Interview on 03/16/2026 at 10:55 a.m. with S4LPN revealed she did not report, or complete an incident report related to Resident #1's abuse allegation as she did not think, or feel it required reporting. S4LPN confirmed she received abuse and incident reporting training from the facility. S4LPN stated she did not think the incident between Resident #1 and Resident #2 was verbal abuse as she only heard Resident #2 mumble the B word as she was escorting him away from Resident #1, and she did not think Resident #1 heard. S4LPN stated she felt verbal abuse would be if he kept on repeating bad words or repeating/loudly stating things to someone. S4LPN stated because she did not witness or see physical contact between the residents there was no need to report. S4LPN acknowledged Resident #1 reported to her and alleged Resident #2 shoved her, pulled her hair, and called her a b*tch, and the allegation should have been reported, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but was not. Telephone interview on 03/17/2026 at 11:12 a.m. with S5RN revealed she was the RN weekend supervisor. S5RN revealed on 03/07/2026, S4LPN informed her that Resident #1 reported to S4LPN that Resident #2 had went into Resident #1's room, and put his hands on Resident #1. S5RN revealed Resident #1 did not state to her specifically what occurred, as the resident had reported this to S4LPN, and S4LPN informed her that she had already taken care of the situation. S5RN revealed S4LPN reported to her that she had separated the residents, and contacted the physician about Resident #2's increase in behaviors. S5RN revealed she did not feel Resident #1's abuse allegation needed to be reported because the resident had no injuries, and she did not witness the incident. S5RN confirmed she received abuse training on hire and annually. S5RN confirmed abuse allegations require reporting.Interview on 03/17/2026 at 2:00 p.m. with S2DON confirmed any allegation of abuse required reporting by staff, so that a proper investigation could be completed. S2DON acknowledged that Resident #1's abuse allegation had not been reported to administrator by staff, and should have been.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who are unable to carry out ADLS (Activities of Daily Living) received the necessary services to maintain good grooming and personal hygiene for 5 (#R2, #R3, #R4, #R5, and #R7) of 10 Sampled Residents. The facility failed to ensure Resident's received proper assistance for elimination and bed mobility.Findings:Review of the facility policy on 03/16/2026 at 1:22 p.m. titled Activities of Daily Living, Supporting and dated 03/2018 read in part. 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. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: 1. Hygiene (bathing, dressing, grooming, and oral care); 2. Mobility (transfer and ambulation, including walking); 3. Elimination (toileting); 4. Dining (meals and snacks); and 5. Communication (speech, language, and any functional communication systems). Interview on 03/12/2026 at 4:20 a.m. with S6CNA revealed she worked the 7:00 p.m. - 7:00 a.m. shift fulltime. S6CNA revealed the facility had only been staffing 1 CNA to work the 7:00 p.m. shift on X hall. S6CNA stated she was overworked and gets no help. S6CNA revealed the 2 CNAs from Y hall come to help round on her back half of the X hall. S6CNA stated she was unable to complete all of her assigned duties for her shift revealing she had approximately 7 residents to get up in the morning. S6CNA stated she had not gotten these residents up, and the residents had to wait on the 7:00 a.m. CNA's to finish serving breakfast until they could get them up. S6CNA revealed she had spoken to her supervisor on numerous occasions about her concerns of not being able to accomplish her duties alone, but nothing had changed and the facility informed her it was because the census was low.A random selection of residents was observed with CNA staff to assess for ADL care. #R2Record Review revealed Resident #R2 was admitted to the facility on [DATE]. Resident #R2 had diagnoses that included in part. Epilepsy, Urinary Incontinence, Falls, and Generalized Weakness.Review of Resident #R2's Quarterly MDS with ARD of 02/05/2026 revealed Resident #R2 had BIMS of 03, indicating severe cognitive impairment. Resident #R2 was dependent on staff for toileting and required substantial/maximal assistance from staff for bed mobility.Review of Resident #R2's Care plan with target completion date of 05/19/2026 read in part.The resident has an ADL self-care performance deficit related to: Other Lack of Coordination secondary to effects of CVA. Interventions included; Resident requires assistance with bed mobility. Observation on 03/12/2026 at 4:34 a.m. with S6CNA of Resident #R2, in his room revealed Resident #R2 had bilateral lower legs and feet dangling off the end of his bed. S6CNA revealed, S7CNA and S8CNA from Y Hall had just changed Resident #R2's adult brief, but left him dangling off bed. S6CNA revealed she was the only CNA on X hall and she could not reposition Resident #R2 by herself as the resident required 2 person assist for bed mobility. #R3Record review revealed Resident #R3 was admitted to the facility on [DATE] and had diagnoses that included in part. Retention of Urine, Urinary Tract Infection, and Generalized Muscle Weakness.Review of Resident #R3's Quarterly MDS with ARD of 01/22/2026 revealed Resident#R3 had BIMS of 04 which indicated severe cognitive impairment. Resident #R3 required substantial/maximal assistance of staff for toileting.Review of Resident #R3's Care plan with target completion date of 06/03/2026 read in part.The resident has an ADL self-care performance deficit related to traumatic hemorrhage of cerebrum. Interventions included in part: Resident requires assistance with personal hygiene, and toilet use. Observation on 03/12/2026 at 4:36 a.m. of Resident #R3 in her room with S6CNA revealed a strong urine odor. S6CNA checked Resident #R3's adult brief and confirmed the resident was wet and needed to be changed. S6CNA revealed she had not had a chance to do rounds on this resident yet. #R4Record review revealed Resident #R4 was admitted to the facility on [DATE] and had diagnoses that included in part. Neuromuscular dysfunction of bladder, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hemiplegia and Hemiparesis following CVA, Generalized muscle weakness, and Pressure Ulcer of Sacral Region-Stage 3.Review of Resident #R4's Quarterly MDS with ARD of 12/19/2025 revealed Resident #R4 BIMS was not assessed due to being never or rarely understood. Resident #R4 was totally dependent of staff for ADL care.Review of Resident #R4's Care plan with target completion date of 06/24/2026 read in part.The resident has an ADL self-care performance deficit related to hemiplegia affecting right side, confusion, impaired mobility, and poor activity tolerance. Interventions: Resident is totally dependent in toilet use. Observation on 03/12/2026 at 4:38 a.m. of Resident #R4 in his room with S6CNA revealed a strong BM odor. S6CNA checked Resident #R4's adult brief and confirmed Resident had a BM and needed to be changed. Resident #R4 observed with foley catheter with 1300cc of urine, S6CNA revealed the catheter bag needed to be emptied, but she had not had a chance yet. Interview on 03/12/2026 at 4:43 a.m. with S9LPN on X hall confirmed residents who require assistance with ADL's should be assisted timely and the above observed residents should be free of soiled adult briefs or ADL needs. #R5Record review revealed Resident #R5 was admitted to the facility on [DATE] and had diagnoses that included in part. Congestive Heart Failure, Urinary Tract Infection, Cerebral Infarction, and Chronic Kidney Disease. Review of Resident #R5's Quarterly MDS with ARD of 03/05/2026 revealed Resident #R5 had BIMS of 05 which indicated severe cognitive impairment. Resident #R5 required substantial/maximal assistance of staff for toileting.Review of Resident #R5's Care plan with target completion date of 05/03/2026 read in part.The resident has an ADL self-care performance deficit related to impaired balance, muscle wasting/atrophy and contracture of left hand. Interventions: Resident requires assistance with toilet use. Observation on 03/12/2026 at 4:51 a.m. of Resident #R5 in his room revealed a BM odor. S7CNA and S8CNA checked the resident's adult brief and confirmed resident had a BM and needed to be changed. #R7Record Review revealed Resident #R7 was admitted to the facility on [DATE] and had diagnoses that included in part. Schizophrenia, Mild Intellectual Disability, Personal History of Urinary Calculi, Full incontinence of Feces, and Unspecified Urinary Incontinence.Review of Resident #R7's Quarterly MDS with ARD of 02/27/2026 revealed Resident #R7's BIMS was not assessed due to being never or rarely understood. Resident #R7 was totally dependent of staff for ADL care.Review of Resident #R7's Care plan with target completion date of 05/28/2026 read in part.The resident has an ADL self-care performance deficit r/t Schizophrenia, Mild Intellectual Disability. Interventions: Resident requires assistance with toilet use. Observation on 03/12/2026 at 4:58 a.m. of Resident #R7 in his room revealed a urine odor. S7CNA and S8CNA checked the resident's adult brief and confirmed the resident's brief was saturated with urine and needed to be changed. Interview on 03/12/2026 at 5:00 a.m. with S7CNA revealed most of the residents on Y Hall get up prior to 7:00 a.m. shift coming on. S7CNA revealed they did not have time to help S6CNA on X hall get any resident up, as they had to get the Y hall residents up. Interview on 03/12/2026 at 5:03 a.m. with S10LPN revealed she and other staff had spoken to the CNA supervisor regarding the staffing concerns they had at night and was informed that they were working on getting more staff. S10LPN revealed although there was enough staff on Y hall, when the 2 Y Hall CNAs leave to round on the X hall, she was alone and could not assist residents that required 2 person assist. S10LPN confirmed residents who require assistance with ADL's should be assisted timely and the above observed residents should be free of soiled adult briefs or ADL needs.