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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255148 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Woodlands Rehabilitation and Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 102 Woodchase Park Drive Clinton, MS 39056 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>42807</p> <p>Based on observations, interviews, facility policy review, and record review, the facility failed to ensure a clean, homelike environment for three (3) of five (5) sampled residents, Residents #2, #3, and #4.</p> <p>Findings Include:</p> <p>A review of the facility's policy titled Homelike Environment, revised February 2021, revealed Residents are provided with a safe, clean, comfortable, and homelike environment . 1. Staff provides person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include: a. clean, sanitary, and orderly environment . f. pleasant, neutral scents .</p> <p>On 09/23/24 at 1:25 PM, during an observation of Resident #2's room, an extremely strong urine odor was noted. A wet incontinence brief was found in a plastic bag inside the room's trash can.</p> <p>On 09/23/24 at 1:30 PM, during an interview, Licensed Practical Nurse (LPN) #1 agreed Resident #2's room had a very strong odor of urine.</p> <p>On 09/23/24 at 2:05 PM, during an interview, Certified Nursing Assistant (CNA) #1 stated that she had noticed the strong urine odor before 11:00 AM but had not located the source or notified housekeeping. The room continued to have a pungent urine smell throughout the day.</p> <p>On 09/23/24 at 2:35 PM, during an interview with the Assistant Housekeeping Supervisor, she confirmed that she smelled the strong odor of urine in the room of Resident #2.</p> <p>On 09/23/24 at 3:20 PM, an observation of Resident #3 and Resident #4 in their shared room revealed both residents seated on their beds with an extremely strong urine odor in the room. A urinal and a pool of spilled urine was noted under the bed of Resident #3.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 09/23/24 at 4:10 PM, during an observation and interview, CNA #2 assisted Resident #3 to stand, revealing a non-disposable incontinence pad. The pad was white around three edges but yellowed on one side, with brown streaks and stains in the middle. The pad emitted a strong odor of urine and feces. CNA #2 stated, It's soaking wet under there, the sheet is wet too. It looks like he's just been sitting there letting it go. She reported that she had not entered the room since 1:00 PM.</p> <p>On 09/24/24 at 2:50 PM, during an interview with the Housekeeping Supervisor, she stated that the floor in the room of Resident #3 and Resident #4 needed to be stripped, waxed, and possibly have the tiles replaced. She described the room as smelling like hot pee.</p> <p>On 09/25/24 at 12:05 PM, during an interview with the Director of Nursing (DON), she confirmed that CNAs could summon housekeeping services at any time or provide cleaning of urine or bodily fluids themselves to maintain a clean and safe environment for residents.</p> <p>A record review of Resident #2's Admission Record revealed that the facility admitted the resident on 03/24/2020. The resident had diagnoses that included Cerebral Infarction (Stroke), Repeated Falls, and Malignant Neoplasm of the Bladder.</p> <p>A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated no cognitive impairment. Section GG indicated Resident #2 required moderate assistance for toileting hygiene. Section H indicated Resident #2 was frequently incontinent of bowel and bladder.</p> <p>A record review of Resident #3's Admission Record revealed that the facility admitted the resident on 11/29/21. The resident had diagnoses that included Stage 3 Chronic Kidney Disease, Psychotic Disorder, and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms.</p> <p>A record review of Resident #3's Quarterly MDS with an ARD of 08/17/24, in Section C revealed a BIMS score of thirteen (13), which indicated Resident #3 was cognitively intact. Section GG indicated revealed the resident required substantial assistance for personal hygiene and supervision for toileting.</p> <p>A record review of Resident #4's Admission Record revealed that the facility admitted the resident on 10/30/23 with diagnoses of Cerebral Infarction (Stroke) and Cognitive, Social or Emotional Deficit following Cerebral Infarction.</p> <p>A record review of Resident #4's Quarterly MDS with an ARD of 07/26/24 revealed a BIMS score of 99, indicating the resident was unable to participate in the interview.</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42807</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the Comprehensive Care Plan interventions were implemented for two (2) of five (5) sampled residents. Residents #2, and #3</p> <p>Findings Include:</p> <p>A review of the facility policy titled Care Plans Comprehensive Person-Centered, reviewed January 2023, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .</p> <p>Resident #2</p> <p>A record review of the comprehensive care plan for Resident #2 with a date initiated of 3/25/2020 revealed Focus: The resident has an ADL (activities of daily living) self-care performance deficit .Interventions/Task . Personal Hygiene: The resident requires ext (extensive) assistance x 1 staff with personal hygiene and oral care.</p> <p>Record review of the comprehensive care plan for Resident #2 with a date initiated of 3/7/2022 revealed Focus: The resident has a communication problem .Interventions/Task .Anticipate and meet needs.</p> <p>Record review of the comprehensive care plan with a date initiated of 3/25/2020 revealed Focus: The resident is at risk for falls .Interventions/Task .Anticipate and meet the resident's needs .</p> <p>Record review of the comprehensive care plan revealed with a date initiated of 3/25/2020 revealed The resident has .impairment to skin integrity .Interventions/Task .Provide peri care with each incontinent episode .anticipate and meet the resident's needs and ensure the resident's call light was within reach.</p> <p>On 9/23/24 at 1:25 PM, an observation of Resident #2 revealed the resident was kneeling at his bedside wearing a saturated incontinence brief that had sagged down to his lower thighs.</p> <p>On 9/23/24 at 2:05 PM, during an interview, Certified Nursing Assistant (CNA) #1 stated that she last checked Resident #2 for incontinence care before 11:00 AM. CNA #1 confirmed that Resident #2's care plan required incontinence with every incontinent episode, to prevent skin breakdown. CNA #1 stated that she returned from lunch at 1:29 PM but had not checked on Resident #2 until 1:50 PM.</p> <p>A record review of Resident #2's Admission Record revealed that the facility admitted the resident on 3/24/2020, The resident had diagnoses that included Cerebral Infarction (Stroke), Repeated Falls, and Malignant Neoplasm of the Bladder.</p> <p>(continued on next page)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/24 revealed in Section C, a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated Resident #2 was cognitively intact. Section GG indicated Resident #2 required moderate assistance for toileting hygiene. Section H indicated Resident #2 was frequently incontinent of bowel and bladder.</p> <p>Resident #3</p> <p>A record review of the comprehensive care plan, undated, revealed Focus: .Prefers to have his urinal on his bedside table .Interventions: Assist with emptying urinal as needed .</p> <p>A record review of the comprehensive care plan, undated, revealed Focus: The resident is at risk for falls r/t (related to) weakness .Interventions .Anticipate and meet the resident's needs .</p> <p>A record review of the comprehensive care plan, undated revealed Focus: The resident has potential/actual impairment to skin integrity . Interventions .Provide peri-care every 2 hrs (hours) and prn (as needed).</p> <p>On 9/23/24 at 3:20 PM, an observation of Residents #3 revealed his room had a strong urine odor. Resident #3 was sitting up in bed on a saturated incontinence pad. There was a urinal and a pool of urine under the resident's bed.</p> <p>On 09/23/24 at 4:10 PM, as CNA #2 provided incontinence care to Resident #3, an observation revealed the incontinence pad was soaked with urine and feces. CNA #2 confirmed that she had last checked Resident #3's urinal and incontinence pad around 1:00 PM and had not provided care since then.</p> <p>A record review of Resident #3's Admission Record revealed that the facility admitted the resident on 11/29/21. The resident had diagnoses that included Stage 3 Chronic Kidney Disease, Psychotic Disorder, and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms.</p> <p>A record review of Resident #3's Quarterly MDS with an ARD of 08/17/24, in Section C revealed a BIMS score of thirteen (13), which indicated Resident #3 was cognitively intact. Section GG indicated revealed the resident required substantial assistance for personal hygiene and supervision for toileting.</p> <p>On 9/25/24 at 12:05 PM, during an interview, the Director of Nursing (DON) confirmed that it was crucial for staff to follow each resident's care plan interventions and care instructions. The DON explained that all care plans were accessible via the facility's documentation software, generating care instructions available to CNAs through the Kardex.</p> <p>On 9/25/24 at 1:50 PM, the Minimum Data Set (MDS) Coordinator emphasized that following the care plan was essential, as it detailed the instructions for providing individualized care to each resident. She stated that if staff did not follow care-planned instructions for an incontinent resident, it could result in falls or skin damage.</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>42807</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that timely incontinent care was provided two (2) of five (5) sampled residents. Residents #2 and #3</p> <p>Findings Include:</p> <p>Resident #2</p> <p>On 09/23/24 at 1:25 PM, during an observation and interview, Resident #2 was found kneeling on a bedside mat with his upper torso resting on the mattress. He was wearing a saturated incontinence brief that had sagged down to his lower thighs.</p> <p>On 09/23/24 at 2:05 PM, during an interview, Certified Nursing Assistant (CNA) #1 stated that she last checked Resident #2 for incontinence care before 11:00 AM on 09/23/24. CNA #1 confirmed that Resident #2's care instructions included incontinence care every two (2) hours and as needed. CNA #1 returned from lunch at 1:29 PM and found the resident on the floor but had not provided care between 11:00 AM and 1:29 PM.</p> <p>A record review of Resident #2's Admission Record revealed that the facility admitted the resident on 03/24/2020, The resident had diagnoses that included Cerebral Infarction (Stroke), Repeated Falls, and Malignant Neoplasm of the Bladder.</p> <p>A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated no cognitive impairment. Section GG indicated Resident #2 required moderate assistance for toileting hygiene. Section H indicated Resident #2 was frequently incontinent of bowel and bladder.</p> <p>Resident #3</p> <p>During an observation of incontinence care and interview on 09/23/24 at 4:10 PM, revealed CNA #2 began providing incontinence care to Resident #3. The incontinence pad was soaked with urine and feces. CNA #2 confirmed that she had last checked Resident #3's urinal and incontinence pad around 1:00 PM and had not provided care between 1:00 PM and 3:47 PM.</p> <p>A record review of Resident #3's Admission Record revealed that the facility admitted the resident on 11/29/21. The resident had diagnoses that included Stage 3 Chronic Kidney Disease, Psychotic Disorder, and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms.</p> <p>A record review of Resident #3's Quarterly MDS with an ARD of 08/17/24, in Section C revealed a BIMS score of thirteen (13), which indicated Resident #3 was cognitively intact. Section GG indicated revealed the resident required substantial assistance for personal hygiene and supervision for toileting.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 09/23/24 at 4:35 PM, Registered Nurse (RN) #1 stated that CNAs were expected to make rounds every two (2) hours and provide incontinence care as needed.</p> <p>During an interview on 09/24/24 at 12:41 PM, the Risk Management Nurse confirmed that CNAs were expected to make rounds every two (2) hours to ensure residents' needs were met and call lights were within reach.</p> <p>During an interview on 09/25/24 at 12:05 PM, the Director of Nursing (DON) confirmed that CNAs were responsible for making rounds every two (2) hours and as needed. She stated that all residents' care instructions were documented in the Kardex within the facility's documentation software, and CNAs had access to these instructions.</p> |

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| <p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Keep all essential equipment working safely.</p> <p>42807</p> <p>Based on observation, policy review, record review, and staff interviews, the facility failed to ensure mechanical patient care equipment was maintained in a safe operational condition for one (1) of six (6) mechanical lifts.</p> <p>Findings Include:</p> <p>A review of the facility policy titled Safe Patient Handling and Moving Protocol, with a review date of 06/10/24, revealed, The QA (Quality Assurance) Committee will ensure implementation of this policy to identify, assess, and develop strategies to control risk of injury to residents and nursing staff associated with the lifting, transferring, repositioning or movement of a resident . Mechanical or Electric Lift . All staff shall adhere to each lift's specific manufacturer guidelines for safe handling and operation .The facility should develop and assign routine maintenance schedules to ensure equipment is in good working order .</p> <p>A record review of the User Manual Stand Up Patient Lift, with copyright 2013, revealed . Detecting wear and damage . It is important to inspect all stressed parts . for signs of cracking, fraying, deformation, or deterioration. Replace any defective parts IMMEDIATELY and ensure that the lift is not used until repairs are made .</p> <p>On 09/23/24 at 1:25 PM, during an observation revealed Registered Nurse (RN) #2 and Licensed Practical Nurse (LPN) #1 attempting to use a mechanical lift to move Resident #2 to his bed. The 100 Hall stand-up lift did not work when the hand control buttons were pressed. LPN #6 retrieved two (2) additional batteries, however, that did not resolve the issue with the lift. She then retrieved a third battery from another lift, and the transfer was completed at 1:45 PM.</p> <p>On 09/23/24 at 2:00 PM, during an interview, LPN #6 stated that the lift wouldn't work, so she retrieved a battery from the charger at the 100 Hall nurse's station, but it did not fix the problem. She ultimately retrieved a third battery from another lift on a different hall, leaving that lift inoperable due to the lack of a battery.</p> <p>On 09/24/24 at 5:00 PM, during an observation and interview with CNA #3 and the Risk Management Nurse, it was demonstrated that the stand-up lift on the 100 Hall did not operate unless the battery was squeezed into place with one hand while pressing the control buttons with the other hand. The Risk Management Nurse stated that the lift presented a risk to residents and should be removed from service until repaired by the Maintenance Director.</p> <p>On 09/25/24 at 12:05 PM, during an interview, the Director of Nursing (DON) stated that the facility had seven (7) lifts, but one (1) was out of service, leaving six (6) in operation. She confirmed that CNAs were supposed to place the batteries on chargers at the nursing stations at the end of each shift and when charging was necessary to power lifts for resident care. She further explained that any equipment in need of repair should be removed from use using the tag-out/lock-out procedure and documented in TELS (maintenance management software).</p> <p>(continued on next page)</p> | | |

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| <p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 09/25/24 at 2:17 PM, during an interview, CNA #4 stated that CNAs were responsible for charging lift batteries as needed and reporting equipment in need of repair. She confirmed that any staff member could tag equipment that was not functioning properly to notify others.</p> <p>On 09/25/24 at 2:35 PM, during an interview, LPN #4, Staff Coordinator, stated that she was aware of the issues with lift batteries and that nurses were supposed to monitor to ensure that batteries were charged. She was surprised to learn that any staff had used lifts that were malfunctioning.</p> <p>On 09/25/24 at 2:45 PM, during an interview, CNA #5 confirmed that she had received in-service training on the use of mechanical lifts, including instructions not to use lifts that were broken or in disrepair.</p> <p>On 09/25/24 at 4:08 PM, during an observation and interview, the Maintenance Director explained that the facility staff used TELS to report any maintenance issues. He had not received any work orders for lifts as of the interview. The Maintenance Director demonstrated that the prong on the lift where the battery snapped into place was bent forward, causing a gap between the battery and the lift, explaining why it only worked when the CNA squeezed the battery. He emphasized that using malfunctioning equipment could lead to resident injury.</p> <p>A record review of Resident #2's Admission Record revealed that the facility admitted the resident on 03/24/20. Resident #2's diagnoses included Cerebrovascular Disease, Repeated Falls, and Malignant Neoplasm of the Bladder.</p> <p>A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated the resident was cognitively intact.</p> | | |