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	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Rehabilitation and Healthcare Center	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42807 Based on observation, interviews, record review, and facility policy review, the facility failed to provide adequate supervision to prevent Resident #1, a vulnerable resident, from leaving the facility premises unsupervised for one (1) of six (6) residents reviewed. Resident #1. On 3/22/25 at 8:17 AM, Resident #1, who has a Brief Interview for Mental Status (BIMS) score of 7, left the facility unsupervised. The facility's transportation aide let the resident out of the front door to sit on the porch. Licensed Practical Nurse (LPN) #1 encountered Resident #1 in the facility parking lot and attempted to redirect the resident back to the facility. She left the resident unsupervised to get help from additional staff. When staff returned, the resident had moved further off-site, and was across the street in a daycare parking lot, approximately one-fourth (1/4) of a mile from the facility. The resident was out of sight and unsupervised for approximately 13 minutes. The facility's failure to adequately supervise Resident #1, a vulnerable resident, put this resident and all other vulnerable residents at risk for serious injury, serious harm, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 3/22/25, when Resident #1 exited the facility. The State Agency (SA) notified the Administrator of the IJ on 3/28/25 at 10:55 AM and provided an IJ Template. Based on the facility's implementation of corrective actions on 3/25/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 3/26/25, prior to the SA's entrance on 3/27/25. Findings Included: A review of the facility's policy, Wanderer Management, Monitoring System & (and) Resident Elopement Protocol, reviewed 01/2023, revealed, .It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible .All staff is responsible to ensure resident safety . (continued on next page)

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/27/25 at 8:17 AM, an observation revealed the street where the facility was located on a two-way roadway with 18 inches of cement along the edge of both sides of the street between the asphalt. There were no crosswalks and the curbs were approximately eight (8) inches high. The speed limit was posted as 25 miles per hour (mph). There was a wooded area across from the facility and a local business comprised of two separate buildings with a fenced-in playground between the buildings that were across the street and to the right of the facility. There were three (3) vehicles observed on the roadway during a five-minute observation. The facility driveway was one-fourth (1/4) mile from the facility's portico (front entrance) to the street at the lower driveway entrance. It was one-half (0.5) mile from the lower driveway entrance to the parking lot of the second building of the local business across the street from the facility. Observation included that the front entrance of the facility was locked and required a code to be entered into a wall-mounted keypad beside the door on the outside or depression of a button at the front desk in the entranceway. Record review of the Admission Record revealed the facility admitted Resident #1 on 11/19/2024 and he had current diagnoses including Chronic Obstructive Pulmonary Disease (COPD). Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 2/21/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated he his cognition was severely impaired. Record review of the facility's investigation, dated 3/27/25, revealed on 3/22/25, Resident #1 exited through the front door and was observed by LPN #1 while she was leaving the facility at approximately 8:30 AM. LPN #1 went to the resident and tried to assist the resident back to the facility without success and had to reenter the facility for assistance. According to the Facility Investigation, LPN #1 and other staff located Resident #1 across the street in a local business parking lot, approximately one quarter mile from the facility upper driveway and assisted the resident back into the facility at 8:43 AM. Record review of the historical weather information on Wunderground.com, the local weather on 3/22/25 at 8:00 AM had zero (0) precipitation and the temperature was fifty (50) degrees Fahrenheit. On 2/27/25 at 8:35 AM, an interview with the Administrator revealed that on 3/22/25 she was notified of the elopement of Resident #1 by Registered Nurse (RN) #1 at approximately 8:30 AM. She reported that SA was notified, and thorough investigation initiated. She stated that based on security camera footage and interview with RN #1 and LPN #2 it was determined that the resident exited the facility through the front entrance, opened by the Transportation Aide (TA). She said that according to the security camera footage the resident walked down the driveway towards the lower driveway entrance. She stated that LPN #1 was driving out of the parking lot and observed Resident #1 walking up the street towards the upper driveway entrance, parked her car and walked up the street with the resident and attempted to return him to the facility. When Resident #1 refused, LPN #1 went for assistance, returned with other staff and located the resident across the street approximately 1,320 feet from the facility and assisted to return to the facility. The Administrator confirmed that the Quality Assurance (QA) committee met and determined that the root cause of the incident was that resident had been permitted to sit outside in front of the facility near the driveway and street unaccompanied and during a QA meeting on 3/24/25 made recommendations for change of procedure which was presented to the Resident Council on 3/24/25. She confirmed that the resident remained at a behavioral unit with plans for him to return to the facility following assessment and treatment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/27/25 at 2:50 PM, an interview with Certified Nursing Assistant (CNA) #1 revealed she arrived at the facility at 7:00 AM on 3/22/25 and responded to request for assistance at approximately 8:30 AM outside the facility front entrance and she observed Resident #1 across the street in the (local business) parking lot and that the staff assisted the resident to return to the facility. On 3/27/25 at 2:56 PM an interview with the TA revealed that he had opened the door for Resident #1 at approximately 8:17 AM, whom he recognized as a resident who liked to sit outside. The TA said that when he was made aware of the elopement at approximately 8:30 AM he went outside and assisted nursing staff to return the resident to the facility. On 3/27/25 at 4:30 PM an interview with CNA #2 revealed that she was working from 7:00 AM to 7:00 PM on 3/22/25 and was made aware of the elopement per intercom announcement at approximately 8:30 AM and went outside and assisted in returning the resident to the facility. On 3/28/25 at 11:00 AM, during a telephone interview with LPN #2, she reported that she was on duty 7:00 AM through 3:00 PM on 3/22/25 and assigned to the care of Resident #1, with whom she was familiar. At approximately 8:30 AM, she heard an overhead announcement and reported to the Unit 1 Nurses Station where she was notified by LPN #1 that the resident was outside and refused to return to the facility. She confirmed that she and other staff went to assist the resident who had walked a little way up the street and crossed over into the parking lot of a local business that was closed due to it being Saturday. She said following return to his room, Resident #1 refused a body audit but allowed incontinent care during which she was able to observe for signs of injury and observed none. On 3/28/25 at 2:00 PM, an interview with the Director of Nursing (DON) revealed she reported that LPN #1 made her aware of the elopement via telephone on 3/22/25 at approximately 8:30 AM. She stated she was responsible for referrals to behavioral units and securing placement with Resident #1's Representative (RR) consent at a behavioral unit for assessment and treatment due to behavioral chances. She confirmed that she conducted a new Wander/Elopement Assessment and reviewed and updated the resident's care plan and facility elopement binders on 3/22/25. She said that Resident #1 had never exhibited exit seeking or aggressive behaviors prior to 3/22/25. On 3/28/25 at 2:30 PM an interview with the Administrator revealed she stated, The facility could not anticipate that the resident's normal behavior would change. She said that Resident #1's BIMS score indicated cognitive impairment, but he had never exhibited exit seeking or aggressive behaviors prior to 3/22/25. The Administrator confirmed that all steps on the facility's Corrective Action Plan had been completed as of 3/24/25. The facility submitted a corrective action plan as follows: On March 28, 2025, at 10:55 AM -State Agency (SA) notified facility Administrator of Immediate Jeopardy (IJ). The State Agency Surveyor provided the facility with the Immediate Jeopardy (IJ) templates. Facility respectfully submits this corrective action plan. Brief Summary of Events (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/22/2025 at approximately 8:17 AM it was discovered that Resident #1 exited the building through the front entrance with assistance by the facility Transportation Aide #1. Resident #1 was not deemed a wander risk on wander assessment completed 02/2l/2025 and never exhibited wandering behaviors while in the facility. The facility failed to provide supervision to prevent the elopement of Resident# 1, who left the facility unattended. This failure allowed Resident# I to be away from the facility unnoticed and unsupervised on 03/22/2025 from 08:17 AM until 08:30 AM, when the facility nurse noted resident outside in front of the facility. This was approximately 13 minutes after Resident# I was last observed in the facility by Van Driver #1. Corrective Actions On 03/22/2025 at 8:30 AM, LPN (Licensed Practical Nurse) #1 was exiting the facility grounds when she noticed resident#1 pushing his wheelchair and at 8:36 A.M. along with additional staff assisted the resident to return to the facility On 03/22/2025, at approximately 08:40 AM, the Administrator was notified by RN (Registered Nurse)#1 of Resident#1 exited the building without supervision and was back in the building. On 03/22/2025 at approximately 08:45 AM, resident#1 was placed on 1:1 monitoring. On 03/22/2025 at approximately 08:50 AM, Resident#1 Responsible Party was notified by the DON that Resident#1 exited and had been returned to the facility. On 03/22/2025 Nurse Practitioner (NP)#1 was notified by the Director of Nursing of Resident#1 exit of facility and return along with behaviors. NP#1 placed an order for behavioral unit evaluation of Resident#1 for inpatient stay. On 03/22/2025 at approximately 8:55 AM DON contacted Behavior facility with a referral for resident#1 for further evaluation. On 03/22/2025 at approximately 9 AM, Resident# 1 refused a head-to- toe assessment but LPN #2 was able to visually inspect resident#1 during incontinence care. No injuries were noted. On 03/22/2025 at approximately 2:43 PM Resident#1 exited the facility with Behavioral Unit for inpatient stay. On 03/23/2025 at 8:14 PM the State Agency (SA) was notified by the Director of Nurses of the incident. On 03/24/2025 at approximately 9:30 AM, the SOC initiated a 100%, mandatory In-service Training which was completed on 03/25/2025 for elopement (including facility policy review) and the care of residents with difficult behaviors, to be continued for all new hires going forward. No staff are allowed to work until in service completed. On 03/24/2025 at 4:53 PM, the DON completed a post Elopement wander evaluation on Resident #1 and changed to high risk for Elopement, and the care plan was updated to reflect this. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/24/2025 at approximately 12:00 PM, DON reviewed the wander and elopement binders to ensure all were up to date. On 03/24/2025 at approximately 2:00 PM, a Quality Assurance Committee Meeting was held with the Medical Director, Administrator, Director of Nursing/Infection Preventionist, and the Assistant Director of Nursing to discuss Resident #1 elopement along with plan of correction; policies were reviewed with no revisions. The facility procedure for residents sitting outdoors was updated. On 03/24/2025 at approximately 5:00 PM, the Director of Nursing audited current high-risk wander patients to review orders and care plans for accuracy. There was currently one (1) wander patient. And the Administrator performed an elopement drill on 03/25/2025 at 6:30 AM. On 03/24/2025 at 2:48 PM and 03/24/2025 at 5:40 PM the Maintenance director performed elopement drills with staff to review and educate on policies and procedures on elopement. On 03/24/2025 at approximately 9 am a Staff quiz was initiated by the CNA # 2 with all staff on knowledge of the elopement policy. On 03/25/2025 at approximately 10 am Resident council meeting was held by the Administrator to include the President and 19 members to notify of current events and procedure changes to outdoor sitting with supervision in ungated areas. On 03/25/25 at 10 am new procedures were implemented by the Administrator related to residents prohibited from sitting in ungated areas without supervision. On 03/25/25 at approximately 10:10 am new procedures were placed in the new hire orientation package by the Administrator for implementation of the procedure change of residents prohibited from sitting in ungated areas without supervision. On 03/25/25 at approximately PM Wander evaluations were audited by the Director of Nursing on all current residents reveals six residents requiring schedule adjustments. The Director of Nursing will monitor current residents for potential risks through incident report reviews, observation and communication with staff for three (3) months; the Maintenance Director will conduct elopement drills monthly (with rotating shifts until all shifts completed) for three (3) months. The Administrator will present incident report reviews and documentation of drills for review to QA team weekly to monitor compliance with the plan for three (3) months then quarterly. The facility alleges that all corrective actions were completed as of 3/25/25 and the IJ removed 3/26/25 prior to the SA entry on 3/27/25. Validation: The SA validated through interview and record review view, that all corrective actions had been implemented as of 3/25/25, and the facility was in compliance as of 3/26/25, prior to the SA's entrance on 3/27/25.