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	04/29/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review the facility failed to ensure residents were treated with respect and dignity during the provision of care for two (2) of three (3) sampled residents. Resident #2 and Resident #3. Findings Included:Record review of the facility policy, Nursing Facility Resident Rights dated 3/06/26 revealed, The following rights are guaranteed to residents.To be treated with dignity, courtesy and respect.To privacy during personal care, visits, and phone calls .Record review of the facility document titled, Skills Checklist: Feeding a Resident (undated) revealed Procedure Step 11. Stated, Sits facing resident. Sits at resident's eye level. Sits on the stronger side if resident has one-sided weakness. Record review of the facility document titled, Peri care-Incontinent Care revised 1-2023 revealed the procedure indicated .Provide privacy (draw curtain from foot of bed to side up to wall, pull window curtain) .Resident #2On 4/28/26 at 12:55 PM, during an observation Certified Nursing Assistant (CNA) #1 provided incontinent care for Resident #2 without closing the door to the resident's room and with the privacy curtain partially drawn. The State Agency (SA) was at the bottom right corner of the resident's bed and able to see out into the hallway and watch the procedure during which the resident was uncovered and exposed.On 4/29/26 at 2:15 PM, during an interview CNA#1 confirmed that she was aware that assistance with incontinence care required provision of privacy and that she had received training from the facility and passed a competency check-off for incontinent care that included provision of privacy. She confirmed that in-service training included provision of privacy for respectful care and dignity which was each resident's right. On 4/29/26 at 2:15 PM, during an interview CNA#1 confirmed that she was aware that assistance with incontinence care required provision of privacy and that she had received training from the facility and passed a competency check-off for incontinence care that included provision of privacy. She confirmed that in-service training included provision of privacy for respectful care and dignity which was each resident's right. Record review of the admission Record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses that included epilepsy, infection of the skin and subcutaneous tissue, open wound of left upper arm, and gastrostomy status. Record review of the admission Record for Resident #2 revealed the facility admitted him on 12/11/23 and he had diagnoses of epilepsy, infection of the skin and subcutaneous tissue, open wound of left upper arm, and gastrostomy status.Record review of the Quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 3/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 11, which revealed moderate cognitive impairment. Section GG revealed the facility assessed Resident #2 was dependent for toilet hygiene.Resident #3On 4/29/26 at 12:15 PM, during an observation CNA #3 assisted Resident #3 to eat lunch while standing over the resident. The Director of Nursing (DON) instructed CNA #3 that staff were to sit next to residents while assisting with eating. On 4/29/26 at 12:20 PM, during an interview CNA #3 revealed that she forgot to sit beside the resident while assisting with eating.On 4/29/26 at 3:00 PM, during an interview CNA #2 revealed that she was the CNA Supervisor and Scheduler and provided orientation and competency checks-offs for new CNAs and would observe the new CNA s to complete the skills check offs ensure competency (continued on next page)

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

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	04/29/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during orientation and at least annually using the Skills Checklist: Feeding a Resident and the Peri care-Incontinent Care Skills Checklist. She confirmed that nursing staff (nurses and CNAs) received in-service training on residents' rights and treating residents and providing care in a respectful and dignified manner at least monthly. CNA#2 confirmed that provided training included provision of privacy for incontinent care and that staff were to sit beside residents while assisting with eating to provide respectful and dignified care.On 4/29/26 at 2:45 PM, during an interview with Licensed Practical Nurse (LPN)#1, confirmed that nursing staff (nurses and CNA s) received in-service training on residents rights and treating residents and providing care in a respectful and dignified manner at least monthly and that CNAs competency was assessed through competency checks during orientation upon hire and annually using the Skills Checklist: Feeding a Resident and the Peri care-Incontinent Care Skills Checklist (among others that addressed specific skills/procedures). She confirmed that in-service training, resident rights and competency check offs included ensuring respectful care during each procedure and resident interaction, which included provision of privacy, especially for any procedure that involved exposure of residents and sitting beside residents while assisting them to eat.On 4/29/26 at 3:12 PM, during an interview the Director of Nursing (DON) stated the facility provided in-service training that included provision of privacy for all procedures that involved exposure of residents and sitting next to residents while assisting with eating to ensure respectful and dignified care in accordance with Residents' Rights. She confirmed that she observed CNA #2 standing over Resident #3 while assisting her to eat lunch on 4/29/26. On 4/29/26 at 4:10 PM, during an interview with the Administrator revealed that she expected call lights to be left within reach of residents and answered in a timely manner. She confirmed that she expected residents' rights to be protected and promoted for all residents as instructed through monthly facility provided in-service training. She confirmed that the Residents' Rights to dignified and respectful treatment included staff be seated while assisting residents to eat and provision of privacy for incontinence care. Record review of the admission Record for Resident #3 revealed the facility admitted the resident on 4/27/26 and she had diagnoses of cerebral infarction (stroke), anemia, hemiplegia and hemiparesis affecting right dominant side.Record review of the Baseline Care Plan for Resident #3 revealed .A.1. Eating.01 Dependent.

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	04/29/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and skills checklist review the facility failed to ensure a call light was maintained within reach for one (1) of three (3) residents. Resident #2.Findings Included:Record review of the facility policy document titled, Skills Checklist: Feeding a Resident (undated) revealed Procedure Step 21 Leaves call light within resident's reach . The facility was unable to provide a call light policy.On 4/28/26 at 2:15 PM, observation and interview revealed Resident #2 was awake and resting in bed with his lunch tray on the over the bed table in front of him. The resident's call light was lying on the floor under the head of his bed. He stated that he could use his call light but did not know where it was.On 4/29/26 at 12:00 PM, observation revealed that Resident #2 was resting in bed with his lunch tray on the over the bed table in front of him. The resident's call light was behind the head of his bed, hanging behind the mattress and out of the resident's sight and reach. He stated that he could use her call light but did not know where it was. The Director of Nurses (DON) retrieved the call light and placed it within reach of the resident.On 4/29/26 at 2:15 PM, during an interview Certified Nursing Assistant (CNA) #1 said that call lights were to be within the reach of residents. She confirmed that she had received in-service training and passed competency checked off on regarding feeding/serving resident meals and leaving their call lights within reach. On 4/29/26 at 3:00 PM, an interview with CNA #2 confirmed that call lights were to be within the reach of residents and that the facility provided in-service training on resident rights and call lights at least monthly. During an interview on 4/29/26 at 3:15 PM, Licensed Practical Nurse (LPN) #1 stated nurses make rounds throughout the day and use direct observation to ensure call lights are answered in a timely manner, which requires call lights to be within the reach of residents. On 4/29/26 at 3:12 PM, an interview with the DON revealed that she expected call lights to be left within reach of residents and answered in a timely manner. She confirmed that Resident #2 was unable to find or reach his call light at 12:00 PM on 4/29/26.During an interview on 4/29/26 at 4:10 PM, the Administrator stated she expects call lights to be left within the reach of residents and answered in a timely manner. She confirmed the facility does not have a specific policy regarding call light placement. Record review of the admission Record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses that included epilepsy, infection of the skin and subcutaneous tissue, open wound of left upper arm, and gastrostomy status.Record review of the Quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 3/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 11, which revealed moderate cognitive impairment.

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	04/29/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility policy review, and interviews the facility failed to provide treatment and care in accordance with professional standards of practice to prevent urinary tract infections for one (1) of three (3) sampled residents who required incontinent care. Resident #2Findings Included:Record review of the facility policy/procedure titled, Peri Care-Incontinent Care with revision Date 1-2023 (January 2023) revealed the procedure stated, FOR MALE RESIDENTS: For a male resident: a. Wet washcloth/cleaning wipes and apply soap or skin cleansing agent. b. Wash perineal area starting with urethra and working outward.c. Retract foreskin of the uncircumcised male. d. Wash and rinse urethral area using a circular motion. e. Continue to wash the perineal area including the penis, scrotum, and inner thighs. F. Thoroughly rinse perineal area in same order, using fresh water and clean washcloth/cleaning wipes. G. Gently dry perineum following same sequence.On 4/28/26 at 12:55 PM, observation revealed Certified Nursing Assistant (CNA) #1 provided incontinent care for Resident #2. CNA #1 removed Resident #2's wet brief, assisted the resident to turn onto his right side, loosened the fitted sheet, tucked the sheet under the resident, replaced the fitted sheet with a clean one on the left side of his bed, walked to the right side of the bed, assisted him to turn onto his left side and adjusted and secured the fitted sheet and replaced his incontinent brief with a clean, dry brief without cleansing the resident's perineal area front or back. On 4/29/26 at 2:15 PM, during an interview CNA #1 confirmed that she was aware and had completed in-service training and competency check offs for perineal cleansing during incontinent care. She confirmed that on 4/28/26 at 12:55 PM she provided incontinent care for Resident #2, whose incontinence brief was wet with urine, without cleansing his perineal area. She stated that she was nervous but had received training and knew that she was supposed to cleanse the resident's perineal area in addition to replacing his wet brief with a dry one. On 4/29/26 at 3:00 PM, during an interview CNA#2, (the CNA Supervisor and Schedular) revealed she provided in-service training upon hire and during orientation and competency checks-offs for new CNAs and employees during orientation and then annually to ensure skills competency using the Peri- care/ Incontinent Care Skills Checklist. She confirmed that the procedure for incontinent care included cleansing the perineal area, front and back in addition to removal of wet briefs and replacement with a clean dry brief. On 4/29/26 at 2:45 PM, an interview with Licensed Practical Nurse (LPN) #1 confirmed that nursing staff received in-service training using the Peri Care-Incontinent Care Skills Checklist. She confirmed that incontinent care included cleansing the perineal area, front and back. On 4/29/26 at 3:12 PM, during an interview the Director of Nursing (DON) stated the facility provided in-service training that included provision of incontinent care and toileting hygiene for all incontinent residents as needed with orientation and annual competency check offs for CNA s. She confirmed that incontinent care included cleansing the perineal area, front and back. On 4/29/26 at 4:10 PM, an interview with the Administrator revealed that she expected CNA s to provide cleansing the perineal area, front and back along with brief changes for incontinent care.Record review of the admission Record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses that included epilepsy, infection of the skin and subcutaneous tissue, open wound of left upper arm, and gastrostomy status.Record review of the Quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 3/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 11, which revealed moderate cognitive impairment. Section GG revealed the facility assessed Resident #2 was dependent for toilet hygiene.