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	07/01/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview, record review, and facility policy review, the facility failed to implement physician ordered treatments for one (1) of eight (8) residents sampled residents. Resident #2.Findings include:A record review of the facility policy titled Medication Orders, revised 11/2014, revealed the purpose of the procedure is to establish uniform guidelines for receiving and recording all medication and treatment orders. The policy further revealed treatment orders are to specify the treatment, frequency, and duration of the treatment.On 7/1/26 at 12:52 PM, during a phone interview, Resident #2's Patient Advocate stated Resident #2 never received ice to her surgical site during her stay despite being instructed it was to be provided following surgery.On 7/1/26 at 1:35 PM, during an interview, the Director of Nursing (DON) stated medical records staff enter hospital discharge orders into the electronic medical record and the admitting nurse reviews the orders.On 7/1/26 at 2:30 PM, during an interview, Licensed Practical Nurse #1 stated she enters hospital discharge medication orders into the system but wound care orders are entered by the treatment nurse or admitting nurse.On 7/1/26 at 2:36 PM, during an interview, Registered Nurse #1 stated medical records staff enter medication orders and the wound care nurse enters treatment orders.On 7/1/26 at 2:50 PM, during an interview, the DON confirmed the physician order for ice therapy had been missed and should have been entered into the system. She acknowledged the omission could result in postoperative discomfort at the surgical site and stated staff are expected to provide quality care to all residents.A record review of the hospital discharge orders dated 6/5/26 revealed an order, Ice to the operative area 20 minutes on then 20 minutes off as needed for post-operative swelling and pain. A record review of Resident #2's June 2026 electronic Treatment Record (TAR), June 2026 electronic Medication Administration Record (MAR), and Order Summary Report with active orders as of 6/5/26 revealed the physician ordered ice treatment was not entered into the facility's TAR, MAR or on the physician orders.A record review of Resident #2's admission Record revealed an admission date of 6/5/26 with diagnoses including aftercare following joint replacement surgery and presence of a right artificial knee joint.Record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 6/10/26 revealed a Brief Interview for Mental Status (BIMS) score of (15) indicating the resident was cognitively intact.

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

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	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Rehabilitation and Healthcare Center	102 Woodchase Park Drive Clinton, MS 39056

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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 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. Based on observation, interview, record review, and facility policy review, the facility failed to provide appropriate perineal care by thoroughly cleansing the perineal area following an incontinent episode for one (1) of three (3) residents observed receiving incontinent care. Resident #6.Findings include:A record review of the facility policy titled Perineal Care, revised 3/3/26, revealed the purpose of the procedure is to provide cleanliness and comfort, prevent infection and skin irritation, and observe the resident's skin condition. The policy further revealed that for female residents staff are to separate the labia and cleanse from front to back.On 7/1/26 at 9:40 AM, Certified Nursing Assistant (CNA) #1 was observed providing incontinent care to Resident #6. The resident's brief contained feces. CNA #1 cleansed the perineal area multiple times but did not separate the labia while cleansing. After completing care and applying a clean brief, the State Agency staff requested the CNA reassess the resident's cleanliness. Upon removal of the clean brief, feces remained on the resident's vaginal and anal areas. CNA #1 required six additional cleansing wipes before the perineal area was free of fecal material.On 7/1/26 at 9:56 AM, during an interview, CNA #1 confirmed feces remained on the resident after she completed incontinent care. She stated, I guess I did not wipe good enough. She acknowledged the resident could develop skin irritation, pressure injuries, or a urinary tract infection if feces remained on the skin and confirmed she should have continued cleansing until the wipes were free of fecal material.On 7/1/26 at 3:00 PM, during an interview, the Director of Nursing confirmed CNA #1 should have continued cleansing until no fecal material remained on the wipes. She stated leaving feces on the resident's skin could result in skin breakdown and confirmed staff are expected to provide quality care to all residents.A record review of Resident #6's admission Record revealed an admission date of 11/13/24 with diagnoses including vascular dementia, anxiety, and dysphagia.A record review of Resident #6's Minimum Data Set with an Assessment Reference Date of 4/20/26 revealed a Brief Interview for Mental Status (BIMS) score of six (6), indicating severe cognitive impairment. Section GG revealed the resident was dependent on staff for personal hygiene.