

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  04/11/2024
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37415</p> <p>Based on interviews, record reviews, and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) for one (1) of 26 sampled residents. Resident #126</p> <p>Findings include:</p> <p>Review of the facility's policy titled, MDS (Minimum Data Set) Coding Policy, reviewed 1/4/23, revealed, (Proper Name) affiliated facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately .</p> <p>Review of the facility's, Admission Record, for Resident #126, revealed an admitted [DATE]. The resident's admission diagnoses included Acute kidney failure and Type 2 Diabetes Mellitus.</p> <p>A record review of the Discharge MDS dated [DATE], revealed Resident #126 had the Type of Assessment coded as a discharge assessment with return not anticipated. However, further review of the MDS revealed the Discharge Status as a discharge as a short-term general hospital discharge.</p> <p>A record review of the facility's Progress Notes, dated 1/88/24 at 17:00 (5PM) revealed Resident #126 was discharged to home with medications with home health, that included physical therapy, occupational therapy, and speech therapy.</p> <p>During an interview on 4/11/24 at 10:01 AM, the Social Worker Assistant explained that Resident #126 was discharged home to live with her sister.</p> <p>During an interview on 4/11/24 at 10:10 AM, Registered Nurse (RN) # 2 explained she is the MDS Coordinator. The MDS Coordinator confirmed Resident #126 was sent home with her family, so the MDS was not coded correctly. The MDS Coordinator confirmed Licensed Practical Nurse (LPN) #2 coded the MDS.</p> <p>During an interview on 4/11/24 at 11:37 AM, the Director of Nursing (DON) confirmed the Residents MDS was coded incorrectly because the resident was discharged to home with her family. The DON confirmed the MDS nurse should have done a discharge home MDS instead of a hospitalization discharge. The DON commented that she expected the nurse to code the MDS correctly.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0641  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During an interview on 4/11/24 at 12:29 PM, the Administrator stated that she expects the staff to code the MDS correctly. The Administrator said she thought the MDS Coordinator checked behind the other MDS nurses to make sure the coding was correct.

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>41680</p> <p>Based on interviews, record reviews, and facility policy review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) Level II was obtained for a resident diagnosed with a serious mental disorder for one (1) of 26 sampled residents. (Resident #31)</p> <p>Findings include:</p> <p>Review of the facility's policy titled, PASRR policy and Procedure, reviewed 1/24/23, revealed, (Proper Name) uses the most current version of PASRR Rules of the Mississippi Division of Medicaid: Administrative Code, Medicaid Title 23: Part 207, Chapter: Long Term Care Pre-Admission Screening as they pertain to the Level 1 (PAS) and Level 2 (PASSR) long term care processes and procedures .</p> <p>Review of Admission Record for Resident #31 revealed the facility admitted the resident on 5/30/23, with diagnoses that included Paranoid Schizophrenia.</p> <p>Review of the Pre-Admission screening (PAS) dated 6/19/23, for Resident #31 revealed the PAS was completed when Resident #31 was admitted to the facility for short term therapy. Review of the PAS revealed that the resident needed orthopedic after care and was directly admitted from a hospital for short-term convalescent care.</p> <p>On 04/10/24 at 10:01 AM in an interview, the Assistant Business Office Manager (ABOM) stated she answered the questions on the PAS. She stated Resident #31 came in for skilled care, however, Resident #31 was not able to go back home after therapy and it was necessary for the resident to stay in the facility as a long-term care resident. The ABOM confirmed she should have updated the PAS once the resident was changed to long term care.</p> <p>Review of the medical records for Resident #31 revealed there was no documentation the facility referred Resident #31 for a PASRR Level II screening when Resident #31 became a long term care resident.</p> <p>On 04/11/24 at 3:55 PM, in an interview the Administrator stated she was not aware that when Resident #31 became a long-term care resident, she should have been referred for a Level II PASRR. The Administrator confirmed that she expects staff to follow the state guidelines to ensure that residents get the care that they need.</p> <p>Review of Resident #31 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/24 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated resident was cognitively intact.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>43283</p> <p>Based on observations, interviews, record reviews, and the facility policy review, the facility failed to revise the Care Plans for two (2) of 26 sampled residents. (Residents #80 and #105)</p> <p>Findings include:</p> <p>Review of facility's policy titled, Care Plans, Comprehensive Person-Centered, reviewed 1/23, 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 . Facility Interpretation and Implementation . 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's conditions; b. When the desired outcome is not met .</p> <p>Resident # 80</p> <p>Record review of the Care Plan, undated revealed Focus: The resident needs hemodialysis r/t (related to) renal failure. There were no interventions listed for the removal of the dialysis pressure dressing. The facility added an additional intervention to address the dressing removal after the State Agency (SA) entered the facility.</p> <p>On 4/10/24 at 9:29 AM, an observation and interview of Resident #80 revealed a dressing to the resident's right forearm at the location of the AV (Arteriovenous) graft . The resident indicated that the dressing was from the previous day's dialysis session.</p> <p>Record review of the Hemodialysis Communication form dated 3/21/24 revealed .Follow up includes: Please remove dialysis bandage 1 day after dialysis treatment.</p> <p>Record review of the Hemodialysis Communication form dated 3/30/24 revealed .Follow up includes: . Please remove dressing 4-6 hrs (hours) after returning to facility.</p> <p>During an interview on 04/10/24 at 10:56 AM, with Registered Nurse (RN) #4, the dialysis unit Facility Administrator, revealed communication has been sent on several occasions stressing the importance of not the leaving pressure dressing, as it may damage his new access.</p> <p>During an interview on 4/10/24 at 3:00 PM, with RN #2 revealed that it is the responsibility of the RN's and Licensed Practical Nurses (LPNs) to maintain accurate documentation and communication with the multidisciplinary team to make sure care plans are up to date with the most recent information for better patient outcomes. She commented the facility failed to get clarification on communications from dialysis regarding the timely removal of the AV shunt dressing. RN #2 confirmed the facility had made no revisions to the care plan for the timely removal of the pressure dressing on Resident #80's AV site, prior to the entrance of the SA.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/24 at 3:31 PM, an interview with the Director of Nursing (DON) revealed that it is the responsibility of Registered Nurses and Licensed Practical Nurses (LPNs) to maintain accurate documentation and communication with multidisciplinary team to make sure care plans are up to date with the most recent information for better patient outcomes. The DON revealed the facility failed to get clarification on communications to revise the care plan of Resident # 80. The DON also confirmed the facility did not have revisions to Resident #80's care plan regarding timely removal of the pressure dressing of the resident's AV site prior to SA entrance.</p> <p>Resident #105</p> <p>Record review, of Resident #105's Comprehensive Care Plan, revealed Focus The resident requires tube feeding r/t Dysphagia .Interventions Glucerna 1.5 at 50 cc/hr (cubic centimeters/hour) x 22 hours .</p> <p>On 04/10/24 at 10:00 AM, observed Resident #105 sitting up in wheelchair by the nurse's station with no tube feeding infusing.</p> <p>On 4/10/24 at 1:00 PM, during an interview with LPN #1, she explained Resident #105 is NPO (nothing by mouth) and gets bolus feedings five (5) times a day, instead of the continuous feedings, as the resident had been known to unhook the feeding, making him a high risk for aspiration.</p> <p>On 4/10/24 at 3:53 PM, during a record review and an interview with LPN #2/Care Plan Nurse, she explained care plans are updated with each new orders daily. LPN #2 reviewed Resident #105's care plan and physician orders and confirmed the resident was no longer on continuous tube feedings, as the order was changed on 3/4/24. The nurse acknowledged that the care plan continued to indicate that the resident was receiving continuous feedings. The Care Plan Nurse confirmed that the care plan was not updated to reflect the new order.</p> <p>Record review of Resident #105's Order Summery Report with active orders as of 04/11/24 revealed an order dated 3/4/24 Enternal Feed Order five (5) times a day Tube Feeding: Glucerna 1.5 Cal, 1 can bolus 5 times a day.</p> <p>At 1:31 PM, on 4/11/24, during an interview with the DON, she explained she expects the care plan nurses to update the care plans daily with all new orders. She revealed the staff has daily meetings to ensure all new orders are recognized and care planned and does not know how orders were missed.</p> <p>47873</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>37415</p> <p>Based on observations, interviews, record review, and facility policy review, the facility failed to maintain less than a 5% medication error administration rate for two (2) errors of 25 medication administration opportunities. This observation resulted in an 8% medication error rate.</p> <p>Findings Include:</p> <p>Review of the facility's, Instillation of Eye Drops, revised January 2014, revealed, . General Guidelines . 4. When administering two or more different eye drops allow three to five minutes between each application .</p> <p>During a medication administration observation on 04/10/24 at 9:00 AM, Registered Nurse (RN) # 1 instilled one (1) drop of Prednisolone Acetate Ophthalmic Suspension 1 % in the left eye of Resident #81. The nurse immediately instilled one (1) drop of Ofloxacin Ophthalmic Solution 0.3 % 1 into the resident's left eye. The nurse failed to wait three (3) to five (5) minutes between drops.</p> <p>During an interview on 04/10/24 at 9:23 AM, RN # 1 confirmed she failed to wait three (3) to (5) minutes before administering the second eye drop. RN #1 stated I only waited 20 seconds.</p> <p>During an interview on 04/11/24 at 1:20 PM, the facility Pharmacist explained RN # 1 should not administer the eye drops together because one drop will wash out the other. The Pharmacist confirmed the nurse should wait three (3) to five (5) minutes between drops. The Pharmacist said they do not put the instructions on the box about the eye drops, because this is taught in nursing school.</p> <p>During an interview on 04/11/24 at 2:13 PM, the Director of Nursing (DON) states that RN #1 should have waited three (3) to five (5) minutes between the eye drops to keep one from washing out the other. The DON said this nurse has been trained on how to administer eye drops because she has been a nurse for several years.</p> <p>Record review of an inservice dated 1/22/24, titled EDUCATION AND REMINDERS revealed . Follow medication procedures/guidelines/orders for each medication administered . RN #1's signature was on the inservice sign in sheet as having attended the inservice.</p> <p>Review of the Order Summary Report, with active orders as of revealed physician orders dated 3/22/24 for Resident #81 for Ofloxacin ophthalmic solution 0.3 % instill one (1) drop in left eye four times a day for eye surgery and Prednisolone Acetate Ophthalmic Suspension 1 % instill one (1) drop in left eye four times a day for eye surgery.</p> <p>Record review of the Admission Record for Resident # 81 revealed the facility admitted the resident on 03/24/23. Current diagnoses included Total retinal detachment of left eye and Presence of intraocular lens.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37415</p> <p>Based on observations, interviews, record review, and the facility policy review, the facility failed to transport dirty linen in a manner to prevent the possible spread of infection, for one (1) of three (3) days of observations.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Laundry and Bedding, Soiled, revised 10/18, revealed, .Soiled laundry/bedding shall be handles, transported and processed according to best practices for infection prevention and control . Handling 1. All used laundry is handled as potentially contaminated until it is properly bagged and labeled for appropriate processing . b. Laundry . is placed in leak proof bags or containers. c. Contaminated laundry is placed in a bag or container at the location where it is used . Transport 1. Contaminated laundry bags/containers are not held close to the body or squeezed during transport .</p> <p>During an observation on 04/09/24 at 9:18 AM, Certified Nursing Assistant (CNA) #2 was observed walking down the hallway with dirty linen braced against her clothes. CNA #2 placed the linen in the dirty clothes barrel several rooms down the hall.</p> <p>During an interview on 04/09/24 at 9:20 AM, CNA #2 confirmed she had the dirty linen braced against her clothes. CNA #2 explained that she should have place the linen in a plastic bag because she could get an infection or cause other residents and staff to become infected. CNA #2 said she could not find a bag at that time.</p> <p>During an interview on 04/11/24 at 2:34 PM, the Director of Nursing (DON) confirmed CNA #2 should have placed the linen in a plastic bag prior to taking it down the hallway to the dirty clothes barrel. The DON said the CNA's actions could cause other residents, herself, or other staff to be infected.</p> <p>In an interview on 04/11/24 at 3:21 PM with the Administrator explained she expect the staff to follow the infection control policy at all times.</p> <p>Record review of an orientation checklist dated 12/12/23 revealed CNA #2 had been trained in infection control. Review of a completion certificate dated 1/23/24 revealed CNA #2 had successfully completed an eLearning educational activity titled Infection Prevention in Long-Term Care Settings.</p> <p>47873</p>		