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	08/15/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on staff interview, record review, and facility policy review, the facility failed to ensure that a resident was informed of their right to formulate an advance directive (AD) and was provided assistance to do so for one (1) of (26) sampled residents (Resident #22).Findings Include:A review of the facility's policy, Resident Rights, undated, revealed, .Facility must protect and promote the rights of each resident, including each of the following rights . 5. Advance Directives .a. Facility will inform and provide written information to Resident concerning the right to accept or refuse medical or surgical treatment and, at the Resident's option, formulate an advance directive.A record review of Resident #22's clinical record revealed there was no documentation indicating whether the resident had been informed of ADs or was offered assistance by the facility in formulating one.On 8/12/25 at 8:00 AM, during an interview and concurrent observation of the electronic health record (EHR), Licensed Practical Nurse (LPN) #1 in Medical Records confirmed that Resident #22 had no documentation indicating the resident had been informed or was offered assistance in formulating an AD. LPN #1 explained that if it was not scanned into the system, then it was not present in the building, and verified that the resident's entire chart had been scanned into the new system.On 8/12/25 at 1:26 PM, during an interview with the Administrator, she confirmed that Resident #22's AD had lived in the facility for several years. She acknowledged that a care plan conference was held on 8/6/25 with the resident, at which time it was identified that the resident had no Power of Attorney (POA) or AD in place. However, the Administrator confirmed that, since that time, the facility had taken no steps to ensure the resident was informed of their right to formulate an AD or offered assistance in doing so.A record review of the admission Record revealed Resident #22 was initially admitted by the facility on 6/17/16 with diagnoses including Unspecified Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/25 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.A record review of the Care Plan Conference document, dated 8/6/25, revealed interdisciplinary team (IDT) discussion that Resident #22 did not have an AD plan.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, facility policy review, and interview, the facility failed to implement care plan interventions related to Enhanced Barrier Precautions for one (1) of 26 sampled residents (Resident #115). Findings included: Review of the facility’s policy “Care Plans Comprehensive Person-Centered”, with a review date of 6/2/25, revealed, “A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical psychological and functional needs is developed and implemented for each resident…” Record review of the “Care Plan Report” for Resident #115 revealed a “Focus” of “Resident requires Enhanced Barrier Precautions r/t (related to) Feeding tube” with “Interventions/Tasks” including “EBP…used during high-contact resident care activities as applicable such as…Changing briefs…” On 08/13/2025 at 1:58 PM, in an observation of Resident #115 receiving perineal revealed Certified Nursing Assistant (CNA) #2 did not wear a protective gown. On 08/13/2025 at 2:16 PM, in an interview with CNA #2 confirmed that she did not wear a gown doing peri care or washing hands doing care. She stated she was supposed to put on a gown before starting peri care. She stated she forgot to put on the gown. She stated she has had training on Enhanced Barrier Precautions. (EBP). On 08/14/25 at 11:36 AM, in an interview with Registered Nurse (RN)/Minimum Data Set (MDS)/Care plan nurse stated CNA #2 did not follow the comprehensive care plan. She stated the purpose of the care plan is to help staff take care of the Resident. She stated she expects the staff to follow the care plan. She stated CNA #2 should have worn a gown while providing care. Record review of the “admission Record” revealed the facility admitted Resident #115 on 9/29/20 with diagnosis including of Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident #140) received supervision and assistance during activities of daily living (ADL) bathing to prevent accidents or injury. The facility failed to ensure staff followed the resident's functional status, used appropriate transfer assistance, and sought help when the resident displayed signs of weakness during a shower transfer. Findings included:On 08/13/2025 at 11:44 AM, during an observation, Certified Nursing Assistant (CNA)# 3 was observed providing shower care to Resident #140. The resident was seated on a rolling shower chair and required transfer back to his wheelchair. CNA #3 instructed Resident #140 to stand twice to be dried and dressed. The resident was visibly weak and unsafe while standing both times. During the second attempt, the resident's arms were noted to shake while holding himself upright. No other staff were present during the bathing process, and CNA#3 did not request assistance.On 08/13/2025 at 2:01 PM, during an interview CNA #3, explained it was their first time caring for Resident #140. When asked how a CNA would know how to safely transfer a resident, they stated, It's usually in the care plan, but I can usually look in a room at a resident and decide if they can walk . I can tell if they need two people or not if I see a lift pad or other things in the room. CNA #3 reported they had assistance transferring the resident to the wheelchair earlier but did not think help was needed in the bathroom because he had done so well in the room. When asked why assistance was not sought during the observed episode of weakness, CNA#3 stated they did not want to leave the resident alone and chose not to call using the call light because they didn't think anyone would answer it and the surveyor was present. CNA #3 acknowledged the resident's arms were visibly shaking but stated they did not want to place the resident back in the shower chair because it had been soiled with stool. They admitted in hindsight that it would have been safer. When asked whether it was within a CNA's scope to determine transfer needs by observation alone, they responded, No, and acknowledged that improper transferring could lead to resident falls and injury.On 08/13/2025 at 5:10 PM, during an interview the Director of Nursing (DON), explained the resident was listed as a one-person assist upon admission assessment. The DON stated that CNA #3 should have sought help or sat the resident back down when he became visibly unstable. The DON confirmed that both the care plan and CNA Point of Care Kardex contain transfer status guidance. The DON stated that failure to follow proper transfer protocols or making assumptions about resident ability based solely on appearance, places the resident and staff at risk for injury.A record review of the admission Assessment - Functional Abilities, dated 08/08/2025, section GG of the Minimum Data Set (MDS), revealed the resident was coded as 01 - Dependent, meaning the helper does all of the effort, or that two or more helpers are required to complete the activity.A review of the admission Record revealed Resident #140 was admitted on [DATE] with a diagnosis of Syncope and Collapse, a condition that may contribute to weakness or fainting.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one (1) of (26) sampled residents (Resident #46) receiving dialysis treatment was transported in a timely manner to receive the full duration of the prescribed treatment. This resulted in multiple shortened dialysis sessions over the previous month and placed the resident at risk for adverse health outcomes, including hyperkalemia, gastrointestinal distress, and other dialysis-related complications.Findings included:On 08/12/2025 at 10:58 AM, during an interview, Resident #46 reported that she had been consistently arriving late to her scheduled dialysis appointments and stated, I'm supposed to be there by 11:00, but I've been getting there around 12:00. She further stated that her dialysis sessions had been shortened as a result.On 08/14/2025 at 11:46 AM, during an interview with the dialysis Nurse Manager, they explained that Resident #46 had arrived more than 15 minutes late to her appointments on five separate occasions in the last month: 07/25/2025, 07/28/2025, 08/08/2025, 08/11/2025, and 08/13/2025. The dialysis Nurse Manager stated that the resident's scheduled chair time was 11:30 AM to 3:00 PM, and her average arrival time had been 12:16 PM. She stated the resident's late arrivals had caused the clinic to reschedule her chair time to 11:55 AM to 3:25 PM effective 08/15/2025, making her the last patient of the day and resulting in early removal from dialysis on late arrival days because the clinic closes at 5:00 PM. The dialysis Nurse Manager reported that shortened dialysis sessions result in incomplete treatment, and complications associated with inadequate dialysis include hyperkalemia (high potassium), nausea, vomiting, and itching. On 08/14/2025 at 12:05 PM, during an interview Director of Nursing (DON), explained that they had contacted the dialysis clinic and were told the resident had only been late a few times and only by about ten minutes. The DON stated that the chair time had been adjusted effective 08/12/2025, which may have contributed to the resident's tardiness on that date.On 08/14/2025 at 2:29 PM, during an interview with Driver# 1, explained that the dialysis clinic had informed him of a chair time of 11:50 AM, which was later changed to 11:55 AM effective 08/12/2025. He stated the resident was only late on 08/13/2025 due to that change. He acknowledged that the dialysis clinic had made multiple chair time changes without clearly communicating them and that one of the facility's vans was currently out of service, causing occasional delays in transportation. However, he confirmed that dialysis patients were treated as a transport priority.A review of the dialysis attendance log and interview documentation confirmed that the resident had repeatedly arrived late, leading to shortened treatment durations and increasing the risk of adverse medical outcomes due to incomplete dialysis sessions.On 8/14/25 at 5:30 PM, in an interview with Resident #46, she stated that it is frustrating and inconvenient the fact that her chair time is being changed to later in the day because her body is used to the time already. She doesn't understand why the facility can't just take her early and drop her off at the dialysis facility so she doesn't miss getting her whole treatment she started and wondered why the facility can't get her there on time. On 08/15/2025 at 1:00 PM, In an interview with the Administrator, she stated that the company had two vans go down one due to the air conditioning being out on one and the other due to car wreck damage. This led to the facility using the only service for transport in town to cover more appointments, however this provider had a past history of being late for dialysis, so the facility van drivers are responsible for getting residents to and from dialysis and it is her expectation that residents be transported in a timely manner to their appointment and follow policy and doctor's orders.Record review of the admission Record revealed Resident #46 was admitted on [DATE] with diagnoses that included End Stage Renal Disease.Record review of the Order Summary Report with active orders as of 8/14/25 revealed a physician order dated 7/25/25 Resident to receive hemodialysis three (3) days a week on M/W/F (Monday, Wednesday, Friday) at (Proper name of dialysis center) .Chair Time: 11:30 AM.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interview, record review, and facility policy review, the facility failed to maintain a medication error rate below five (5) percent (%), for two (2) of 31 medication opportunities observed, resulting in a 6.45 % medication error rate. Included was Resident #3, who was not instructed to rinse with water following administration of a steroid inhaler, and Resident #141, for whom the nurse prepared an incorrect dosage of Thiamine.Findings include:Record review of facility Medication Administration policy, reviewed and revised June 2025, revealed Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident right, right medication, right dosage, right time and right method (route) of administration before giving the medication. Resident #3On 8/13/2025 at 8:33 AM, during an observation of medication administration, Licensed Practical Nurse (LPN) # 5 administered Symbicort Inhalation Aerosol to Resident #3. LPN #5 did not rinse Resident #3's mouth after administering the inhalation medication. LPN# 5 explained that she forgot and acknowledged that mouth rinsing should occur because it can cause thrush, and reported she would go back and do it.On 8/12/2025 at 11:30 AM, during an interview with the Director of Nursing (DON), explained that a resident's mouth should be rinsed with water following administration of an inhaled corticosteroid, such as Symbicort, to prevent oral thrush.A record review of Order Summary Report with active orders as of 8/14/25 revealed an order dated 7/18/25 Symbicort Inhalation Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate), two (2) puffs inhaled orally every morning and at bedtime for wheezing.A record review of the admission Record for Resident #3 revealed the facility admitted the resident on 7/18/2025 with diagnoses that included Toxic Encephalopathy.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/2025 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of (14), indicating the resident was cognitively intact.A record review of the Quick Guide to Using Your Symbicort Inhaler, dated 2018, revealed, .After you finish taking Symbicort.rinse your mouth with water. Spit out the water.Resident #141On 8/12/2025 at 8:14 AM, during an observation of medication administration, LPN #6 prepared medications for Resident #141. She prepared Thiamine 100 mg and placed it in the medication cup with the resident's other medications to be administered. The resident's physician orders indicated the correct dosage as Thiamine 50 mg. On 8/12/2025 at 8:30 AM, during an interview with LPN #6, she confirmed she intended to administer the medications to Resident #141, however, when she reviewed the Thiamine medication label, she confirmed the dosage was listed as Thiamine 100 milligrams (mg). She removed the 100 mg tablet and explained that it was what they had available.On 8/12/2025 at 10:15 AM, during an interview the DON, explained that administering an incorrect dose could result in negative outcomes and that medications must be administered in accordance with physician orders. A record review of the admission Record revealed the facility admitted Resident #141 on 8/5/2025 with diagnoses including Fracture of Shaft of Humerus.A record review of the Medication Administration Record (MAR) for August 2025 revealed Resident #141 had a Physician's Order, dated 8/12/25, for Thiamine HCl Oral Tablet 50 mg to be given by mouth every morning as a supplement.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure medications were securely stored and monitored to maintain safety and integrity for one (1) of five (5) residents reviewed for medication administration and storage, Resident #62. Findings included: Record review of facility storage and medication policy dated July 2024 review 6/24/2025 reveal the facility stores all drugs and biologicals in a safe secure and orderly manner On 08/13/2025 at 11:32 AM, during an observation, a medication prescribed to Resident #62 was noted sitting unattended on the bedside table. The medication was Dulera Inhalation Aerosol 100-5 MCG/ACT (Mometasone Furoate–Formoterol Fumarate Dihydrate). The label included resident-identifying information and dosage instructions: “2 puffs orally, twice daily”. The medication was not secured in a medication cart or locked storage area, and no staff were present in the room. Record review of the “Order Details” revealed a physician order dated 8/8/25 for “Dulera Inhalation Aerosol…related to Acute and Chronic Respiratory failure with hypoxia.” A review of the resident’s August 2025 Medication Administration Record (MAR) revealed Dulera was ordered for treatment of acute and chronic respiratory failure with hypoxia. A review of the admission Record revealed Resident #62 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia. A review of the resident’s most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/28/2025 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. On 08/13/2025 at 11:32 AM, during an interview, the Director of Nursing (DON) stated that nurses were not supposed to leave medications in residents’ rooms. She stated that Resident #62 would not be able to self-administer the inhaler. The DON removed the medication from the room.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interview, record review, and facility policy review, the facility failed to maintain a complete and accurate medical record by not documenting whether a resident had an advance directive (AD) in place, declined to complete one, or was offered assistance to formulate one for one (1) of (26) sampled residents (Resident #22).Findings Include:A record review of Resident #22's clinical record revealed there was no documentation indicating whether the resident had an AD in place, declined to complete one, or had been offered assistance by the facility in formulating one.During an interview and concurrent observation of the electronic health record (EHR), on 8/12/25 at 8:00 AM, Licensed Practical Nurse (LPN) #1 in Medical Records confirmed that Resident #22 had no documentation indicating the resident did or did not have an AD. The LPN verified Resident #22's entire chart had been scanned into the new system and commented that if the information was not scanned into the system, then it was not present in the building. During an interview on 8/12/25 at 1:26 PM, the Administrator, confirmed that Resident #22's information regarding an AD was not readily available in the medical record. The Administrator reported that the resident had lived for several years in the facility and acknowledged that a care plan conference was held on 8/6/25 with the resident, at which time it was identified that the resident had no Power of Attorney (POA) or AD in place. However, the Administrator confirmed that, since that time, the facility had taken no steps to ensure documentation of the resident's AD status in the medical record.A record review of the admission Record revealed Resident #22 was initially admitted by the facility on 6/17/16 with diagnoses including Unspecified Dementia.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/25 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.A record review of the Care Plan Conference document, dated 8/6/25, revealed interdisciplinary team (IDT) discussion that Resident #22 did not have an AD plan.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to maintain a medication error rate below 5 percent (%) during an annual recertification survey on 4/11/24 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of nine (9) deficiencies cited. (F759)Findings Include: Review of the facility's policy Quality Assurance Performance Improvement (QAPI) Program, reviewed 6/25, revealed, . The purpose of Quality Assurance Performance Improvement committee is to create a system for improving the care for our residents.Record review of the Provider History Profile revealed the facility received a citation for F759 - Free of Medication Error Rates 5 Percent or More.Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 4/11/24, revealed the facility received a citation for F759, . 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.During the current recertification survey, the facility failed to maintain a medication error rate below five (5) percent (%), for two (2) of 31 medication opportunities observed, resulting in a 6.45 % medication error rate. This included Resident #2, who was not instructed to rinse with water following administration of a steroid inhaler, and Resident #141, for whom the nurse prepared an incorrect dosage of Thiamine. On 8/15/25 at 2:20 PM, during an interview with the Nursing Home Administrator (NHA), she explained the Quality Assurance Committee meets quarterly and all members attend. She acknowledged awareness of previous citations and reported that the facility plans to increase education and provide one-on-one training. She explained that additional monitoring will be implemented by the Assistant Director of Nursing (ADON) and Director of Nursing (DON). She stated spot checks will be conducted, and pharmacy staff will provide additional oversight.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview, record review, and facility policy review, the facility failed to maintain an infection prevention and control program to help prevent the possible development and transmission of communicable diseases and infections for three (3) of 26 sampled residents, as evidenced by failing to conduct hand hygiene between glove changes (Resident #5 and Resident #115) and failing to adhere to Enhanced Barrier Precautions (EBP) during care (Resident #32).Findings Include: Review of the facility’s policy, “Infection Prevention and Control Program” with a revision date of 6/30/25 revealed “Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection…” Review of the facility’s “Non-Sterile Dressing Change Skills Checklist”, dated 6/27/25, revealed, “…Step 10 Remove gloves, place in plastic bag Step 11 Wash hands (or hand sanitizer) & put on gloves…” Review of the facility’s “Handwashing/Hand Hygiene Residents” with a revision date of 6/30/25 revealed “Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections…” Review of the facility’s “Enhanced Barrier Precaution” dated 6/30/25 revealed, “… EBP refer to infection control interventions designed to reduce transmission of multidrug-resistant organism that employ targeted gown, and gloves use during high contact residents care activities…” Resident # 5 On 8/13/25 at 1:03 PM, during an observation of wound care for Resident #5’s left foot, Registered Nurse (RN) #3 removed and changed gloves a total of five (5) times throughout the procedure without performing hand hygiene between glove changes. On 8/13/25 at 1:23 PM, during an interview with Registered Nurse (RN) #3, he explained that he was not aware hand hygiene should be performed between glove changes. He acknowledged that failing to do so was an infection control issue with the potential to spread infection to Resident #5’s wound. He further stated that he had previously received training on infection control. On 8/13/25 at 5:10 PM, during an interview with the Director of Nursing (DON), she explained that Registered Nurse (RN) #3 should have performed hand hygiene with either soap and water or hand sanitizer between each glove change. She stated that by not doing so, RN #3 placed the resident at risk for infection during wound care. A record review of the admission Record revealed the facility admitted Resident #5 on 5/30/23 with current diagnoses including Pressure Ulcers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the “Order Summary Report” revealed Resident #5 had a Physician’s Order, dated 8/7/25, for wound care to the 5th toe on the left foot. A record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/4/25 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Resident # 115 On 08/13/2025 at 1:58 PM, in an observation of Resident #115 receiving perineal care by Certified Nursing Assistant (CNA) #2, the CNA applied gloves but did not place a gown on. She removed the front of the resident’s brief, which was heavily soiled, and then used pre moistened perineal wipes from a package, pulling out two to three wipes at a time while continuing to wear dirty gloves. Throughout the care, she removed soiled gloves and applied clean gloves a total of four times but never performed hand hygiene with soap and water or hand sanitizer between glove changes. There was signage on the resident’s door indicating Enhanced Barrier Precautions. On 08/13/2025 at 2:16 PM, in an interview with Certified Nursing Assistant (CNA) #2, she confirmed she did not wear a gown while providing perineal care and did not perform hand hygiene during the care for Resident #115. She stated she was supposed to apply a gown before starting perineal care. She acknowledged she forgot to wash her hands and apply a gown. She explained she had received training on hand hygiene and Enhanced Barrier Precautions. She stated she also forgot to place a barrier on the table and to remove all needed wipes from the package before starting care. She acknowledged she was not supposed to pull wipes out of the package with dirty gloves on. She stated Resident #115 was placed at risk for infection due to her not following Enhanced Barrier Precautions, not performing hand hygiene, and pulling wipes out of the package with contaminated gloves. On 08/13/2025 at 5:13 PM, in an interview with the Director of Nursing (DON), she explained that CNA #2 should have placed a barrier on the table and gathered all needed supplies, including pulling wipes out of package, before beginning care for Resident #115. She stated the CNA should have washed her hands and donned (put on) a gown prior to starting perineal care. She further stated that CNA #2 placed the residents at risk of infection by not following the facility’s Enhanced Barrier Precautions policy during care. Record review of the “admission Record” revealed the facility admitted Resident #115 on 9/29/20 with diagnosis including of Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease. Record review of the Comprehensive Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/24/25 revealed Resident #115 had a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Resident #32 On 8/13/2025 at 9:00 AM, during an observation of Percutaneous Endoscopic Gastrostomy (PEG) site care performed by Licensed Practical Nurse (LPN) #2, a protective gown was not worn during the procedure. (continued on next page)

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	08/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the “admission Record” revealed the facility admitted Resident #32 on 3/13/20 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 5/11/25, revealed Resident #32 had a BIMS of 00, which indicated severe cognitive impairment. A record review of the “Order Details” revealed a physician’s order, dated 7/29/24, for PEG site care. On 8/13/2025 at 3:15 PM, during an interview with the Director of Nursing (DON) with the Administrator present, the DON confirmed that a gown should be worn during care identified for EBP and stated she would conduct additional staff training. On 8/13/2025 at 4:02 PM, during an interview, LPN #2 acknowledged that she did not wear a gown during the procedures and agreed this was an infection control issue.