

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255163	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2025
NAME OF PROVIDER OR SUPPLIER MEMORIAL WOODLAND VILLAGE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5427 GEX ROAD DIAMONDHEAD, MS 39525		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS	K 000			
K 372 SS=D	<p>42 CFR 483.90(a)</p> <p>The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).</p> <p>Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101</p> <p>Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING</p> <p>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on the observation, the facility failed to provide half hour rating in the smoke barrier wall in accordance with NFPA 101 sections 19.3.7.3 and 8.5.6.2. This standard deficiency affected two (2) of six (6) smoke compartments and 28 of 113 residents in the facility on the day of Survey.</p> <p>Findings Include:</p> <p>On 6/24/25 at 11:05 AM, observation revealed</p>	K 372			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255163	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2025
NAME OF PROVIDER OR SUPPLIER MEMORIAL WOODLAND VILLAGE NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5427 GEX ROAD DIAMONDHEAD, MS 39525		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 1 unsealed holes around electrical piping at the smoke barrier wall near the Nurses Station of the facility. The smoke barrier wall was incapable of resisting the passage of smoke throughout the facility. The findings were acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 6/24/25.	K 372		