STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 000	INITIAL COMMENTS The State Agency (SA) conducted a recertification survey at the facility from 2/11/18 to 2/16/18. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for Participation. The SA cited deficiencies at F583, F645, F655, F656, F657, F658, F690, F692, F695, F772, F773, F812, and F880. The census at the time of the survey was 124, and the facility was certified for 132 beds.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure	F 583		4/9/18

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

Electronically Signed | 04/05/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 583	Continued From page 1 and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure privacy for one (1) of four (4) incontinent care observations; Resident #77. Findings include: Review of the facility's policy titled, "Quality of Life-Dignity", no date, revealed each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care, and during treatment procedures. Review of the facility's policy titled, "Violations of Basic Human Rights" not dated, revealed, violations of basic human rights that should avoid, and be alert for: leaving a cubical curtain, window curtain, door, etc., open when providing care (i.e., giving a bath, taking the resident to the bathroom,, etc.). Resident #77 An observation, on 02/15/18 at 11:07 AM,	F 583	F583 – Personal Privacy/Confidentiality of Records • Resident # 77 is being provided privacy during incontinent care. • The facility recognizes that all residents requiring incontinent care have the potential to be affected by the deficient practice. • All RNs (Registered Nurses), LPNs (Licensed Practical Nurses) and CNAs (Certified Nursing Assistants) are being in-serviced by the QA (Quality Assurance) nurse on respecting the resident's right to personal privacy, including closing the door, closing the privacy curtain and window blinds and/or curtain when providing care. The RCM (Resident Care Manager) or CN (Charge Nurse) will conduct (5) or more random, unannounced observations of resident care weekly for (6) six weeks to ensure the residents right to personal privacy is being respected and to ensure the plan of correction is sustained. All in-services for nursing personnel were completed on or before April 9, 2018. • The DON (Director of Nursing) or QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 583	Continued From page 2 revealed Certified Nursing Aide (CNA) #1, and CNA #2 did not close the door or curtains prior to starting Resident #77's incontinent care. An interview, on 02/15/18 at 11:30 AM, with CNA #1 and CNA #2, revealed they were nervous and forgot to close door or curtain prior to starting incontinent care on Resident # 77. The CNAs revealed they knew the door and curtain should have been closed due to a privacy issue. An interview, on 02/16/18 at 09:48 AM, with Quality Assurance Nurse (QA), #1 revealed training for CNAs are to close windows, curtains, and doors for privacy. QA Nurse #1 revealed the CNAs leaving the door open was a privacy issue. An interview, on 2/16/18 at 10:30 AM, with the Director of Nursing (DON), revealed the issue with the CNAs not closing the window, curtain or doors was a privacy issue. The DON revealed all staff has been trained in these areas.	F 583	nurse will bring the results of the weekly unannounced observations of care to the Quality Assurance Committee, which will meet at least quarterly and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. • Corrective Action will be completed on or before April 9, 2018	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental	F 645		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 645	Continued From page 3 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 645	Continued From page 4 is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to complete a Pre-Admission Screening prior to admission, for one (1) of 24 resident records reviewed; Resident #13. Findings include: Review of the facility's policy titled, "Admissions-From Other Healthcare Facility", with a revision date of 07/17, revealed a resident admitted from another health-care facility should furnish the MI/MR (Mental Illness/Mental Retardation) prescreening documentation, PAS and PASRR (Preadmission Screen and Preadmission Screen Resident Review) as appropriate. Resident #13 Interview, and review of the Resident #13's medical records, with the Admission Coordinator Director, on 2/12/18 at 11:23 AM, confirmed she was responsible for completing Resident #13's	F 645	F645 – PASRR Screening for MD & ID • The Pre-Admission Screening and Resident Review (PASRR) was been completed for Resident # 13 by the Admissions Coordinator on or before April 9, 2018. • The facility recognizes that all residents that are required to have a PASRR completed have the potential to be affected by the deficient practice. • The personnel who complete the PASRR have been in-serviced on the regulation and required timeframe to complete the PASRR by the Administrator on 4/3/2018. The Medical Records Coordinator or Administrator will conduct a weekly audit of all new admission files beginning the week of 4/9/2018, for 4 (four) weeks to ensure all PASRR s have been completed and are on file to ensure the plan of correction is achieved and sustained. • The Administrator and/or designee will bring the results of the PASRR audit to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 645	Continued From page 5 Preadmission Screening prior to the resident's admission, and confirmed she did not complete it. Interview with the Social Services Director, on 02/16/18 at 2:47 PM, revealed she is responsible for following-up with the Mental Health Clinic after she receives notice from the Admission Coordinator Director of the need for a Level II. Review of Resident #13's Face Sheet, revealed she was admitted by the facility, on 01/03/17, with diagnoses which included Influenza Due To Certain Identified Influenza Viruses. Review of the Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/17, revealed Resident #13 had a Staff assessment score of 3, indicating the resident had severe cognitive impairment.	F 645	Quality Assurance Committee, which will meet quarterly and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. • Corrective Action will be completed on or before April 9, 2018.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 655	Continued From page 6 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to develop a base line Care Plan related to a Foley cather, for one (1) of 20 records reviewed; Resident #4. Findings include: A review of the facility's policy titled, "Care Plans-Comprehensive", revised June 2017, revealed the facility's Care Planning/Interdisciplinary Team in coordination	F 655	F655 – Baseline Care Plan • The care plan for Resident # 4 was revised by the care plan nurse to include the foley catheter and discontinuation of the foley catheter on or before April 9, 2018. • The facility recognizes that all residents with a foley catheter have the potential to be affected by the deficient practice. All residents were assessed to identify if a foley catheter was present and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 655	Continued From page 7 with the resident, his/her family, or representative, develops and maintains a comprehensive care plan. "The comprehensive care plan is based on an assessment that includes, but is not limited to the Minimum Data Set (MDS)." Resident #4 Review of Resident #4's Minimum Data Set Assessment, with an Assessment Reference Date (ARD) of 11/01/17, Section H- Bladder and Bowel, revealed the resident had an indwelling catheter. Review of the Quarterly MDS, with an ARD of 01/15/18, Section H- Bladder and Bowel, revealed the resident did not have an indwelling catheter. Review of the resident's medical records, revealed Nurse's Notes dated, 11/04/17 at 6:23 AM, stated Resident #14's Foley catheter was leaking, and replaced with a 16 French (Fr) 30 centimeter (cc) foley catheter. Interview, and review of Resident #4's medical records, with Licensed Practical Nurse (LPN)/ Minimum Data Set (MDS) Assessment Nurse #2, on 02/13/18 at 11:47 AM, revealed the resident's medical records did not reveal Nurse's Notes, or MD Progress Notes to confirm when the Foley catheter was inserted or discontinued (d/c'd), or a physician's order to continue the Foley catheter when the resident was readmitted to the facility after a hospitalization for an upper respiratory infection. LPN/MDS Assessment Nurse #2 said the resident was readmitted to the facility on 10/19/17. LPN/MDS Nurse #2 said she did a	F 655	the care plan was reviewed to ensure it was identified on the plan of care by the MDS/Care Plan Nurse. • All RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) will be in-serviced by the QA (Quality Assurance) nurse on the development and implementation of a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. All Baseline Care Plans will be reviewed by the QA nurse or RCM (Resident Care Manager) within 48 hours to ensure any resident identified with a foley catheter has it identified on their care plan for eight (8) weeks to ensure the plan of correction is sustained. All in-services of nursing personnel will be completed on or before April 9, 2018. • The DON (Director of Nursing) or QA nurse will bring the results of the baseline care plan review to the Quality Assurance Committee, which will meet on a quarterly basis, and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. • This corrective action will be completed by April 9, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 655	Continued From page 8 seven (7) day look-back for the MDS, which revealed the resident had a catheter. LPN/MDS Nurse #2 stated she was unable to locate a physician's order for the catheter, and informed the Charge Nurse, who is no longer employed by the facility. Further review of the medical record revealed no care plan related to the resident having a Foley catheter upon admission. LPN/MDS Nurse #2 stated she did not develop a care plan because there was no order for the Foley catheter. Interview with the Director of Nurse (DON), on 02/16/18 at 1:30 PM, confirmed the facility failed to develop a baseline care plan related to the care of Resident #4's Foley catheter. Review of the resident's Face Sheet revealed Resident #4 was admitted by the facility, on 09/08/15, and readmitted on 10/19/17, with diagnoses which included Sepsis, Unspecified Organism, Enterococcus As The Cause Of Diseases Classified Elsewhere. Review of the Quarterly Minimum Data Set (MDS, with an Assessment Reference Date (ARD) of 10/26/17, revealed Resident #4 had a staff assessment score of 3, indicating the resident had severe cognitively impairment.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 656	Continued From page 9 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to develop a Comprehensive Care Plan related to Resident	F 656	F656 Develop/Implement Comprehensive Care Plan • Resident # 4's Foley Catheter was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 656	Continued From page 10 #55's Foley catheter, and to follow Resident #4's care plan related to Percutaneous Endoscopic Gastrostomy (PEG) tube feeding, for two (2) of 24 resident records reviewed. Findings include: Review of the facility's policy titled, Care Plan - Comprehensive, with a revision date of 06/17, revealed each resident will have an individualized comprehensive person-centered care plan with measurable objectives to meet the resident's medical, nursing, mental, and psychological needs. Resident #4 Review of Resident #4's Minimum Data Set Assessment, with an Assessment Reference Date (ARD) of 11/01/17, Section H- Bladder and Bowel, revealed the resident had an indwelling catheter. Review of the resident's medical records, revealed Nurse's Notes dated, 11/04/17 at 6:23 AM, stated Resident #4's Foley catheter was leaking, and replaced with a 16 French (Fr) 30 centimeter (cc) Foley catheter. On 02/13/18 at 11:47 AM, interview and record review of Resident #4's medical records, with Licensed Practical Nurse (LPN)/Minimum Data Set (MDS) Assessment Nurse #2, revealed the resident's medical records did not reveal Nurse's Notes or Medical Doctor (MD) Progress Notes to confirm when the resident's Foley catheter was inserted, or discontinued (d/c'd). Further review	F 656	discontinued on 8/3/217, and no longer has a Foley catheter in place. A review of the residents care plan was completed by the MDS/Care Plan nurse on 4/3/18 to ensure this status was reflected. As of 2/16/18 resident # 55 is receiving the amount of tube feeding ordered and noted in the comprehensive care plan. • The facility recognizes that all residents identified with a Foley catheter and/or a PEG (Percutaneous Endoscopic Gastrostomy) tube feeding have the potential to be affected by the deficient practice. • All RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) will be in-serviced by the QA (Quality Assurance) nurse on the development and implementation of a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet the residents needs identified in the comprehensive assessment. The QA (Quality Assurance) nurse or RCM (Resident Care Manager) will identify all residents with a Foley catheter weekly for eight (8) weeks to ensure it is implemented into the residents care plan. The QA nurse or RCM will make daily rounds beginning the week of April 9, 2018, on all residents receiving PEG tube feeding for eight (8) eight weeks to ensure the residents prescribed rate of tube feeding is being infused as ordered and stated in the residents care plan to ensure the plan of correction is achieved and sustained. All in-servicing of nursing personnel will be completed on or before April 9, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 656	Continued From page 11 revealed no physician's order to continue the Foley catheter when the resident was readmitted to the facility after a hospitalization for an upper respiratory infection. LPN/MDS Assessment Nurse #2 said the resident was readmitted to the facility on 10/19/17. LPN/MDS Nurse #2 reported she did a seven (7) day look-back for the MDS, which revealed the resident had a catheter. LPN/MDS Nurse #2 reported she was unable to locate a physician's order for the catheter, and informed the Charge Nurse, who is no longer employed by the facility. Further review of the medical record revealed no care plan related to the resident having a Foley catheter upon admission, and LPN/MDS Nurse #2 stated she did not develop a comprehensive care plan due to there was no order for the Foley catheter. Interview with the Director of Nurses (DON), on 02/16/18 at 1:30 PM, revealed the facility failed to develop a comprehensive care plan for Resident #4's Foley catheter. Review of the resident's Face Sheet revealed Resident #4 was admitted by the facility, on 09/08/15, and readmitted on 10/19/17, with diagnoses which included Sepsis, Unspecified Organism, Enterococcus As The Cause Of Diseases Classified Elsewhere. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/26/17, revealed Resident #4 had a staff assessment score of 3, indicating the resident had severe cognitive impairment. Resident #55 Review of Resident #55's Care Plan revealed a	F 656	• The DON (Director of Nursing) or QA nurse will bring the results of the Foley catheter and PEG tube feeding audit to the Quality Assurance Committee, which will meet on a quarterly basis, and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. • This corrective action will be completed by April 9, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 656	Continued From page 12 problem to address Nutrition, altered related to nothing by mouth (NPO) status, and PEG tube feedings. Approaches included to give "Jevity as ordered." Review of the current Physician's Orders for February 2018 revealed an order written, on 2/8/18, to change feeding to Jevity 1.5 at 65 milliliters/hour (ml/hr). Interview, and observation, on 2/16/18 at 9:45 AM, with LPN #3 confirmed Resident #55's tube feeding was infusing at 60 ml/hr. Upon review of the physician's orders, LPN #3 stated, "It's my fault." LPN #3 further revealed the feeding should have been infusing at 65 ml/hr. LPN #3 revealed she had looked at the printed orders, and not the written orders. Interview, on 2/16/18 at 11:40 AM, with the Director of Nursing (DON) revealed the care plan was not followed.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 657	Continued From page 13 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to revise the Comprehensive Care Plan related to Hospice care for Resident #56, Mobility and Positioning for Resident #14, and Resident #85's Refusal of Care/Treatments, for three (3) of 24 resident records reviewed. Findings include: Review of the facility's policy titled, "Care Plans-Comprehensive", dated June 2017, revealed "Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change." Review of the facility's policy titled, "Goals and Objectives, Care Plans", dated June 2017, revealed goals and objectives are reviewed and/or revised when there is a significant change in the resident's condition, when the desired outcome has or has not been achieved, and at least quarterly. Care plans shall incorporate	F 657	F657 Care Plan Timing and Revision • Resident # 56 has had their comprehensive care plan related to Hospice care reviewed and revised to reflect their nonverbal status by the MDS/Care Plan nurse on 4/3/18. Resident # 14 has had their comprehensive care plan for mobility and positioning reviewed and revised to reflect their inability to position self and follow commands by the MDS/Care Plan nurse on 4/3/18. Resident # 85 has had their comprehensive care plan for refusal of care reviewed and revised to reflect their choice to refuse care by the MDS/Care Plan nurse on 4/3/18. • The facility recognizes that all residents who have been identified on the MDS (Minimum Data Set) as being rarely/never understood, have severely impaired cognition and/or refuse care have the potential to be affected by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 657	Continued From page 14 person centered measurable goals and objectives that lead to the resident's highest practicable physical, mental, and psychosocial well-being. A review of the facility's policy titled, "Refusal of Treatment", revised date of May 2017, revealed that if a resident refused to accept treatment, information relating to the refusal must be entered into the resident's medical record, and incorporated into the resident's care plan. Resident #56 Review of the Comprehensive Care Plan for Resident #56 revealed a problem to address Coping related to admission to [Name of Hospice] due to Alzheimer's Disease as of 6/14/17. Goals were for Resident #56 to identify effective coping skills, and verbalize feelings and concerns with a target date of 3/24/18. Interventions included to encourage resident to express feelings and concerns, actively listen to resident, and validate feelings and concerns when appropriate, and allow resident opportunity to identify own self care needs. Interview, on 2/15/18 at 12:05 PM, with Licensed Practical Nurse (LPN) #2 revealed she doesn't remember Resident #56 ever talking. LPN #2 revealed Resident #56 was "pretty much bedbound" and receiving hospice services. An interview, on 2/15/18 at 12:30 PM, with LPN #4 revealed Resident #56 was nonverbal, required extensive assistance, and was confused. Upon review of Resident #56's Hospice Care Plan, LPN #4 stated it was not person centered, and "needed to be updated."	F 657	deficient practice. • All RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) will be in-serviced by the QA (Quality Assurance) nurse on the requirement of the comprehensive care plan being developed within 7 (seven) days after completion of the comprehensive assessment, prepared by the interdisciplinary team and must be reviewed and revised after each assessment (comprehensive and quarterly). All residents identified on their current MDS as rarely/never understood, having severely impaired cognition or refusing care will have their care plan reviewed and revised, if necessary, by the MDS/Care Plan nurse to ensure the care plan is person-centered. The QA (Quality Assurance) nurse or RCM (Resident Care Manager) will review all residents having a MDS (Minimum Data Set) completed, and will have their comprehensive care plan reviewed to ensure the requirements for Care Plan Timing and Revision CFR (s): 4832.21 (b)(2)(i)-(iii) are met and to ensure the plan of correction is achieved and sustained. All in-services of nursing personnel will be completed on or before April 9, 2018. • The DON (Director of Nursing) or QA nurse will bring the results of the care plan audit to the Quality Assurance Committee, which will meet on a quarterly basis and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this plan of correction is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 657	Continued From page 15 A review of the most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/05/17, revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment per staff interview. Section B600 (Hearing, Speech, Vision) for Resident #56 was coded "no speech" and rarely/neverunderstands. Resident #85 A review of Resident # 85's Comprehensive Care Plan revealed the care plan did not address the resident's frequent refusals, except for wound care and positioning. The Behavior Care Plan for Resident #85 did not address the other issues of refusal for care.. An observation, on 02/15/18 9:08 AM, revealed Resident #85 refused for surveyor to watch care. During an interview, on 02/15/18 3:49 PM, Licensed Practical Nurse (LPN) #1/Wound Care Nurse said after Resident #85 was admitted to facility in June 2017, she would refuse to turn, bathe, use wedges for positioning, and remove the wedges herself. LPN #1 said the resident would be positioned by staff, and the resident would then move in the bed to sit up right by herself. A review of Resident # 85's Nurses Notes revealed the resident refused medications on 2/13/18, 2/10/18, 2/1/18, and 1/28/18. Resident #85 refused positioning, and to get out of bed on 2/13/18 and 1/27/18 per Nurses Notes. Resident #85 refused lab, and transfer to hospital on 1/28/18 per Nurses Notes. On 1/22/18, the	F 657	The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. • This corrective action will be completed by April 9, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 657	Continued From page 16 Nurses Notes revealed the resident refused peri-care, and catheter change. On 12/01/17, the Nurses Notes revealed Resident #85 refused to have lab drawn. A review of Resident #85's lab, dated 12/22/17, revealed resident refused for lab to be drawn. A review of Resident #85's lab, dated 01/18/18, revealed resident refused lab draw. An interview, on 02/16/18 10:29 AM, with LPN #2/Minimum Data Set (MDS) Nurse confirmed the care plan did not cover the refusing of care and lab draws on the Behavior Care Plan. An interview, on 02/16/18 11:03 AM, with the Director of Nursing (DON) revealed the resident did refuse care and blood draws. She said the policy was to notify the physician when medications were refused. She said the the physician would be notified if the resident refused lab draws the entire month. The DON confirmed the lab on the chart said the resident refused in December 2017 and January 2018. She would have to check with the hospital to see if any lab had been drawn for the month of February. Resident #14 A review of Resident #14's Comprehensive Care Plan, with a start date of 02/09/2017, revealed no approaches to encourage the resident to turn and reposition every two (2) hours and as needed, and to encourage the resident to wear shoes/socks/slippers that fit well. A review of Resident #14's Minimum Data Set (MDS), dated 12/19/17, revealed Resident #14's	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 657	Continued From page 17 Brief Interview for Mental Status (BIMS) in Section C (Cognitive Pattern) was a 3 per staff interview, which indicated Resident #14 had severe impaired cognitive skills. Observation, on 2/13/18 at 10:05 PM, revealed Resident #14 lying in bed on the left side. No verbal stimuli noted, or body movement. Observation, on 02/15/18 at 2:45 PM, revealed Resident #14 was a total bed bound resident, and does not respond to verbal stimuli. Per staff interview Resident #14 relies totally on staff for complete care. Interview, on 02/15/18 4:04 PM, with Licensed Practical Nurse #1/ Wound Care Nurse revealed, Resident #14 is unable to communicate with staff. LPN #1 revealed at times Resident #14 will follow the staff with his eyes. Interview, on 02/15/18 at 4:11 PM, with Licensed Practical Nurse #2, revealed Resident #14's Care Plan is not resident centered due to the resident's in-ability to follow command. LPN #2 revealed, Resident #14 is not able to teach to use shoes, slippers, or socks that fit well, or able to turn or reposition self. LPN #2 revealed the care plan was not centered around the needs of the resident. Interview, on 02/15/18 at 4:00 PM, with Director of Nursing revealed Resident #14's Care Plan should have been more resident centered.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 657	Continued From page 18	F 657		
F 658 SS=D	0 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 658	Continued From page 19 Based on observation, record review, staff interview, and facility statement review, the facility failed to ensure feeding pumps were operated by licensed personnel, for one (1) of six (6) residents observed with Percutaneous Endoscopic Gastrostomy (PEG) tube feedings; Resident #14. Findings include: Review of the facility's policies revealed there was not a policy regarding Certified Nursing Assistants (CNA) operating tube feeding pumps.. Review of Mosby's Pocket Guide titled, "Nursing Skills and Procedures", the eighth edition on page 161, related to Enteral Nutrition via a Gastronomy tube revealed the skill of administration of nasoenteral tube feeding can be delegated to nursing assistive personnel (NAP). However, a registered nurse (RN) or licensed practical nurse (LPN) must first verify tube placement and patency. The nurse directs the NAP to: 1) Elevate the head of bed. 2) Not adjust feeding rate; infuse the feedings as ordered. 3) Report any difficulty infusing the feedings or any discomfort voiced by patient. 4) Report any gagging, paroxysms of coughing, or choking. Resident #14 Observation during incontinent care, on 02/16/18 at 10:49 AM, revealed CNA #2 paused Resident #14's feeding pump. Interview, on 02/16/18 at 11:00 AM, with the Director of Nursing (DON) revealed the facility allows the CNAs to pause the feeding pumps during incontinent care.	F 658	F658 – Services Provided Meet Professional Standards • The PEG (Percutaneous Endoscopic Gastrostomy) tube feeding pump of Resident # 14 is only being operated by licensed personnel. • The facility recognizes that all residents with PEG tube feeding pumps have the potential to be affected by the deficient practice. • All RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) are being in-serviced on the requirement that services provided or arranged by the facility as outlined by the comprehensive care plan must meet professional standards of quality by the QA (Quality Assurance) nurse. All RNs, LPNs and CNAs (Certified Nursing Assistants) are being in-serviced on the requirement that tube feeding pumps are only allowed to be operated by licensed personnel. The QA nurse, RCM (Resident Care Manager) or CN (Charge Nurse)will conduct daily observations of care being provided to residents with tube feeding pumps for 4 (four) weeks beginning the week of April 9, 2018, to ensure the tube feeding pumps are only being operated by licensed personnel to ensure the plan of correction is achieved and sustained. All in-servicing of nursing personnel will be completed on or before April 9, 2018. • The DON (Director of Nursing) or QA nurse will bring the results of the daily observations of care to the Quality Assurance Committee, which will meet on quarterly basis and more often as necessary. If any revisions to the plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 658	Continued From page 20 Interview, on 02/16/18 11:17 AM, with the (DON) revealed the facility does not have a policy pertaining to CNA's ability to operate the feeding pump while care is in progress. Interview, on 02/16/18 at 12:27 PM, with CNA #2 revealed the facility allows the CNAs to pause the feeding pumps during care.	F 658	correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. • Corrective Action will be completed on or before April 9, 2018	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 690	Continued From page 21 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to provide Resident #13's incontinent care in a manner to prevent a Urinary Tract Infection, for one (1) of four (4) incontinent care observations. Findings include Resident #13 Observation of incontinent care on Resident #13, by Certified Nurse Aide (CNA) #1, at 02/15/18 at 3:11 PM, revealed the CNA wiped the resident's upper buttocks down towards her groin, instead of wiping from the front to the back, and then used the same wash cloth to wipe the resident's anterior thigh and vaginal area. CNA #1 also donned gloves from her pocket three (3) times during the incontinent care. Interview with CNA #1, on 02/15/18 at 3:11 PM, revealed she forgot to wipe the resident from front to back, and said she knew she should have done so. Interview with the Staff Development Nurse, confirmed the CNA failed to perform incontinent	F 690	F690 – Bowel/Bladder Incontinence, Catheter, UTI • Resident # 13 is receiving incontinent care in a manner to prevent a UTI (urinary tract infection). The Director of Nursing (DON) reviewed and assessed resident #13 on 2/16/18, which demonstrated no signs or symptoms of fever, dysuria, or increase in voiding pattern. Lab values obtained on 2/21/18 shows kidney function within normal limits. • The facility recognizes that all residents requiring incontinent care have the potential to be affected by the deficient practice. • All RNs (Registered Nurses), LPNs (Licensed Practical Nurses) and CNAs (Certified Nursing Assistants) are being in-serviced on providing appropriate treatment and services to prevent UTIs (urinary tract infections) by the QA (Quality Assurance) nurse. In-servicing included proper peri-care instruction of wiping front to back for females and distal to proximal for males, and proper usage and storage of gloves. The RCM (Resident Care Manager) or CN (Charge Nurse) will conduct (5) five random, unannounced	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 690	Continued From page 22 care on Resident #13 with the use of front to back wiping motions, and using one side of the wash cloth during incontinent care. Review of Resident #13's Face Sheet, revealed she was admitted by the facility, on 01/03/17, with diagnoses which included Influenza Due To Certain Identified Influenza Viruses. Review of the Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/17, revealed Resident #13 had a Staff Assessment score of 3, indicating the resident had severe cognitive impairment.	F 690	observations of resident care weekly for (8) weeks to ensure appropriate treatment and services to prevent UTIs is occurring and the plan of correction is achieved and sustained. All in-services were completed for nursing personnel on or before 4/9/18. • The DON (Director of Nursing) or QA nurse will bring the results of the weekly unannounced observations of care to the Quality Assurance Committee for review to ensure appropriate treatment and services to prevent UTI's is achieved and sustained. The QA Committee will continue to meet quarterly and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. Corrective Action will be completed on or before April 9, 2018	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters	F 692		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 692	Continued From page 23 of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to maintain Percutaneous Endoscopic Gastrostomy (PEG) tube feeding as ordered by the physician for one (1) of eight (8) residents observed with PEG tube feedings; Resident #55. Findings include: Review of the facility's policy titled, "Administering Medications through an Enteral Tube", revised April 2007, revealed one of the general guidelines is to administer medications and flushes as ordered by the physician. Review of the facility's policy titled, "Gastric Tube Feeding via Continuous Pump", revised September 2004, revealed to "verify that there is a physician's order for this procedure." Resident #55 An observation, on 02/12/18 at 11:20 AM,	F 692	F692 – Nutrition/Hydration Status Maintenance • Resident # 55 is receiving tube feeding at the ordered rate as of 2/16/18. • The facility recognizes that all residents with orders for tube feeding have the potential to be affected by the deficient practice. • All RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) are being in-serviced on assisted nutrition and hydration based on the resident's comprehensive assessment and ensuring the tube feeding is being received at the ordered rate by the QA (Quality Assurance) nurse. The QA nurse, RCM (Resident Care Manager) or CN (Charge Nurse)will conduct daily observations of residents receiving tube feeding for 4 (four) weeks to ensure the tube feeing is being received at the ordered rate and to ensure the plan of correction is achieved and sustained. All in-services of nursing personnel will be completed on or before April 9, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 692	Continued From page 24 revealed Resident #55's tube feeding Jevity 1.5 via PEG tube was infusing at at 65 ml/hr. Review of the current Physician's Order for February 2018 revealed an order written, on 2/8/18, to change the feeding to Jevity 1.5 at 65 milliliters/hour (ml/hr). On 02/15/18 at 3:05 PM, an observation revealed Licensed Practical Nurse (LPN) #1 performed wound care on Resident #55. During the wound care, an observation revealed the PEG tube feeding was infusing at 60 ml/hr. LPN #1 confirmed the PEG tube feeding was infusing at 60 ml/hr. Observation, on 02/16/18 at 9:30 AM, revealed Resident #55's PEG tube feeding was infusing at 60 ml/hr. The label on the bag revealed the Jevity 1.5 was hung on 2/16/18 at 3:30 AM. Interview, observation, and record review, on 2/16/18 at 9:45 AM, with LPN #3 confirmed Resident #55's PEG tube feeding was infusing at 60 ml/hr. Upon review of the Physician's Orders, LPN #3 stated, "It's my fault." LPN #3 further revealed the feeding should have been infusing at 65 ml/hr. LPN #3 revealed she had looked at the printed orders, and not the written orders. Review of the former Registered Dietician's (RD) notes, dated 11/29/17, revealed Resident #55 was receiving Jevity 1.5 at 60 ml/hr, and his nutritional needs were being met. The next note written by the RD for Resident #55, dated 1/25/18. revealed the resident had been hospitalized with return weight at 150.8 pounds. The RD recommended tube feeding to be increased to 65 ml/hr.	F 692	• The DON (Director of Nursing) or QA nurse will bring the results of the daily observations of care to the Quality Assurance Committee which will meet on a quarterly and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. • Corrective Action will be completed on or before April 9, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 692	Continued From page 25 Review of the medical record revealed Resident #55 was hospitalized, from 12/26/17 to 1/10/18, with Pneumonia. A review of the weight change history for Resident #55 revealed a weight of 164.20 on 10/31/17. Resident #55's weight as of 2/11/17 was 151.20. Interview, on 2/16/18 at 10:25 AM, with the Nurse Practitioner (NP) revealed Resident #55 "has been in and out of the hospital." The NP further revealed she knew Resident #55 was on a Baclofen pump, but was unable to give information regarding his PEG tube feeding pump. An interview, on 2/16/18 at 9:55 AM, with Registered Nurse (RN) #1, who serves as the Quality Assurance and Staff Development Nurse, revealed not running the PEG tube feeding at the right rate could potentially cause weight loss, and dehydration. RN #1 further revealed the nurses are responsible for doing a 24 hour chart check to see if any new orders have been written. Interview, on 2/16/18 at 11:40 AM, with the Director of Nursing (DON) revealed, "it could lead to weight loss, and other problems if the resident is not getting enough fluids." An interview, on 2/16/18 at 2:40 PM, with the current Registered Dietician (RD) revealed Resident #55 was considered a high risk resident. The RD stated five (5) ml was a minor deficit. However, if it occurred over a long period of time, it could cause potential weight loss.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 695	Continued From page 26 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review; the facility failed to maintain the filters in Resident #36's trach Oxygen (O2) concentrator and oxygen flow meter, for one (1) for four (4) residents reviewed with tracheostomies. Findings include: Review of the facility's policy titled, "Cleaning and Disinfection of Resident-Care Items and Equipment", with a revision date of 07/14, revealed durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations, and OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard. Resident #36 Review of Resident #36's "Physician's Orders" dated 08/16/17, revealed an order to clean oxygen filters every week on Fridays. Observation, and interview with Licensed Practical Nurse (LPN) #5, on 02/15/17 at 4:20 PM, regarding Resident #36's oxygen flow meter	F 695	F695 – Respiratory/Tracheostomy Care and Suctioning • The O2 (oxygen) filter for Resident # 36 was cleaned on 2/15/2018 by the RT (Respiratory Therapist. • The facility recognizes that all residents utilizing an O2 concentrator have the potential to be affected by the deficient practice. • All RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) are being in-serviced on providing respiratory care consistent with professional standards of practice by the QA (Quality Assurance) nurse. The RT (Respiratory Therapist) or CN (Charge Nurse) will clean O2 concentrator filters weekly. The QA nurse or RCM (Resident Care Manager) will conduct weekly observations beginning the week of April 9, 2018, of the O2 concentrator filters for 8 (eight) weeks to ensure the O2 filters have been cleaned and the plan of correction is achieved and sustained. All in-servicing of nursing personnel will be completed on or before April 9, 2018. • The DON (Director of Nursing) or QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 695	Continued From page 27 (High Flow Nebulizer) to his tracheostomy revealed the filter with "lots and lots of dust". Observation, and interview with the Director of Nursing (DON), and Respiratory Therapist, on 02/15/17 at 4:20 PM, revealed Resident #36's oxygen flow meter (High Flow Nebulizer), and his oxygen concentrator filter were dusty, and in need of cleaning. The DON confirmed the 11:00 PM -7:00 AM nurses are responsible for cleaning the air filters each Friday. The Respiratory Therapist said she had overlooked the filters needing to be cleaned. Review of Resident #36's Face Sheet, revealed the resident was admitted to the facility, on 08/16/17, with diagnoses which included Acute Hypoxia Respiratory Failure. Review of the Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/17/17, revealed Resident #36 had a Staff assessment cognitive score of 3, indicating the resident had severe cognitive impairment.	F 695	nurse will bring the results of the weekly observations of the O2 concentrator filters to the Quality Assurance Committee, which will review to ensure correction is achieved and sustained. QA Committee will continue to meet quarterly and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. • Corrective Action will be completed on or before April 9, 2018	
F 772 SS=D	Lab Services Not Provided On-Site CFR(s): 483.50(a)(1)(iv) §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by:	F 772		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 772	Continued From page 28 Based on record review, staff interview, and facility policy review, the facility failed to obtain Resident #59's lab as ordered by the physician, for one (1) of five (5) resident records reviewed. Findings include: Review of the facility's policy titled, "Specimen Collection and Test Results", dated April 2007, revealed the facility will collect specimens in accordance with established nursing service procedures, and the resident's attending provider will be notified of the results. Resident #59 Review of the Physician's Orders revealed Resident #59 was receiving Risperdal a two (2) milligrams (mg) tablet twice daily for Psychosis, Sertraline HCL 100 mg one (1) tab by mouth (po) daily for Depression, and Ativan two (2) mg one (1) tablet po every six (6) hours as needed (prn) for Anxiety. A Gradual Dose Reduction (GDR) was completed on 1/26/18 for Ativan. A GDR for Risperdal was done on 12/13/17 with recommendations for a Lipid Panel to be drawn annually, and a Hemoglobin (Hgb) A1c drawn every 6 months. On 02/15/18 at 02:52 PM, an interview with Licensed Practical Nurse (LPN) #3, revealed upon reviewing the chart for the Hgb A1C ordered in 12/14/17, she did not see it on the chart. LPN #3 placed a call to [Name of Hospital] but didn't get a response. On 02/16/18 at 12:40 PM, an interview with the Director of Nursing (DON) revealed the HgbA1C	F 772	F772 – Lab Services Not Provided On-Site • RN for Resident # 59 assessed resident for adverse effects and obtained CBG on 2/15/18 which was 95 and within normal limits. On 2/16/18 the Director of Nursing (DON) obtained a Hgb A1C with result of 6.0 with no signs or symptoms of hyperglycemia which was reported to the physician. No new orders given at this time. • The facility recognizes that all residents with physician orders for lab draws have the potential to be affected by the deficient practice. • All RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) are being in-serviced on obtaining laboratory services ordered to meet the needs of the residents by the QA (Quality Assurance) nurse. The MR (Medical Records) clerk or the RCM (Resident Care Manager) will randomly audit residents medical records weekly beginning the week of April 9, 2018, for 4 (four) weeks to ensure lab draws are being completed as ordered by the physician to meet the needs of the residents and ensure the plan of correction is achieved and sustained. All nursing personnel were provided in-service training on or before 4/9/18. • The DON (Director of Nursing) or QA nurse will bring the results of the weekly audit of lab draws to the Quality Assurance Committee, which will meet quarterly and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 772	Continued From page 29 "was not done." The DON revealed it is the responsibility of the nurses and Resident Care Managers to make sure the lab is drawn. The DON stated the Resident Care Managers are to audit lab records every month. The DON further revealed [Name of Hospital] comes to the facility on Monday, Wednesday and Friday. If the facility needs lab drawn in between time, they use [Name of Hospital] lab services. Review of the most recent Quarterly Minimum Data Set (MDS), assessment with an Assessment Reference Date (ARD) of 12/07/17, revealed Resident #59 scored nine (9) on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment.	F 772	ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. Corrective Action will be completed on or before April 9, 2018.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to notify the physician of lab draws not done due to the resident's refusal, for one (1) of 24 resident	F 773	F773 – Lab Services Physician Order/Notify of Results • The physician of Resident # 85 was notified of the resident's refusal to allow	4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 773	Continued From page 30 records reviewed; Resident #85. Findings include: A review of the facility's policy titled, "Refusal of Treatment", revised date of May 2017, revealed if the resident refused treatment the attending physician must be notified of the refusal. Resident #85 A review of Resident # 85's Nurses Notes revealed documentation on 12/01/17, Resident #85 refused to have lab drawn. No nurses notes were noted for the date of a lab draw dated 12/22/17. No mention of notifying the provider of refusal of lab draw on 1/18/18 in the Nurses Notes. A review of Resident # 85's lab dated, 12/22/17, revealed a written statement on the lab result the resident refused for the lab to be drawn. A review of Resident #85 lab, dated 01/18/18, revealed the resident refused typed on the lab results. An interview, on 02/16/18 11:03 AM, with the Director of Nursing (DON) revealed the resident did refuse care and blood draws. She said the physician would be notified if the resident refused the lab draws for the entire month. The DON confirmed the lab on the chart said the resident refused in December 2017 and January 2018. She would have to check with (Name of Hospital) to see if any lab had been drawn for this month. An interview, on 02/16/18 12:40 PM, revealed the DON said the labs were scheduled to be drawn	F 773	their labs to be drawn. The Director of Nursing (DON) notified the physician on 2/16/18 of the resident's refusal to have labs drawn, with no new orders from physician at that time. • The facility recognizes that all residents with physician orders for lab draws have the potential to be affected by the deficient practice. • All RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) are being in-serviced on obtaining ordered laboratory services and notifying the physician if the resident refuses the service by the QA (Quality Assurance) nurse. The MR (Medical Records) clerk or the RCM (Resident Care Manager) will randomly audit residents medical records weekly beginning the week of 4/9/18 for 4 (four) weeks to ensure lab draws are being completed as ordered by the physician and that the physician is notified if the resident refuses the service to ensure the plan of correction is achieved and sustained. All in-services were completed for nursing personnel on or before April 9, 2018. • The DON (Director of Nursing) or QA nurse will bring the results of the weekly audit of lab draws and notification of physician for any refusal of the service to the Quality Assurance Committee, which will meet quarterly and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 773	Continued From page 31 on Mondays, Wednesdays, Fridays by (Name of Hospital), and (Name of Hospital) would draw labs for emergencies. An interview, on 02/16/18 2:38 PM, revealed the DON said the routine lab was not retried after the resident's refusal in December 2017 and January 2018. The DON confirmed there was not any documentation for notifying the resident's physician of the lab refusals.	F 773	DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. Corrective Action will be completed on or before April 9, 2018.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to prevent the possible spread of infection during delivery of food trays for two (2) of five (5) halls observed;	F 812	F812 – Food Procurement, Store/Prepare/Serve-Sanitary • CNA # 4 and CNA # 5 have been in-serviced on delivering food trays and	4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 812	Continued From page 32 Hall 200 and 300. Findings include: A review of a facility's policy titled, "Food Preparation and Service", revised July 2014, revealed staff may not handle ice with bare hands, and serve food in a manner that complies with safe food handling practices. An observation, on 02/14/18 11:18 AM, revealed a food cart was delivered to the 300 hall. At 11:19 AM, Certified Nursing Assistant (CNA) #4 started to deliver the trays by placing the ice bucket, and the empty tea glasses on an isolation cart in the hallway. At 11:22 AM, CNA #4 used each tea cup with bare hands to dip the ice, and placed the cup back on the isolation cart. An interview, on 02/14/18 11:48 AM, revealed CNA #4 said she did not receive an ice scoop from the kitchen. She said this was only her third day in orientation, and the person who was to be with her was on lunch break. She said she did not know the policy because she was new. An observation, on 02/14/18 11:34 AM, revealed CNA #5 used a tea cup with bare hands to dip ice into the glasses for the food cart delivered down the 200 Hall. She said she did not have an ice scoop. An interview, on 02/14/18 11:37 AM, revealed CNA #5 said she thought she needed a scoop, but would have to ask the Director of Nursing (DON). CNA #5 said this was her first time delivering trays, and needed to be sure. An interview, on 02/14/18 11:39 AM, revealed the	F 812	dispensing ice in accordance with professional standards for food service safety by the QA nurse on 2/14/18. • The facility recognizes that all residents have the potential to be affected by the deficient practice. • All RNs (Registered Nurses), LPNs (Licensed Practical Nurses) and CNAs (Certified Nursing Assistants) are being in-serviced on the delivery of food trays and dispensing of ice in accordance with professional standards for food service safety by the QA (Quality Assurance) nurse. The QA nurse, RCM (Resident Care Manager) or CN (Charge Nurse)will conduct daily observations of food tray delivery for 4 (four) weeks to ensure delivering of food trays and dispensing of ice is in accordance with professional standards for food service safety and to ensure the plan of correction is achieved and sustained. All in-services for nursing personnel were completed on or before 4/9/18. • The DON (Director of Nursing) or QA nurse will bring the results of the daily observations of delivery of food trays and dispensing of ice to the Quality Assurance Committee, which will meet quarterly and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. • Corrective Action will be completed on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 812	Continued From page 33 DON said the CNAs should have had an ice scoop to deliver the ice. An interview, on 02/14/18 12:31 PM, with the Dietician confirmed the policy was to not handle the ice with bare hands. He said the problem with setting the ice bucket and tea glasses onto the isolation cart was infection control. The Dietician stated the staff should have an ice scoop to place the ice in the glasses. 02/16/18 09:53 AM, and interview with Registered Nurse (RN) #1/Quality Assurance said she was just made aware of the concern of the delivery of food by the CNAs. She said CNA #4 had not finished her orientation, and did not have her check list completed. She said the orientation included delivery of trays.	F 812	or before April 9, 2018.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 880	Continued From page 34 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 880	Continued From page 35 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to prevent the possible spread of infection as evidenced by the use of gloves stored in the staff's pockets, and used during incontinent care; Resident #13, for one (1) of four (4) incontinent care observations. Findings include: Review of the facility's policy regarding Standard Precautions - Gloves, with a revision date of 07/17, revealed clean gloves should be worn when anticipating contact with body fluids, and other potentially infected material. Resident #13 Observation of incontinent care on Resident #13, by Certified Nurse Aide (CNA) #1, on 02/15/18 at 3:11 PM, revealed the CNA donned gloves from her pocket three times during the incontinent care. CNA #1 began the care by wiping the resident's upper buttocks down towards her groin instead of from the front to back, and then used the same wash cloth to wipe the resident's anterior thigh and vaginal area.	F 880	F880 – Infection Prevention & Control • Resident # 13 is receiving incontinent care in a manner to prevent an infection. • The facility recognizes that all residents requiring incontinent care have the potential to be affected by the deficient practice. • All RNs (Registered Nurses), LPNs (Licensed Practical Nurses) and CNAs (Certified Nursing Assistants) are being in-serviced on preventing the development and transmission of communicable diseases and infections, including the proper storage of gloves and wiping direction by the QA (Quality Assurance) nurse. The RCM (Resident Care Manager) or CN (Charge Nurse) will conduct (5) five random, unannounced observations of resident care beginning the week of 4/9/18, weekly for 8 (eight) weeks, to ensure gloves are not being stored in staff's pockets and used during care to prevent the transmission of communicable diseases and infections and to ensure the plan of correction is achieved and sustained. All in-services for nursing personnel were completed on or before April 9, 2018. • The DON (Director of Nursing) or QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
F 880	Continued From page 36 Interview with CNA #1, on 02/15/18 at 3:11 PM, revealed she forgot to wipe the resident from front to back during incontinent care, and said she should not have used the gloves from her scrub top during the care because they were contaminated. Interview with the Staff Development Nurse, on 02/15/18 at 12:10 PM, confirmed the CNA did not prevent the possible spread of infection when she used gloves from her pocket, and when not wiping Resident #13 from front to back during incontinent care. Review of Resident #13's Face Sheet, revealed she was admitted by the facility, on 01/03/17, with diagnoses which included Influenza Due To Certain Identified Influenza Viruses. Review of the Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/17, revealed Resident #13 had a Staff assessment score of 3, indicating the resident has severe cognitive impairment.	F 880	nurse will bring the results of the weekly unannounced observations of care to the Quality Assurance Committee, which will meet quarterly and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff members. • Corrective Action will be completed on or before April 9, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	**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 42 CFR 483.70(a) 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) ...	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222		4/9/18

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

Electronically Signed | 04/05/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	**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 222	Continued From page 1 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to properly maintain exit doors as per NFPA 19 2.2.2.5.2. This standard deficiency affect two (2) of seven (7) exits and 17 of 120 residents in the facility on the day of survey. Findings include:	K 222	K222 – Egress Doors • The Service Hall Exit Door is now releasing upon activation and testing of the fire alarm system. The combination lock on the fence gate from the Alzheimer's Unit of the facility has been removed. • The facility recognizes that all doors	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	**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 222	Continued From page 2 On February 16, 2018 at 10:45 AM, observation revealed combination lock on fence door from the Alzheimer's Unit of the facility. This combination lock blocked and denied means of egress from the Alzheimer's Unit of the facility. The Alzheimer's Unit staff did not know the code the combination lock. On February 16, 2018 at 11:10 AM, observation revealed the magnetic locks on the Service Hall exit doors did not release upon activation and testing of the fire alarm system.	K 222	and gates with special locking arrangements for clinical security needs of the patient must be made for the rapid removal of occupants, and all residents in the clinical secure area have the potential to be affected by the deficient practice. • The Maintenance Director will conduct random, unannounced observations of Alzheimer Unit gate to ensure occupants and residents have rapid egress from the fenced yard and gate to ensure the plan of correction is achieved and sustained. Magnetic locks on doors will be monitored to ensure release upon activation and testing of the fire alarm system. • The Maintenance Director will bring the results of the weekly unannounced observations of the Alzheimer Unit Gate and the monitoring of Magnetic Door Locks to the Quality Assurance Committee, which will meet at least quarterly and more often as necessary. If any revisions to the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure this action is achieved and sustained. The QA members will be the Medical Director, DON, Administrator, Infection Control and Prevention Officer and at least one other facility staff member. • Corrective Action will be completed on or before April 9, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	02/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND VILLAGE NURSING CENTER	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
E 000	Initial Comments ********** Survey conducted on 2/13/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 04/05/2018

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.