STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045259	A. BUILDING ______ B. WING ______	C 01/24/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILLS HEALTHCARE AND REHABILITATION	**8701 RILEY DRIVE LITTLE ROCK, AR 72205**

(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 Complaint #13212 was substantiated (all or in part) with a deficiency cited at F314.	F 000		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Complaint #13212 was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure urine and feces were thoroughly removed from the skin during incontinent care to prevent potential deterioration/infection of existing pressure ulcers for 1 (Resident #4) of 2 case mix residents (Residents #1 and #4) who were incontinent of bladder and bowel and had existing pressure ulcers. The failed practice had the potential to affect 3 incontinent residents who resided on the Manor Lodge Wing and had existing pressure ulcers and 31 incontinent residents who were at risk for pressure ulcer development, as documented on a list provided by the Administrator on 1/24/08 at 10:45 a.m. The findings are: Resident #4 had diagnoses of Psychosis and	F 314		

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

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.

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F 314	Continued From page 1	F 314		

Alzheimer's Disease. The Quarterly Minimum Data Set (MDS) dated 10/15/07 documented the resident had modified independence in cognitive skills for daily decision making, had short and long-term memory problems, was totally dependent on staff for personal hygiene and was incontinent of bowel and bladder.

a. The Resident Plan of Care updated on 1/16/08 documented: "ADL [activities of daily living] deficit... at risk for skin breakdown, related to: bowel incont [incontinence]... history of resolved pressure ulcers... provide incontinent care following each episode. Keep resident clean, dry and odor free." As of 1/23/08, there was no documentation on the Plan of Care to address any current pressure ulcers.

b. The Wound/Skin Healing Record dated 1/21/08 documented: "R [right] gluteal fold... Stage II, 0.5 cm [centimeters] x [by] 0.4 cm x < [less than] 0.2 cm... L [left] gluteal fold... Stage II, 0.6 cm x 0.6 cm x < 0.2 cm... coccyx Stage II, 4.2 cm x 0.4 cm x < 0.2 cm."

c. On 1/23/08 at 11:40 a.m., the Treatment Nurse prepared to provide wound treatments to the pressure ulcers on the resident's coccyx and bilateral ischial areas. The following observations were made:

1.) When the resident was positioned on her left side, the incontinent brief was folded back to reveal a 0.5 to 1 inch streak of partially dried feces smeared from the top of the center gluteal fold upward to the level of the resident's waist. There was additional partially dried feces streaked on the inside of the incontinent brief at the same level. The fecal material covered the

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F 314	Continued From page 2 pressure ulcer on the coccyx, which was healed over with a very thin layer of skin. There were no dressings covering the pressure ulcers on the coccyx or bilateral ischeal areas. The center gluteal fold and peri-anal area were completely free of any fecal material. When asked about the absence of dressings for the wounds, the Treatment Nurse stated, "She usually has a BM [bowel movement] after she lays down." The dried stool was cleansed from the resident's skin prior to the Treatment Nurse providing the wound treatments. 2.) Wound treatments were completed to the following pressure ulcers at this time: A dime-sized, thinly-closed area to the coccyx. A pressure ulcer to the right ischium, approximately dime-sized in diameter and open with a clean wound bed and pink wound edges, surrounded by an approximately 2-inch area of redness. A pressure ulcer to the left ischium, approximately quarter-sized in diameter and open with a clean wound bed and pink wound edges, surrounded by an approximately 2-inch area of redness. 3.) After the Treatment Nurse completed the wound treatments, the incontinent brief was removed and found to be saturated with urine. Certified Nursing Assistant (CNA) #1, who had assisted the Treatment Nurse with positioning the resident during the wound treatments, was asked by the Treatment Nurse if she needed help with changing the resident's incontinent brief. The CNA stated, "No, I've got it." The CNA removed	F 314		

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F 314	Continued From page 3 the wet incontinent brief and replaced it with a dry one, without cleansing urine from any part of the resident's skin. The CNA fastened the incontinent brief and pulled up the resident's pants without providing incontinent care to the resident. 3.) CNA #1 was asked if she had provided incontinent care to the resident previously that morning. She stated, "No, I just came on this hall. [CNA #2] was on this hall this morning and caring for this resident." d. On 1/23/08 at 12:10 p.m., CNA #2 was asked if he had provided incontinent care to the resident that morning. The CNA stated, "Yes." When asked if the resident was only incontinent of urine at that time, the CNA stated, "No, she had a big BM." e. The facility's Protocol for Incontinent Care was provided by the Administrator on 1/24/08 at 10:25 a.m. and documented: "...Female: Gently wash perineal area wiping front to back, separate labia, alternating sides, moving outwards to the thighs, using a different side of wipe/cloth or different wipe/cloth, then dry the area in the same fashion... Turn resident on side & [and] cleanse rectum and buttocks from anus outward, including buttocks & thighs, using a different side of wipe/cloth or different wipe/cloth, then dry the area in the same fashion."	F 314		