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 01/31/2007

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 #12283 is unsubstantiated with unrelated deficiencies cited.	F 000		
F 314 SS=E	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: Based on observation, record review and interview the facility failed to ensure that heel protectors, bridging and/or positioning devices were applied for 3 Residents (Resident #2, 5, and 4) of 5 case mix residents (Residents #1, 2, 3, 4, and 5) who were at risk for developing pressure sores. The facility failed to ensure an incontinent pad was not pulled from underneath a resident causing skin friction with the potential for skin breakdown for 1 (Resident #5) of 5 case mix residents (Residents #1, 2. 3. 4. and 5) who were incontinent and at risk for skin breakdown. The facility failed to ensure pressure sores were cleaned and dressed according to physician orders for 1 (Resident #5) of 5 (Residents #1, 2, 3, 4. and 5) case mix residents who had pressure sores. This failed practice had the potential to affect 6 residents who had pressure sores and 15 residents who were at risk for developing pressure sores as identified on a list provided by the Director of Nursing on 1/31/07. The findings	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 are: 1. Resident #5 had diagnoses of Closed Hip Fracture, Weight Loss, Dementia, Anemia, Osteoporosis, Degenerative Joint Disease, and Urinary Retention. The Significant Change Minimum Data Set (MDS) dated 1/25/07 documented the resident had modified independence in cognitive skills for daily decision making, required limited to extensive assistance with activities of daily living, was frequently incontinent of bowel, had an indwelling Foley catheter, weighed 63 pounds, had a weight loss of more than 5% in the last 30 days, and had a Stage IV pressure ulcer. a. A physician order dated 1/15/07 documented, Daily dressing change to (L) left Gluteal; -clean wound with NS (normal saline) -pack wound with wet to dry Betadine -Cover with Border dressing -Apply Xenaderm around wound -Change every day b. The physician order from the wound clinic dated 1/22/07, documented "Keep dressing clean, dry & intact. Do not change." The physician order dated 1/29/07 documented, " If dressing comes off leave packing in place - cover with border dressing " . c. On 1/26/07 at 9:23 a.m., the resident was on a (ALM) Alternating Low Pressure Air Mattress lying on the right side with the head of bed (HOB) elevated approximately 45 degrees. d. On 1/26/07 at 10:39 a.m. and 12:12 p.m., the resident was lying in bed on the left side and there was no padding positioned between the knees or heel protectors applied.	F 314		

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F 314	Continued From page 2	F 314		

e. On 1/26/07 at 12:12 p.m., CNA #1 (Certified Nursing Assistant) stated the dressing was coming off of the pressure sore (Stage IV on the resident's sacrum) and she would get the LPN to change the dressing. LPN #1 (Licensed Practical Nurse) entered the room, removed the loosened dressing and stated, "We use a wet-to-dry dressing of Betadine solution when the dressing comes loose. The wound clinic uses something else. She goes to the wound clinic every Monday."

f. On 1/26/07 at 12:12 p.m., after the dressing change, CNA #1 changed the incontinent pad by pulling the pad out from under the resident causing friction of the bare skin

g. On 1/29/07 at 11:05 a.m., the resident was lying on her back with the HOB elevated approximately 90 degrees and there was no padding positioned between the knees or heel protectors applied.

h. On 1/29/07 at 12:10 p.m., the resident was on her right side with pillows positioned at her back. There was no padding positioned between the knees or heel protectors applied.

i. The progress notes from the wound clinic dated 1/29/07 documented, "Pt (patient) here for scheduled visit. Total lift to stretcher. Vital signs obtained. [No] dressing on wound on arrival." The physician order from the wound clinic dated 1/29/07 at 12:25 p.m. documented, order #2, "Continue to keep dressing clean, dry, and intact. Do not change." Order #3 documented, "If dressing comes off leave packing in place and cover with border dressing. Make sure there is a

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dressing in place at all times."

2. Resident #4 had diagnoses of Hypertension, Amputation of Left Leg, Alzheimer's disease, Dementia, Renal Insufficiency, Dysphagia, and Weight Loss. The Annual Minimum Data Set dated 1/3/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on the staff for activities of daily living, had a history of pressure sores that had been resolved in the past 90 days.

a. The January 2007 Physician Order sheet documented, Order #15, "Bridge to Right Heel at all times" and Order #41, "Heel Protector to R (Right) Heel."

b. On 1/26/07 at 8:54 a.m., 10:12 a.m., 10:35 a.m., 12:05 p.m., and 1/29/07 at 10:57 a.m., the resident was lying in bed wearing white socks, the foot was not bridged and there was no heel protector.

c. On 1/31/07 at 8:45 a.m., the facility "Wound and Skin Care Protocols and Procedures" dated as revised on July 7, 2005 was received from the Director of Nursing.

The Protocols for "At Risk" Patients, "Pressure, Item #2, documented, "When in bed turn and reposition q (every) 2 hours if applicable. Utilize pillows to separate pressure areas (i.e. between the knees)." Item #3 documented, "Heels are extremely vulnerable and can be elevated completely off of bed surface. Pillows or foot splints/heel protectors may be used." The section, "Friction/Shear ..., Item #3, documented, "Minimize shear forces by lifting resident during transfer and turning. Do not slide."

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F 314	Continued From page 4 d. On 1/31/07 at 12:45 p.m., the Director of Nursing was asked what she expected the staff to do relative to the prevention of pressure sores. The DON stated, "I expect the LPN's to complete assessments, including the Braden Scale, use Pressure Relieving devices in bed and wheelchairs or chairs. They should use Pressure Relieving Devices between bony prominences, turn the resident every 2 hours and PRN (as needed) or more frequently, give ample fluids, and keep the residents clean." 3. Resident #2 had diagnoses of Pressure Sores, Diabetes Mellitus, Renal Insufficiency, Congestive Heart Failure and Cerebrovascular Accident (CVA). The MDS dated 12/7/06 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent on staff for activities of daily living and had a Stage II Pressure Ulcer. a. The Braden Scale Assessment dated 12/21/06 documented a score of 16 representing a mild risk for pressure sore development. The Braden Scale Assessment rating is as follows: (Mild risk: 15-18, Moderate Risk: 13-14, High risk: 10-12, and Severe risk: < 9). b. As of 1/26/07, the Nursing Assistant Assessment plan of care documented the resident required "heel protectors". c. On 1/26/07 at 10:06 a.m., 12:07 p.m. and 1:30 p.m., the resident ' s heels were lying on the mattress and there were no heel protectors on.	F 314		