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 06/16/2006

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 PRECEEDED 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 #11645 Substantiated (all or in part) with a deficiency cited at F253.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Complaint #11645 Substantiated (all or in part) in these findings. Based on observation, record review and interview the facility failed to ensure resident equipment in the shower room on the D Hall was maintained in a clean and sanitary manner for 1 of 1 case mix residents (Resident #1) who used a shower gurney. This failed practice had the potential to affect 2 facility residents who were transported to the shower by gurney. The facility further failed to ensure metal door frames were free of rust and corrosion; that floor tiles in the facility were not missing, broken and/or cracked; that wall paper was not torn or loose from the walls. These failed practices had the potential to affect 97 residents in the facility according to the Resident Census and Condition of Residents form dated 6/13/06. The findings are: 1. Resident #1 had diagnoses of Urinary Tract Infection, Sepsis, Anemia and History of Colon Cancer. A Minimum Data Set (MDS) dated 5/13/06 documented the resident had severely impaired cognitive skills for daily decision-making,	F 253		

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.

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 06/16/2006

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 PRECEEDED 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 253	Continued From page 1 required total assistance of 2 persons for transfer, was incontinent of bowel and bladder and had Urinary Tract Infection in the last 30 days. a. On 6/14/06 at 8:50 a.m., the resident received a shower in the shower room on D hall. The resident was on a shower gurney made of a mesh fabric and PVC pipe. While the Certified Nursing Assistant (CNA) #4 was dressing the resident, the resident had a bowel movement that soiled the mesh covering of the gurney beneath the resident and the collapsible side rails. CNA #3 wiped the side rails with a wet washcloth that contained no disinfectant. The resident was taken back to her room and transferred to bed to wait until she could be cleaned and dried. b. On 6/14/06 at 9:20 a.m., CNA #4 took the shower gurney from the resident's room back to the shower room. CNA #4 cleaned the mesh fabric with Comet with Chlorine spray cleaner, but failed to clean the side rails that had been contaminated with feces. The CNA stated, "There! It's ready for the next person." Only after the surveyor informed CNA #4 of the contaminated side rails did she state, "Oh, I need to clean the whole thing." c. On 6/16/06 at 4:25 p.m., the Administrator stated the CNA's are trained in cleaning shower equipment during their orientation, but she had nothing documented. 2. On 6/12/06 at 4:20 p.m. during the initial tour of the facility and 6/14/06 at 3:00 p.m. during the environmental tour the following was noted: a. The lower section of the metal door frames on the D, E, F and G Halls, the Exit doors next to the kitchen and in the day room between the F and G	F 253		

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 06/16/2006

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 PRECEEDED 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 253	Continued From page 2 Halls were rusty and corroded in the areas next to the floor. b. Broken and cracked floor tiles extended from room F6 to F9 on F Hall and between the fire separation doors on the F Hall. c. The right side of the entry wall in room PR1 on A Hall had a 3 by 1 inch chip off the plaster. d. The ceiling tile and the vent filter in the ceiling above the nurses station located between the A and D Halls were rusty. There were brown circles on the tiles as well as the ceiling vent. e. On 6/14/06 at 3:00 p.m., the wall paper and baseboards in the Day Room across from the nurses station between the A and D Halls were loose. The wallpaper had a discolored, reddish stain on the off white background. The wall paper under water fountain had a tear in it that was approximately 24 inches long. f. On 6/14/06 at 3:16 p.m. the floor tiles were missing in front of the washing machines on the laundry room floor where there was a small pool of standing water. Documentation was requested to verify the floor water proofed to prevent water seepage. The Maintenance Director stated that he was not able provide that information.	F 253		
F 272 SS=C	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		

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 06/16/2006

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 PRECEEDED 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 272	Continued From page 3 A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on Record Review and Interview, the facility failed to ensure that Resident Assessment Protocol Summary Forms (RAP's) documented the location and date of information gathered in order to conduct an assessment of triggered problems identified by each resident's Minimum Data Set (MDS) for 17 of 17 casemix residents. This failed practice had the potential to affect all 97 Residents residing in the facility, as identified on the Resident Census and Condition form	F 272		

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 **06/16/2006**

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 PRECEEDED 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 272	Continued From page 4 dated 6/13/06. The findings are: 1. Resident Assessment Protocol summary sheets for Residents #1 through 17 documented in the column titled Location and date of RAP Assessment Documentation "RAP Summary". Clinical Record Review for all 17 active case mix Residents was completed. In every case, the most current RAP Assessment Protocol Summaries contained no information under the heading, Location and Date of RAP Assessment Documentation. That column contained the words, "Rap Summary (and date of summary)". There was no documentation of the specific location of the assessment information that supported decision making relevant to the triggered RAP. 2. On 6/16/06 at 1:15 p.m., the Social Director described her part of the Resident assessment process. She stated she obtains information and about a week before the MDS meeting she, "observes the Resident". She stated she, "Asks general questions, (for example), "how are things going." She provided a copy of the part of the MDS she completes. The MDS sections included Section E, item 1,2,3,4,and 5; Section F, items 1,2, and 3. Section Q, item 1 and 2 and Section P, item 2. The Social Director does not develop her care plans but stated, "The MDS nurse writes the care plans." 3. On 6/16/06 at 12:50 p.m., the Activity Director described how she participated in the Resident Assessments. She stated, "Residents tell her in Resident Council Meeting" and "I do room visits. She stated that she, "does attend Care Plan Meetings" but, "(I'm) not familiar with care plans." She, "did not know about writing care plans."	F 272		

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 06/16/2006

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 PRECEEDED 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 272	Continued From page 5 4. On 6/16/06 at 11:45 a.m., The MDS Nurse stated that she, "collected all the MDS data and coded it on paper and then entered it into the computer. The computer produces RAP summary. If it will be care planned I develop a goal and intervention. I have not been specifying the date or exact location in the clinical record for (the assessment). The disciplines do not develop their care plans." The MDS Nurse was unable to provide any documentation of attendance of special disciplines at the Care Plan Meetings. She stated, " I do not take attendance." 5. On 6/16/06 at 3:30 p.m., the Administrator stated, "I was not aware there was a problem with Care Plan Meetings. I have not attended a Care Plan Meeting."	F 272		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident was transferred in a manner that would prevent the potential for injury for 1 (Resident #16) of 14 case mix residents (Residents #1 - #3, #5 - #8, #10 - #12, and #14 - #17) who required staff assistance with transfers. This failed practice had the potential to affect 68 residents in the facility who were dependent or required assistance of staff for	F 312		

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 06/16/2006

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 PRECEEDED 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 312	Continued From page 6 transferring as documented on the Resident Census And Condition of Residents form dated 6/13/06. The findings are: Resident #16 had diagnoses of Hemiplegia, Alzheimer's Disease and Edema. An Annual Minimum Data Set dated 3/4/06 documented the resident had moderately impaired cognitive skills for daily decision making, and required limited assistance of one person for transfer. a. On 6/15/06 at 9:00 a.m., the resident was in a wheelchair and was rolled into the shower room by Certified Nursing Assistant (CNA) #1 for a shower. CNA #2 helped CNA #1 transfer the resident from the wheelchair into the shower chair. Each CNA placed their arm under the resident's shoulder and placed the resident on the shower chair. After the resident's shower both CNA's transferred the resident back to the wheelchair in the same manner commonly known as the 'chicken wing transfer'. The resident stated, "I'm going to fall on my face." b. On 6/15/06 at 4:15 p.m., the Director of Nursing (DON) provided a "Procedure" for transfer that documented, "...Support the resident by placing a belt around the resident's waist for you to hold and steady the resident." c. On 6/16/06 at 9:34 a.m., CNA #2 stated she believed the resident had been transferred correctly and was unaware the resident should not be picked up from under the arms. d. On 6/16/06 at 10:32 a.m., CNA #1 stated she knew a gait belt should be used and believed it was possible to dislocate a shoulder by lifting a resident under the shoulders.	F 312		

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 06/16/2006

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 PRECEEDED 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 322	Continued From page 7	F 322		
F 322 SS=E	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure gastrostomy tube placement was checked before administering medications for one (Resident #1) of 3 case mix residents (Resident #1, #2, and #11) who had gastrostomy tubes. This failed practice had the potential to affect 10 residents in the facility who had gastrostomy tubes as identified by the Director of Nursing (DON) on 6/13/06 at 12:30 p.m. The findings are: Resident #1 had a Plan of care dated 3/3/06 that documented a problem of "Tube Feeding...related to:swallowing problem [related to] recent CVA [Cerebro-vascular Accident]". An approach documented "Check placement of [gastrostomy] tube [every] shift [and] prior to medication per aspiration [and] auscultation. a. During the medication pass on 6/13/06 at 9:47 a.m., LPN #1 did not check placement before administering the medications. b. During the medication pass on 6/13/06 at	F 322		

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 06/16/2006

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 PRECEEDED 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 322	Continued From page 8 10:38 a.m., LPN #1 did not check placement before administering an additional medication through the feeding tube. c. On 6/13/06, the LPN #1 stated, "I checked the placement this morning around 9:00 a.m." d. The Medication Guide for the Long-Term Care Nurse, Sixth Edition documented: "Administration Medication Via Feeding Tube; Guidelines: Check for correct placement of feeding tube prior to administration of medication."	F 322		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based observation and record review, the facility failed ensure the walk-in freezer was maintained at the proper temperature of 0 degrees Farenheit to prevent the potential for food borne illnesses. This failed practice had the potential to affect 90 residents who eat meals from the kitchen. The findings are: 1. On 6/12/06 at 1:20 p.m., the temperature in the walk-in freezer registered 20 degrees Farenheit. 2. On 6/13/06 at 8:20 a.m., the temperature of the walk-in freezer registered 16 degrees Farenheit.	F 371		

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 06/16/2006

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 PRECEEDED 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 371	Continued From page 9 3. On 6/13/06 at 1:00 p.m., the temperature of the walk-in freezer registered 12 degrees Farenheit.	F 371		
F 426 SS=E	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure expired medications were removed from medication rooms and medication carts. This failed practice had the potential to affect 80 residents in the facility, as identified by the Administrator on 6/12/06 at 1:55 p.m. The findings are: 1. On 6/12/06 at 1:30 a.m., the following were noted in the F and Left side of Medication Cart: a. A medication card that contained 4 Neurontin 100 milligrams (mg) had an expiration date of 5/24/06. b. A medication card that contained 16 Hydrocodone/Acetaminophen (APAP) 10/500 had an expiration date of 4/22/06. c. A medication card that contained 9 Hydrocodone/APAP 7.5/650 ha an expiration date of 4/22/06.	F 426		

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 06/16/2006

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 PRECEEDED 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 426	Continued From page 10 d. A medication card that contained 31 Darvocet N 100 had an expiration date of 4/22/06. 2. On 6/12/06 at 1:55 p.m., the following expired medications were noted in the C and D Medication Cart: One Bottle of 1000 Enteric Coated Aspirin 325 mg had an expiration date of 5/06 3. On 6/12/06 at 2:10 p.m., the following expired medications were noted in the A medication Cart: Four 3 milliliters of Albuterol updraft vials. 4. On 6/12/06 at 2:30 p.m., the following expired medications were noted in the G and H Medication Cart: a. One bottle of 1000 Multivitamin had an expiration date of 5/06. b. A medication card that contained 28 Oxycodone 5 mg had an expiration date of 4/12/06. 5. On 6/12/06 at 2:50 p.m., the following were noted in the A, C, and D medication room: A medication card the contained 6 Ambien 5 mg tablet had an expiration date of 2/14/06.	F 426		
F 431 SS=E	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		

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 06/16/2006

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 PRECEEDED 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 431	Continued From page 11	F 431		

appropriate accessory and cautionary instructions, and the expiration date when applicable.

This REQUIREMENT is not met as evidenced by:

Based on observation of the medication room and medication carts, the facility failed to ensure that items which required a physician's prescription were identified with the name of resident to ensure the medication is administered to the right resident. This failed practice had the potential to affect 97 residents according to the Administrator on 6/13/06 at 1:15 p.m. The findings are:

1. On 6/12/06 at 1:30 p.m., the following prescription only items were stored in the F and Left side of the E medication cart with no prescription labels:

a. Two 3 milliliters (ml) vial of Xopenex 1.25 milligrams (mg).

b. One 3 ml Albuterol updraft vial.

c. Six 2 ml Pulmicort updraft vial.

2. On 6/12/06 at 1:55 p.m., the following prescription only items were stored in the C and D medication cart with no prescription labels:

Two 5 ml 1% lidocaine 10 mg/ml [milligrams per milliliter] vials.

3. On 6/12/06 at 2:10 p.m., the following prescription only items were stored in the A medication cart with no prescription labels:

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 06/16/2006

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 PRECEEDED 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 431	Continued From page 12 Four 3 ml Albuterol updraft vial. 4. On 6/12/06 at 2:18 p.m., the following prescription only items were stored in the TCC medication cart with no prescription labels: a. One Advair 500/50 Inhaler. b. Four 3 ml Albuterol updraft vial. c. Fifteen 3 ml Xopenex 1.25 mg vials. d. Two Heparin IV [intravenous] flush syringe 100 units/ml 5 ml syringe. e. One 3 ml DuoNeb updraft vial. 5. On 6/12/06 at 2:18 p.m., the following prescription only items were stored in the TCC medication room with no prescription labels: Ten Heparin IV flush syringe 100 units/ml 5 ml syringe. 6. On 6/12/06 at 2:36 p.m., the following prescription only items were stored in the G and H and 1/2 of E medication cart with no prescription labels: a. One 3 ml Xopenex 1.25 mg vial. b. One Mirtazapine 15 mg tablet. c. Three Promethazine 25 mg/ml 1 ml vial. d. Two 3 ml Albuterol updraft vial. e. Four Lovenox 30 mg/0.3 ml syringes.	F 431		

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 06/16/2006

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 PRECEEDED 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 502	Continued From page 13	F 502		
F 502 SS=E	483.75(j)(1) LABORATORY SERVICES 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure laboratory tests were obtained in a timely manner for 1 Resident (#1) of 17 case mix residents (#1 through #17) with physicians orders for laboratory tests. This failed practice had the potential to affect 97 residents in the facility who have had orders for laboratory tests as stated by the Administrator and the Director of Nursing on 6/16/06. The findings are: Resident #1 had diagnoses of Urinary Tract Infection, Sepsis, Anemia and a History of Colon Cancer. A Minimum Data Set (MDS) dated 5/13/06 documented the resident had a Urinary Tract Infection in the last 30 days. a. A Urine Culture and Sensitivity dated 4/6/06 documented the resident had a Urinary Tract Infection with a causative organism of Proteus mirabilis greater than 100,000 CFU's (colony forming units) per milliliter. A physician's order dated 5/1/06 documented: "[follow-up] UA, C&S [Urinalysis, Culture and Sensitivity] if indicated." There was no documentation the urine specimen was obtained. b. A physician's order dated 3/15/06, documented "Stool Guiac x 3 [three specimens]	F 502		

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 06/16/2006

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 PRECEEDED 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 502	Continued From page 14 (Anemia)." The resident had a laboratory report dated 3/14/06 that documented Hemoglobin and Hematocrit in the low range. c. Nurse's Notes dated 3/15/06 on the 3 p.m. - 11 p.m. shift documented "Unable to obtain stools for Guiac. [word illegible] nurse notified," There was no other documentation that any stool Guiac specimens were obtained. d. The Bowel Movement Monitoring sheet for 3/16/06 and 3/17/06 documented the resident had 3 bowel movements. e. On 6/14/06 at 2:11 p.m., the DON stated the Urinalysis was not done and the Advanced Practice Nurse was notified. The stool Guiac's were also not done.	F 502		