

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

PRINTED: 06/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/20/2008
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS HEALTHCARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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 #13557 was unsubstantiated. Complaint #13635 was unsubstantiated. Complaint #13571 was substantiated, all or in part, with deficient practice cited at F225 and F226.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

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 225	<p>Continued From page 1</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13571 was substantiated, all or in part, with these findings:</p> <p>Based on interview and record review, the facility failed to ensure an allegations of misappropriation of a resident property was investigated for 2 (Residents #1 and #2) of 5 (Residents #1 - 5) case mix residents in the facility and an allegation of neglect with provision of incontinent care was investigated for 1 (Resident #5) of 4 (Residents #2, #3, #4, and #5) case mix resident that were incontinent. These failed practice had the potential to affect all 116 residents who were at risk for misappropriation of resident property and 54 residents incontinent of bowel and/or bladder as listed on the Roster Sample Matrix received from the Administrator on 6/9/08 at 9:00 a.m. The findings are:</p> <p>1. Resident #1 had diagnoses of Anxiety, Hearing Loss, Hypertension, Vertebral Fracture, Osteoporosis, and Coronary Artery Disease. The Significant Change Minimum Data Set dated 5/23/08 documented the resident to had no issues with short or long-term memory loss and had modified independence with cognitive skills for daily decision making.</p> <p>a. The DMS-762 documented an incident that was discovered on 5/28/08 at 2:00 p.m. and reported to the Office of Long Term Care on</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>5/29/08 at 11:00 a.m. The Complete Description of Incident form documented, "Residents daughter attended quarterly careplan meeting and informed SSD (Social Service Director) that her mother had \$9.00 missing and also the top tray from her jewelry box missing. The items missing from he jewelry box were and obituary, a picture and a necklace. The money came up missing approx. (approximately) 2 weeks ago and the top tray of the jewelry box approximately 3 weeks ago. Resident interviewed by Adm. (Administrator) and [Little Rock Police Department] and resident stated that her daughter in law had given her \$4.00 and her sister had given her a new \$5.00 bill. She placed them both in a napkin in a blue Estee Lauder bag in her top drawer. Resident was noted to have several things in napkins in the drawers and in room. Resident also stated that the items in the jewelry box were not a great monetary value but of sentimental value."</p> <p>b. On 6/9/08 at 3:25 p.m. the Administrator was interviewed relative to investigative efforts of this event. The Administrator stated there were no resident interviews conducted or documented to determine if other cognitively alert and oriented residents were aware of this incident or had been the victims of like incidents. The Administrator also stated there were no employee interviews conducted or documented to determine if any employees had any knowledge of the perpetrator of these events.</p> <p>2. Resident #2 had diagnoses of Alzheimer's Disease, Depression, and TIA (Transischemic Attack). The Significant Change Minimum Data Set dated 3/25/08 documented the resident to had short and long-term memory problems and</p>	F 225			

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F 225	Continued From page 3 was moderately impaired in cognitive skills for daily decision making. a. The DMS-762 documented an incident that was discovered on 5/28/08 at 3:00 p.m. and reported to the Office of Long Term Care on 5/29/08 at 11:00 a.m. The "Complete Description of Incident form" documented, "Residents daughter presented residents bank statement to Administrator. On 4/24/08 and 5/1/08 there were two "electronic checks" that had been presented to [Name of Bank] on behalf of [C.N.A.] Check number 9999 in the amount of \$79.00 was made payable to [Company Name]. Check number 1000 was made payable to [Company Name] in the amount of \$139.95. Resident's daughter contacted [Name of Bank] and a hold has been placed on resident account. Facility Risk Management Representative contacted [Company Name] to inform them. [Company Name] stated that they record all conversations and the transaction is recorded. The recording can be released with a faxed request from police. This information was provided to [Name of Officer of Police Department]. When resident was approached by Adm (Administrator) and daughter resident had two checkbooks in her possession and there were no checks missing. It was also discovered that residents green billfold was mission. Per daughter the contents were Medicare Card, ATM Card and Drivers License." b. On 6/9/08 at 3:30 p.m. the Administrator was interviewed relative to investigative efforts of this event. The Administrator stated there were no resident interviews conducted or documented to determine if other cognitively alert and oriented residents were aware of this incident or had been the victims of like incidents. The Administrator	F 225			

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F 225	Continued From page 4 also stated there were no employee interviews conducted or documented to determine if employees had any knowledge of the perpetrator of these events. 3. Resident #5 had diagnoses of Dementia and Depression. The Minimum Data Set dated 4/28/08 documented the resident had independent cognitive skills for daily decision making and was incontinent of bowel and bladder. a. On 5/28/08 the DMS-762 documented an incident of "neglect" of 5/24/08 at 2:30 p.m. which documented, "Resident's [Resident #5's] daughter informed Administrator that her mother was soaking wet when she arrived at facility. States resident was so wet that she was leaking underneath her wheelchair." The findings and actions take section documented, "Resident's medical condition remains the same. Family, police and physician were notified. [C.N.A. #1] was identified and was suspended pending investigation. [C.N.A. #1] was allowed to return to work as video surveillance noted [C.N.A. #1] interacting with resident and other C.N.A.'s on hall and resident did not ask for assistance as she so often does. Interviewable residents on Hall interviewed and there were no negative findings. A review of resident's physician orders shows that resident is on Lasix. Lasix is known as 'the water pill' and therefore, increases urination in most. Resident was placed on Lasix on 5/16/08. When resident was interviewed by Administrator, resident stated that she was aware of the Lasix and what it does and that she will be glad when she gets off of it because it makes her urinate more."	F 225			

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F 225	Continued From page 5 b. There was no documented interviews with CNA #1, other staff or residents relative to the incident available for review as of 6/9/08 at 3:30 p.m. available for review. c. On 6/9/08 at 3:30 p.m. the Administrator was interviewed relative to investigative efforts of this event. The Administrator stated there were no resident interviews conducted or documented to determine if other cognitively alert and oriented residents who were incontinent were aware of this incident or had been the victims of like incidents. The Administrator also stated there were no employee interviews conducted or documented to determine if employees had any knowledge of this event.	F 225			
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Complaint #13571 was substantiated, all or in part, with these findings: Based on interview and record review, the facility failed to ensure to fully implement the Facility ' s Abuse and Neglect Policy and Procedure following allegations of misappropriation of a resident property, as evidenced by the failure of the facility to interview staff and other residents who may have had knowledge of the incidents that occurred for 2 (Residents #1 and #2) of 5 (Residents #1 - 5) case mix residents in the facility and an allegation of neglect with provision	F 226			

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F 226	<p>Continued From page 6</p> <p>of incontinent care for 1 (Resident #5) of 4 (Residents #2, #3, #4, and #5) case mix resident that were incontinent. These failed practice had the potential to affect all 116 residents who were at risk for misappropriation of resident property and 54 residents incontinent of bowel and/or bladder as listed on the Roster Sample Matrix received from the Administrator on 6/9/08 at 9:00 a.m. The findings are:</p> <p>1. The facility policy/procedure entitled, "Abuse and Neglect Policy and Procedures" revised August 2006 and adopted by QA&A on 8/31/2006, was received from the Administrator on 6/8/08 at 8:45 p.m. The policy/procedure documented, "Item 5, Investigation Protocols - The facility ensures that any incidents of abuse, neglect, injuries of unknown source and misappropriation of residents' property are investigated in a timely and thorough manner. Sub-item F. The investigation may include interviews of employees, visitors, or resident who may have knowledge of the alleged incident. Factual information shall be documented, not assumptions or speculations. Written statements from involved parties should be requested."</p> <p>2. Resident #1 had diagnoses of Anxiety, Hearing Loss, Hypertension, Vertebral Fracture, Osteoporosis, and Coronary Artery Disease. The Significant Change Minimum Data Set dated 5/23/08 documented the resident to had no issues with short or long-term memory loss and had modified independence with cognitive skills for daily decision making.</p> <p>a. The DMS-762 documented an incident that was discovered on 5/28/08 at 2:00 p.m. and reported to the Office of Long Term Care on</p>	F 226			

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F 226	<p>Continued From page 7</p> <p>5/29/08 at 11:00 a.m. The Complete Description of Incident form documented, "Residents daughter attended quarterly careplan meeting and informed SSD (Social Service Director) that her mother had \$9.00 missing and also the top tray from her jewelry box missing. The items missing from he jewelry box were and obituary, a picture and a necklace. The money came up missing approx. (approximately) 2 weeks ago and the top tray of the jewelry box approximately 3 weeks ago. Resident interviewed by Adm. (Administrator) and [Little Rock Police Department] and resident stated that her daughter in law had given her \$4.00 and her sister had given her a new \$5.00 bill. She placed them both in a napkin in a blue Estee Lauder bag in her top drawer. Resident was noted to have several things in napkins in the drawers and in room. Resident also stated that the items in the jewelry box were not a great monetary value but of sentimental value."</p> <p>b. On 6/9/08 at 3:25 p.m. the Administrator was interviewed relative to investigative efforts of this event. The Administrator stated there were no resident interviews conducted or documented to determine if other cognitively alert and oriented residents were aware of this incident or had been the victims of like incidents. The Administrator also stated there were no employee interviews conducted or documented to determine if any employees had any knowledge of the perpetrator of these events.</p> <p>3. Resident #2 had diagnoses of Alzheimer's Disease, Depression, and TIA (Transischemic Attack). The Significant Change Minimum Data Set dated 3/25/08 documented the resident to had short and long-term memory problems and</p>	F 226			

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F 226	Continued From page 9 also stated there were no employee interviews conducted or documented to determine if employees had any knowledge of the perpetrator of these events. 4. Resident #5 had diagnoses of Dementia and Depression. The Minimum Data Set dated 4/28/08 documented the resident had severely impaired cognitive skills for daily decision making and was incontinent of bowel and bladder. a. On 5/28/08 the DMS-762 documented an incident of "neglect" of 5/24/08 at 2:30 p.m. which documented, "Resident's [Resident #5's] daughter informed Administrator that her mother was soaking wet when she arrived at facility. States resident was so wet that she was leaking underneath her wheelchair." The findings and actions take section documented, "Resident's medical condition remains the same. Family, police and physician were notified. [C.N.A. #1] was identified and was suspended pending investigation. [C.N.A. #1] was allowed to return to work as video surveillance noted [C.N.A. #1] interacting with resident and other C.N.A.'s on hall and resident did not ask for assistance as she so often does. Interviewable residents on Hall interviewed and there were no negative findings. A review of resident's physician orders shows that resident is on Lasix. Lasix is known as 'the water pill' and therefore, increases urination in most. The resident was placed on Lasix on 5/16/08. When resident was interviewed by Administrator, resident stated that she was aware of the Lasix and what it does and that she will be glad when she gets off of it because it makes her urinate more." b. There was no documented interviews with	F 226			

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F 226	Continued From page 10 CNA #1, other staff or residents relative to the incident available for review as of 6/9/08 at 3:30 p.m. available for review. c. On 6/9/08 at 3:30 p.m. the Administrator was interviewed relative to investigative efforts of this event. The Administrator stated there were no resident interviews conducted or documented to determine if other cognitively alert and oriented residents who were incontinent were aware of this incident or had been the victims of like incidents. The Administrator also stated there were no employee interviews conducted or documented to determine if employees had any knowledge of this event.	F 226			