

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

PRINTED: 08/25/2006
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 08/17/2006
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	F 000			
F 225 SS=C	<p>Complaint #11932, unsubstantiated with an unrelated deficiency cited at F225 and F226.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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 certification agency) within 5 working days of the incident, and if the alleged violation is verified</p>	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 appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure allegations of abuse were immediately reported to the local law enforcement agency as required by Arkansas law for 2 (Residents #2 and #6) of 4 (Residents #1, #2, #3 and #6) case-mix residents who were subjects of allegations of staff to resident abuse. This failed practice had the potential to affect all 103 residents in the facility, as stated by the Administrator on 8/15/06. The findings are:</p> <p>1. Resident #2 had diagnoses of Depression, Compression fracture of Lumbar and Dementia. The Quarterly Minimum Data Set dated 6/28/06 documented the resident had short/long-term memory problems, was moderately impaired in cognitive skills for daily decision making and required extensive assistance with bed mobility and transfers.</p> <p>a. The OLTC (Office of Long Term Care) Incident and Accident Report (I&A) form documented: "Date and Time Submitted (if known): 08/11/2006 11:00am.....Date &Time of Discovery: 08/11/2006 09:30 amName of Resident: [Resident #2].... Type of Incident: Verbal Abuse...." The Incident and Accident Report documented that on 08/09/06 CNA #1 witnessed CNA #2 tell Resident #2 to get her [expletive] up and stand up and get into bed but was too "scared to tell" of the incident.</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>b. The OLTC (Office of Long Term Care) Incident and Accident Report (I&A) form documented: "Date and Time Submitted (if known): 08/14/2006 11:00.....Date &Time of Discovery: 08/11/2006 12:00 pmName of Resident: [Resident #2].... Type of Incident: Physical Abuse...." The Incident and Accident Report documented that Resident #2 documented that approximately 3 days ago some female hit her in the head with a pillow but the resident did not know if the female was another resident or a staff member and she could not describe the female.</p> <p>c. On 8/17/06 at 11:35 a.m., the Administrator stated, "I notified the Police yesterday (of both incidents), I just thought you had to notify them any time during the investigation.</p> <p>2. Resident #6 had diagnoses of Cerebral Palsy and Bipolar Disorder. The DMS 762 "Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, and Exploitation of Residents in Long-Term Care Facilities" documented the resident was alert and oriented and required total assist of 2 for ambulation and bathing.</p> <p>a. The DMS 762 documented: "Date Incident Reported to OLTC [Office of Long Term Care]: 06/23/2006...Time: 11:00 AM.....Date &Time of Incident (if known): 06/22/2006... Time: 11:00 AM.....Date and Time of Discovery: 06/22/2006 Time: 12:00 PM....Name of Resident: [Resident #6].... Type of Incident: Physical Abuse...." The Report documented the resident was being transported to doctors appointment and refused to wear safety belt. Transporter allowed resident to be transported without being properly secured</p>	F 225			

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F 225	Continued From page 3 and the wheelchair tipped to the right and the resident went to his knees and incurred abrasions on both legs. The Report documented the local law enforcement agency was not contacted until 06/28/2006 at 4:00 p.m.	F 225			
F 226 SS=C	b. On 8/17/06 at 11:35 a.m., the Administrator stated the Police were not notified until 6/28/06. 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: Based on record review and interview, the facility failed to ensure the Abuse and Neglect Policy and Procedures were implemented regarding the immediate reporting of allegations of abuse to the local law enforcement agency as required by Arkansas law for 2 (Residents #2 and #6) of 4 case-mix residents (Residents #1, #2, #3, and #6) who were subjects of allegations of staff to resident abuse. This failed practice had the potential to affect all 103 residents in the facility, as stated by the Administrator on 8/15/06. The findings are: 1. The facility Abuse and Neglect Policy and Procedures adopted by the facility April 1, 2004 documented under the area of Reporting/ Response Protocols and Corrective Action- The facility ensures that any incidents of abuse and neglect are reported and responded to in a timely and thorough manner. A. The facility shall report	F 226			

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F 226	Continued From page 4 all alleged incidents, as required by state law. 2. Resident #2 had diagnoses of Depression, Compression fracture of Lumbar and Dementia. The Quarterly Minimum Data Set dated 6/28/06 documented the resident had short/long term memory problems, was moderately impaired in cognitive skills for daily decision making, and required extensive assistance with bed mobility and transfers. a. The OLTC (Office of Long Term Care) Incident and Accident Report (I&A) form documented: "Date and Time Submitted (if known): 08/11/2006 11:00am.....Date &Time of Discovery: 08/11/2006 09:30 amName of Resident: [Resident #2].... Type of Incident: Verbal Abuse...." The Incident and Accident Report documented that on 08/09/06 CNA #1 witnessed CNA #2 tell Resident #2 to get her [expletive] up and stand up and get into bed but was too "scared to tell" of the incident. b. The OLTC (Office of Long Term Care) Incident and Accident Report (I&A) form documented: "Date and Time Submitted (if known): 08/14/2006 11:00.....Date &Time of Discovery: 08/11/2006 12:00 pmName of Resident: [Resident #2].... Type of Incident: Physical Abuse...." The Incident and Accident Report documented that Resident #2 documented that approximately 3 days ago some female hit her in the head with a pillow but the resident did not know if the female was another resident or a staff member and she could not describe the female. c. On 8/17/06 at 11:35 a.m., the Administrator stated, "I notified the Police yesterday (of both	F 226			

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