

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Woodland Hills Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1320 West Braden Street Jacksonville, AR 72076	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Number of residents sampled: Number of residents cited: Based on interviews, record review and facility policy review, it was determined that the facility failed to keep a resident free from verbal abuse for one (Resident #30) of one resident reviewed for abuse. The findings include: A review of the facility's undated policy titled Residents Rights, revealed As a resident of this facility, you have the right to a dignified existence and You have the right to be free from verbal, sexual, physical, and mental abuse. A review of a facility policy titled Resident Abuse, Neglect, and Misappropriation of Property, revised on 02/05/2018, revealed that Each resident of this facility has the right to be free from verbal, sexual, physical, and mental abuse. Accordingly, this facility prohibits the abuse of a resident by anyone including but not limited to, facility staff. A review of the Resident #30's Face Sheet revealed the facility admitted Resident #30 on 05/10/2024 with diagnoses that included diabetes, dementia, high blood pressure, coronary artery disease, hearing loss, pain, mood disorder, depression, muscle wasting and atrophy, and breast cancer. A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/24/2026, revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed that Resident #30 displayed verbal behaviors towards others such as screaming and cussing at others one to three days out of seven of the look back period. The MDS also indicated that Resident #30 was independent with all self-care and mobility other than bathing. A review of Resident #30's Care Plan dated 09/08/2025, revealed the resident made repetitive anxious complaints/concerns that were non-health related, repetitive complaints against staff members and attempts to play staff against each other. The Care Plan also revealed Resident #30 provoked other residents to make complaints with Resident #30, as well as loudly voicing complaints (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	against other residents. Interventions included staff to intervene as needed, maintain a calm environment and approach the resident, establish a trusting relationship with the resident and communicate with family as needed. A review of the facility's Medication Administration Record (MAR) dated July 2026, revealed Resident #30 had active orders for daily medication to treat antianxiety, depression, and dementia. The MAR also indicated an order for behavior monitoring with zero behaviors displayed for the month of July. A review of a CNA #11's employee file, revealed a statement contained in the file titled Employee Memorandum that indicated a written warning was given to Certified Nursing Assistant (CNA) #11 by the Director of Nursing (DON) signed on 07/27/2026. The memorandum indicated that the code of conduct rule that was violated was that CNA #11 had failed to maintain acceptable standards of respect to residents, visitors' coworkers and supervisors. The memorandum indicated, Employee became involved in a verbal confrontation with a resident, during the interaction communication became inappropriate and escalated beyond expected professional standards. The employee file contained two statements from CNA #11. The first statement on 07/21/2026 indicated Resident #30 is mad because I said [the resident] sounded racist. CNA #11 stated she asked Resident #30 to shut up and indicated that she should not have done that. On the second statement of the OLTC witness statement form, CNA #11 indicated that There is a misunderstanding of this situation. I was caught in a verbal dispute with Resident #30. She got verbal with me and I got caught in an emotional. CNA #11 indicated she was aware she should have walked away and not said anything back to the resident. The form labeled Job Description signed by CNA #11 on 05/12/2026 indicated abuse training was completed per the policy listed above. CNA #11's employee file also included a copy of the facility's Resident Rights. During an interview on 07/30/2026 at 10:45 AM, CNA #11 stated on 07/19/2026 when she returned from break she heard Resident #30 shouting that she was lazy. CNA #11 stated at different times during the shift Resident #30 continued to shout at her that she was just absolutely lazy. She stated that Resident #30 demanded she put another resident to bed, and CNA #11 responded with If you have such a problem with putting [pronoun] to bed, you can put [pronoun] to bed. CNA #11 stated Resident #30 moved their walker to the side, approached CNA #11 and Resident #30 put her finger in CNA #11's face. CNA #11 stated she told Resident #30 to get away from her and to shut up and that she was acting racist. CNA #11 reported verbal abuse was a form of abuse and that she received training on abuse in May 2026 upon hire. CNA #11 stated she was trained to be calm, not interact, do not respond, walk away, do not shout back, avoid the situation and allow the residents to calm down. During an interview on 07/30/2026 at 11:07 AM, CNA #12 stated that on 07/19/2026 there was a lot of hollering and arguing back and forth between Resident #30 and CNA #11. CNA #12 stated CNA #11 did call Resident #30 racist. During an interview on 07/30/2026 at 11:19 AM, Licensed Practical Nurse (LPN) #13 stated she was in a resident's room providing care and walked out into the hall because she heard yelling. LPN #13 indicated Resident #30 and CNA #11 were standing directly in front of each other in the hall with CNA #11 and Resident #30 yelling at each other. LPN #13 advised CNA #11 to walk away. LPN #13 reported CNA #11 told Resident #30 You can shut up talking to me. LPN #13 indicated CNA #11 was (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the phone and continued to state, She needs to shut up talking to me. LPN #13 indicated she has had in-services on abuse, and abuse information was also in the employee handbook. LPN #13 reported verbal abuse was a form of abuse and stated that you do not yell back at a resident. We de-escalate the situation. During an interview on 07/30/2026 at 4:19 PM, the Director of Nursing (DON) stated forms of abuse were verbal, physical, sexual, mental and financial. The DON stated she had no firsthand knowledge of the incident that occurred on 07/19/2026 between CNA #11 and Resident #30 but was only aware of what was discovered in the facility's investigation. She stated that Resident #30 called CNA #11 lazy, and CNA #11 told Resident #30 to shut up. She stated, Resident #30 did have a diagnosis of dementia, but the diagnosis was low, and Resident #30 was fully aware of what is going on. The DON stated CNA #11 was written up, counseled to walk away from altercations and removed from the hall Resident #30 resided on.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Number of residents sampled: Number of residents cited: Based on interviews, and facility document review, it was determined that the facility failed to prevent a resident from falling while being transferred with a mechanical lift for one (Resident #60) of one resident reviewed for accidents. The findings include: During an interview on 07/30/2026 at 9:00 AM, the DON stated the facility did not have a policy for accidents but did hand this surveyor a policy on Event investigation. The Event Investigation policy did not cover relevant information regarding accidents. A review of the Face sheet, indicated the facility admitted Resident #60 on 06/08/2019 with diagnoses that included right hip fracture, pressure ulcers, weakness, unsteadiness on feet. A review of the significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/16/2026, revealed Resident #60 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. The MDS also indicated Resident #60 was dependent for all mobility functional abilities. A review of Resident #60's Care plan, dated 05/27/2026, revealed the resident required a mechanical lift for transfers. Interventions included two staff members to assist with transfers, and ensure equipment was in proper working condition. A review of Resident #60's reportable revealed that CNA #5 had put two lift pads under Resident and two other staff members used mechanical lift to get resident up causing the two pads to separate causing Resident #60 to fall onto floor. During an interview on 07/29/2026 at 2:35 PM, CNA #5 stated she put two lift pads under Resident #60 before getting the resident into a wheelchair to leave for an appointment. CNA #5 stated Resident #60 slides down in wheelchair so she thought two lift pads would help staff pull Resident #60 up in wheelchair. The idea was that Resident #60 would have the second lift pad under them just in case the first one came out when pulling Resident #60 up. CNA #5 then told the oncoming shift that Resident #60 had two lift pads under them. CNA revealed she had not been trained to use two lift pads for a transfer. CNA #5 indicated she was trying to prevent any problems with getting Resident #60 out of the chair. CNA #5 stated she was disciplined for the incident with a written write up and staff were in serviced with hands training on mechanical lifts. During an interview on 07/29/2026 at 7:35 PM, CNA #7 revealed that she watched two other staff members use a mechanical lift to get Resident #60 out of their wheelchair and back into bed. CNA #7 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated staff got Resident #60 up out of chair and were starting to move the lift when the resident fell out of the lift pads onto the floor hitting their head on lift and falling on their right side. CNA #7 revealed that Resident #60 had two lift pads under them one pad was connected to the top hooks and the other pad was connected to the back hooks causing the lift pads to separate and the resident to fall out of the lift pads. CNA #7 indicated staff complete checkoffs on lifts yearly and as needed. CNA #7 revealed after the incident staff were checked off again on lifts by completing the check-off in front of staff right after the incident. A review of an Employee Memorandum for CNA#6 indicated a written warning for breaking of company policy, date of violation was indicated as 05/27/2026. Under the section to indicate corrective action taken the memorandum indicated the employee will follow correct procedure and only place one sling under a resident. The Employee Memorandum was signed by CNA#6 and dated 05/28/2026 to indicate receipt of notification. During interview on 07/29/2026 at 8:07 PM, CNA #6 stated she had hooked the lift pads up to the mechanical lift before the transfer knowing that Resident #60 had two lift pads under them. CNA #6 revealed that she used the mechanical lift to get the resident up out of their wheelchair and Resident #60 slid out of the lift pads falling onto floor hitting their head and landing on their right side. CNA #6 stated that facility policy did not say to use two lift pads for the resident and they were not trained to use the mechanical lift with two lift pads under resident. Review of an in-service dated 05/27/2026 over the subject of proper mechanical lift operation conducted by the DON, revealed how to properly place a sling, attach the patient to the lift, and lifting and transferring. Attached to this in-service were Mechanical Lift Competency Checklists for all CNAs employed where the CNAs had given a return demonstration to the DON of understanding the instruction. The return demonstration checklists were all signed and dated 05/28/2026. During interview on 07/30/2026 3:14 PM, LPN #8 revealed she assessed Resident #60 due to a fall during mechanical lift transfer. LPN indicated that two lift pads were hanging on the mechanical lift, with one lift pad hanging on each lift arm. LPN #8 stated Resident #60 was sent to ER for evaluation after the incident. Review of Resident #60's hospital records with an admission date of 05/28/2026 indicated an admitting diagnoses of closed right hip fracture (broken right hip) and a discharge date of 06/09/2026. Review of an orthopedic surgery visit note with an encounter date of 07/15/2026 indicated Resident #60 was bedbound and dropped out of bed at the nursing home in May 2026 resulting in a right femur fracture, and was status post-surgery for intramuscular nail fixation (to stabilize the hip). The facility re-educated all direct care staff including CNA #5 on how to properly place a sling, attach the patient to the lift, lifting and transferring and how to use a mechanical lift with return demonstration provided on 05/28/2026. CNA #5 received disciplinary action on 05/28/2026 by written warning for the incident and not following company policy and procedure. These actions were performed before the survey team entered the facility, resulting in this finding being cited at past non-compliance.		