STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045376	A. BUILDING ______ B. WING ______	02/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD NURSING & REHABILITATION CENTER, INC	245 INDIAN BAY DRIVE SHERWOOD, AR 72120

(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 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the labia was spread and cleaned and a back to front motion was not used during Foley catheter care for 1 of 1 (Resident #7) case mix resident who had an indwelling catheter. This failed practice had the potential to affect 2 residents who had an indwelling catheter as documented on the Resident Census and Conditions of Residents report dated 2/23/09. The findings are: Resident #7 had diagnoses of Neurogenic Bladder, Chronic Urinary Tract Infections (UTIs), Bladder Spasms and Massive Edema. The Annual Minimum Data Set dated 12/17/08 documented the resident was moderately impaired in cognitive skills for daily decision making and required limited assistance of one person for personal hygiene and had an indwelling catheter. a. A physician order dated 8/27/07 documented to provide Foley catheter care each shift. b. On 2/24/09 at 10:00 a.m., CNA #1 (Certified Nursing Assistant) provided Foley catheter care. CNA #1 used a washcloth and soap, and with a	F 309		

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 309	Continued From page 1 back to front and front to back motion washed the left and right groin and over the labia lips three times and did not spread the labia and cleanse the labia folds. c. On 2/24/09 at 2:00 p.m., CNA #1 stated, "I shouldn't have washed back and forth."	F 309		
F 314 SS=D	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 nursing staff were informed of the identification of a pressure ulcer so treatment could be initiated for 1 (Resident #1) of 3 case mix residents (Resident #1, 2 and 3) who had pressure sores. This failed practice had the potential to affect 11 residents who had pressure sores as identified on the Resident Census and Conditions of Residents form dated 2/24/09. The findings are: Resident #1 had diagnoses of Post Cerebral Vascular Accident and Decubitus Ulcer with Methicillin Resistant Staphylococcus Aureus. The Significant Change Minimum Data Set dated 1/9/09 documented the resident was severely impaired in cognitive skills for daily decision	F 314		

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F 314	Continued From page 2 making, totally dependent on staff for all activities of daily living and had one Stage I, one Stage II and one Stage III pressure ulcer. a. The weekly skin audit dated 2/4/09 documented, "...Stage II coccyx - Rt. [right] buttocks..." b. The weekly skin audit dated 2/9/09 documented, "...coccyx healed..." c. On 2/25/09 at 8:15 a.m., Certified Nursing Assistant (CNA) #2 provided incontinent care. The right side of the coccyx area was macerated and had a Stage II open area. The CNA was asked if the resident had this area before this incontinent episode and the CNA stated, "I don't know." d. On 2/25/09 at 10:16 a.m., the treatment nurse was asked if anyone had said anything to her concerning the resident's coccyx and the treatment nurse stated no. e. On 2/25/09 at 10:20 a.m., the surveyor and the treatment nurse entered the resident's room to perform a body audit. After viewing the resident's coccyx, the nurse stated, "Yes, that is a Stage II... I'll get an order and treat it..."	F 314		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. and the	F 332		

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F 332	Continued From page 3 4:00 p.m. medication passes on 2/25/09 and record review and interview, the facility failed to ensure the medication error rate was less than 5%. Physicians orders were not followed on 3 (Resident #18, #19, and #11) of 9 residents observed during the medication pass resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurse (LPN) (LPN #1 and #2) of 3 licensed nurses observed administering medications in the facility. The medication error rate was 6.66% based on administration of 44 medications with 1 omission for a total of 45 medications with 3 medication errors observed. This failed practice had the potential to affect all 78 residents according the Administrator on 2/23/09. The findings are: 1. Resident #18 had a physician order dated 6/11/08 for Colace 100 mg (milligram) 1 po (by month) bid (twice a day). On 2/25/09 at 7:48 a.m., LPN #1 administered all scheduled medications except the Colace 100 mg. 2. Resident #19 had a physician order dated 12/16/08 for Folic Acid 0.4 mg 2 po every day (0.8 mg). On 2/25/09 at 8:11 a.m., LPN #2 administered Folic Acid 0.4 mg 1 tablet. 3. Resident #11 had a physician order dated 10/28/08 for Lopressor 25 mg 1 po. On 2/25/09 at 8:45 a.m., LPN #1 administered Lopressor 25 mg 1/2 tablet for a total of 12.5 mg.	F 332		
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS	F 333		

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F 333	Continued From page 4	F 333		

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure physician orders were followed to prevent a significant medication error for 1 (Resident #11) of 3 case mix residents (Resident #4, 11, 12) who received Metoprolol. This failed practice had the potential to affect 14 residents who received Metoprolol 25 mg (milligrams) according to the Director of Nursing (DON) on 2/26/09. The findings are:

Resident #11 had a diagnosis of Hypertension.

a. Admission Orders dated 10/28/08 and the November 2008, December 2008, January 2009 and February 2009 Physician Order sheets documented Metoprolol 25 mg (milligrams) 1 pt (peg [percutaneous endoscopic gastrostomy] tube) bid (twice a day).

b. On 2/25/09 at 8:45 a.m., LPN #1 administered Metoprolol 25 mg 1/2 tablet.

c. On 2/25/09 at 5:10 p.m., the Provider Pharmacy Bubble Pack documented Metoprolol 25 mg "take 1/2 tablet per tube twice daily."

d. The Medication Administration Record (MAR) dated 10/28/08 thru 2/21/09 documented that Metoprolol 25 mg, 1 pt, was given.

e. On 2/25/09 at 5:15 p.m., LPN #1 asked, "Why are you [the surveyor] looking at the bubble cards?" The surveyor stated, "The physician

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F 333	Continued From page 5 order and the MAR document Metoprolol 25 mg 1 tablet and the bubble pack states Metoprolol 25 mg 1/2 tablet and the pills are 1/2 tablets." The LPN #1 stated they had not realized that. f. On 2/25/09 at 6:05 p.m., the DON (Director of Nursing) and Nurse Consultant stated there was no documentation in the facility that the physician had changed the order from Metoprolol 25 mg 1 tablet to Metoprolol 25 mg 1/2 with the Provider Pharmacy. g. This was a significant error due to the frequency of the error.	F 333		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, the facility fail to ensure staff washed their after handling soiled items and before handling clean dishes, utensils or food to prevent the potential for cross-contamination. This failed practice had the potential to affect all 70 residents who took their meals from the kitchen according to the Diet List dated 2/28/09. The findings are: 1. The facility's policy on "How To Wash Your	F 371		

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F 371	Continued From page 6 Hands" documented to dry hands then turn faucet off with paper towel. 2. On 2/25/09 the following observations were made: a. At 9:55 a.m. Dietary Employee #1 touched the trash can lid to throw away trash, then removed clean trays and dried them with a dry cloth, and stored 3 clean plastic lids on a shelf across from the dietary manager's office without washing her hands. b. At 9:59 a.m., after washing hands Dietary Employee #1 dropped a white towel on the floor in the dish room, picked it up and hung it onto her apron pocket, then took clean black plastic containers and placed them on the storage shelf without washing her hands. The white cloth hanging from her apron pocket touched the outside of the three compartment sink as she leaned over it. c. At 10:27 a.m., Dietary Employee #1 washed her hands, pulled a paper towel, turned the faucet off with the paper towel, then dried her hands with the same paper towel before taking clean silverware from the dish room to the kitchen and wrapped clean silverware in napkins by picking up forks, knives and spoons. d. At 10:55 a.m., Dietary Employee #1 carried a trash can lid against the towel in her apron pocket to the dish room, ran clear water from the three compartment sink over her hands with no soap, then took clean silverware from the dish room and continued to wrap silverware without proper handwashing.	F 371		

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F 371	Continued From page 7 e. On 2/25/09 at 3:40 p.m. and 4:10 p.m., Dietary Employee #2 washed his hands, turned the faucet off on the handwashing sink, dried his hands with the same paper towel, then stacked trays of clean glasses on a rack and wrapped clean silverware for dinner.	F 371		