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 ____	C 03/19/2007

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 000	INITIAL COMMENTS Complaint #12430 was substantiated, all or in part, with findings cited at F224, F324, and F490.	F 000		
F 224 SS=G	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 #12430 was substantiated, all or in part, with these findings. Based on observation, record review and interview the facility failed to prevent neglect as evidenced by the facility's failure to develop and implement written policies and procedures to ensure protection for wandering residents and the residents affected by wanderers for 5 of 5 (Resident #2, 3, 4, 6 and 7) case mix residents who had episodes of wandering. The failed practice resulted in actual harm [fear] for 1 case mix resident [Resident #1] and had the potential to effect all 77 residents as identified by the Roster Sample Matrix received from the Administrator on 3/14/07 at 3:00 p.m. The findings are: 1. As of 3/19/07 at 5:00 p.m., there was not a policy or procedure available for review relative to the care of the wandering resident. a. On 3/16/07 at 9:12 a.m., the Director of Nursing stated: "A list [of wanderers] is being developed based on the Minimum Data Set so the staff can be trained. The list is not currently	F 224		

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
	045376	A. BUILDING ______ B. WING ______	C 03/19/2007

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 224	Continued From page 1 prepared." b. On 3/19/07 at 3:45 p.m., the Director of Nursing stated "We do not have a policy or procedure specific to caring for the wandering resident." 2. Resident #1 had diagnoses of Hypertension, Anxiety, Dementia, Arthritis, Mental Status Change [Lethargy], Depression, Coronary Artery Disease, and Dizziness. The Quarterly Minimum Data Set dated 2/16/07 documented the resident had problems with short-term memory, modified independence in cognitive skills for daily decision making, required supervision and limited assistance with the performance of activities of daily living, was unable to maintain balance while standing without physical help during the test for balance, and had no falls within the past 30 days or the past 31-180 days. a. An Incident/Accident Report dated 3/12/07 at 10:00 a.m., received from the Administrator on 3/14/07 at 1:45 p.m., documented, "Description of Incident (Who, What, When, Where and Why): Resident [Resident #1] was laying in bed resting and another female resident entered room and began pulling on resident's clothes. Resident became very upset crying and shaking. Both residents were hitting @ [at] each other." 1) An "OLTC Witness Statement Form", no date or time, completed by the Maintenance Supervisor and attached to the Incident/Accident Report documented, "As I was walking down 100 hall when I heard [Resident #1] screaming down the hallway. So I go and ask her what as wrong. She stated someone was in her room and she seemed very agitated (or mad). So I held her	F 224		

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 ____	C 03/19/2007

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 224	Continued From page 2 hand to steady her because she seemed unsteady, and I called for a nurse. [LPN #1] came to the room 114 as I was calling and removed [Resident #3] from the room." 2) An "OLTC Witness Statement Form" dated 3/14/07 at 14:05 [2:40 p.m.] completed by Licensed Practical Nurse #1 [LPN] and attached to the Incident/Accident Report documented, "When I went down the hall, this resident [Resident #1] was standing outside of room with Maintenance Man, shoes off and she was crying stating 'I'm going to get that N_ _ _ _.' When I asked her what happened she said 'I was laying down and she came in my room and pulling at me see my clothes. She ripped a button off my blouse. I got the w/c [wheelchair] and laid her [Resident #1]down in bed trying to calm her down. A CNA [Certified Nursing Assistant] stayed /c [with] her. I called [Resident #1's physician] to try to get her something for her nerves. He ordered Ativan 0.5 mg. X 1 only. I reported to [Director of Nursing] and we put up a stop sign at doorway and CNA's were instructed to keep wanderers from going to her /r [resident] room." 3) On 3/15/07 at 9:00 a.m., Resident #1 was interviewed and stated, "A big black woman came into my room the other day and I couldn't get her out of here. I saw her coming in the door and told her to stop. She just kept on coming in. I can't stand or walk very well but I scooted to the end of my bed and I got in my chair [wheelchair] and went toward her telling her to get out of my room. She was in a wheelchair. Her chair is bigger than mine. She's tall and real black. When I got to the door I saw a man at the desk and hollered for him. He came running. He took her on down the hall. I told him to let me hit her and she wouldn't	F 224		

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 ______	C 03/19/2007

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 224	Continued From page 3	F 224		

come back. He told me, No, he would take care of her." Resident #1 stated, "this has happened about 5 times before." Resident #1 stated, "I don't know her name". The resident was asked if she was hurt from the encounter. Resident #1 stated, "I was just scared and now I have trouble sleeping because I'm afraid she will come back while I'm in the bed and I couldn't get away from her. She tore buttons off my blouse. I don't like to fight, but I will if I have to. I'm tired of her coming in my room."

b. On 3/14/07 at 1:40 p.m., the Social Director stated that on "Monday [3/12/07] [Resident #1's family member] had a meeting with me and the Administrator and asked what we were going to do about her being attacked and she was not going to leave the building until she knew where the woman [Resident #3] was so Resident #1 could sleep in peace. The Administrator said we would re-direct and a stop sign was put up. The family member said, [Administrator's name] that will not work. Is that all you're going to do? The Administrator told her we can't keep her [Resident #3] in her room without violating her rights."

On 3/16/07 at 11:08 a.m., the Administrator was interviewed and stated, "On 3/12/07 [Social Director] came to me and said [Resident #1's] [Family member] wanted to meet with me and would not leave the building until she did. She was upset about [Resident #3] coming into [Resident #1's] room. I went to the Activities room to meet with [family member]. [Resident #1's family member] wanted to know what we were going to do about [Resident #1's] safety - her words that were written on the Grievance Form documented [Resident #1] was attacked. I told her that I thought the term " Attacked " was a

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 ______	C 03/19/2007

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 224	Continued From page 4	F 224		

little strong because it is not in [Resident #3's] nature to be violent. I agreed that [Resident #1] might have been scared when she awakened and someone was pulling on her clothing but I disagreed with it being called an attack. I saw that the Stop Sign was up, the [family member] stated that was not going to stop anybody. I told her that it might not but it was a first step and that I would also have the CNA supervisor inform all the CNA's that if they saw [Resident #3] going down the hallway to divert her and I would also have the RN and the nursing staff do the same with [Resident #3]. I asked her what else do you think I should do? She [the family member] stated, "I don't know what else you could do." I told her, I can not put a lock on her [Resident #3's] door as it would be a violation of State regulations and I could not interfere with [Resident #3's] rights to be out and about in the facility."

c. On 3/14/07 at 1:30 p.m., the Administrator stated, "On Monday [3/12/07] [Resident #3] went down the 100 hall and into [Resident #1's] room. [Resident #3] is in a wheelchair and is self-mobile. She goes in and out of residents' rooms. The staff removed her. We have found her several times in other rooms - 2 to 3 times in the last 2 weeks. [Resident #3] got hold of [Resident #1's] shirt and pulled on her shirt. It woke her up. She was scared really bad. After the incident the "Stop Sign" was put up." The Administrator further stated, "On Tuesday morning [3/13/07] [Resident #2] went into [Resident #1's] room." The Administrator was asked if the "Stop Sign" was up and he stated, "I don't know. [Resident #1] didn't like the stop sign and would take it down, fold it and put it up in the drawer. [Family Member] was in the facility on

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 ______	C 03/19/2007

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 224	Continued From page 5 Tuesday, the alarm went off and no one was responding. [Resident #1] was sitting on the side of her bed fussing with [Resident #2] who was in a wheelchair in [Resident #1's] room. The [family member] turned the alarm off, pushed [Resident #2] out into the hallway, and left the facility." The Administrator was asked if any action had been taken regarding the alarm going off and no one responding. The Administrator stated, "Not to my knowledge." d. A "Resident Grievance/Complaint Form" dated 3/12/07 documented the date of incident as occurring on 3/12/07 at 9:30 a.m. and signed by the Administrator and the Resident's family member was received from the Administrator on 3/16/07 at 11:19 a.m. The section of the form, "Describe the nature of the grievance/complaint (be specific)" documented, "Another resident came into [Resident #1's] room this a.m. while she was going to sleep and grabbed her shirt and pulled 2 buttons off of shift - resident was screaming and bed alarm going off - no one came to help her. Family wants to know what we are going to do about preventing this from happening again. The stop sign we put across the door will not prevent her from coming into room - also has had a cough for a month and a half - nothing done - family wants answers now. This is the second time she has been attacked by this woman in the w/c [wheelchair]. 'Mom is afraid to go to sleep.' The back of the form documented, "Will speak /c [with] CNA Supervisor and DON [Director of Nursing] to inform staff to divert [Resident #3] from 100 hall. CNA to do inservice. DON placed notice in 24 hr. [hour] report book." e. On 3/16/07 at 10:10 a.m., the Director of	F 224		

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	C 03/19/2007

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 224	Continued From page 6 Nursing [DON] was interviewed and asked, "When [Resident #3] entered the room of [Resident #1] on 3/12/07 and physically touched [Resident #1] was [Resident #1] scared"? The DON stated: " Yes, she was scared. The daughter reported she was scared." The DON stated that LPN #1 had interviewed the resident and had documented her fear in the Nurse's Notes and on the OLTC Witness Statement. The DON was asked what interventions were employed on 3/12/07 to protect Resident #1 and to comfort her anxiety? The DON stated, "The residents were initially separated. Then a magnetic "Stop Sign" banner was put in place across the doorway to deter all wandering residents from entering the room. The doctor was notified and an order was received to administer a one time dose of Ativan 0.5 mg. PO for anxiety. On 3/12/07 at 11:50 a.m. Nurse ' s Notes document the resident was calmer at that time." The DON was asked, "Have you or your staff interviewed other cognitive residents regarding the wanderers and do any of these residents have any anxiety"? The DON stated, "Yes, we began interviewing cognitive residents on 3/15/07 regarding wanderers. I interviewed 3 cognitive residents on the 100 hall that collaborated that other residents have come into their rooms, it was a nuisance, but not distressing. No other residents have been interviewed at this point." f. On 3/19/07 at 1:30 p.m., Resident #1 was asked if the Stop Sign was helping. The resident stated, "The stop sign has helped, but I'm still afraid. When I lay down, I can't know to get out. I'm afraid to go to sleep. She's mean. When she comes in she goes to ramming into things and	F 224		

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 ____	C 03/19/2007

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 224	Continued From page 7	F 224		

when I tell her to get out she won't leave. Last time I sat up and slid to the end of my bed to get her out and she started fighting."

g. On 3/19/07 at 11:52 a.m., the DON was asked if she had interviewed other cognitively non-impaired residents. The DON stated, "I interviewed [Resident #4 and Resident #4's wife], [Resident #1], and [Resident #1's roommate, a non-case mix resident]. I have not interviewed the whole building yet."

h. On 3/16/07 the DON the was asked what interventions were put in place since the incident on 3/12/07 to protect Resident #1 and to comfort her anxiety [when Resident #2 wandered into her room]? The DON stated, "We began shift-to-shift inservices for the staff to re-direct [Resident #3] and [Resident #2] from the 100 hall - do not let residents go into [Resident #1's] or other residents' rooms, pay attention to alarms going off and respond to the alarms, and take [Resident #3] back to her hall and inservices are still ongoing."

2. Resident #3 had a diagnosis of Dementia. The Minimum Data Set dated 12/1/07 documented the resident had moderately impaired cognitive skills for daily decision-making, behavioral symptom of wandering occurred one to three days in the last seven days which was not easily altered and wheeled self in a wheelchair as the primary mode of locomotion.

a. The plan of care dated 12/1/06 and updated 3/8/07 documented, " Problem, behavioral symptoms ... Approach ... Rsd (Resident) wanders hallways in w/c (wheelchair) ... The plan of care also identified a Problem, Res (Resident)

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 ____	C 03/19/2007

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 224	Continued From page 8 propels self in wc (wheelchair) grasping/pulling on anything within reach to assist c (with) locomotion," no corresponding interventions. A new Plan of care dated 3/14/07 documented, a " Problem, R [Resident] often roams facility and often gets in other R's rooms. Freq. (Frequent) monitoring of whereabouts to prevent going into other rooms uninvited ... Approach, documented as "R grabs and pulls at handrails and objects to assist in propelling around facility." b. The facility's Incident/Accident Report dated 3/12/07 at 10:00 a.m., documented, a description of incident as "Res went into another Res room and began pulling and hitting on other R (Resident). No apparent injury to [Resident #3] as told to me. Resident was grabbing and reaching for any object within reach. She was roaming as she usually does anywhere without a purpose direction. Did not witness Resident grabbing. Resident reported [Resident #3] grabbed her clothing." The other investigative findings section documented, "[Resident #3] observed grabbing at objects and roaming about building. Resident has never been known to be aggressive c (with) anyone before. The steps to prevent reoccurrence section documented, "try heading R off when going down other hallways." c. The Social Services Progress Notes dated 3/12/07 [no time] documented, "was reported to me that res went into 114-b and grabbed onto res blouse. Spoke c [with]other family. Stop sign across doorway will hopefully keep other res from coming into 114-b. Will continue to redirect as needed." d. On 3/15/07 at 11:00 a.m., the Director of Nursing stated the 3/14/07 plan of care was	F 224		

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	C 03/19/2007

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 224	Continued From page 9 developed on 3/14/07 "after [surveyors] were here in February." The Director of Nursing was asked what interventions were put in place to protect other residents from those residents that wander into their rooms and protect the residents that wander into residents room that might do harm. She responded "I can't tell you approaches." e. On 3/15/07 at 10:49 a.m., Resident #3 was in the 400 hall day room lodged between the wall and dining room table. She was unable to maneuver the wheelchair to exit the area. She was observed until 11:06 a.m. when C.N.A. # 7 (Certified Nursing Assistant #7) removed her from this area to the 300 Hallway and allowed her be self mobile in her wheelchair. 3. Resident #5 had diagnoses of Atrial Fibrillation, Coronary Artery Disease, Parkinson's Disease and Hypertension. The Minimum Data Set dated 12/20/06 documented the resident had independent cognitive skills for daily decision-making, required supervision for walking in room and in the corridor, required the assistance of a cane, walker or crutch for locomotion. 4. Resident #4 had diagnoses of Dementia, Organic Brain Syndrome and Cerebrovascular Accident. The Minimum Data Set dated 12/5/06 documented the resident had moderately impaired cognitive skills for daily decision making and no behavioral symptom of wandering. a. As of 3/15/07 at 8:30 a.m., the plan of care dated 6/6/06 and updated 12/5/06, did not document a problem of wandering. b. On 3/15/07 at 8:40 a.m., the resident was	F 224		

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 ______	C 03/19/2007

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 224	Continued From page 10 observed in a wheelchair in Resident #5's room. Resident #5 pushed Resident #4's wheelchair backwards from his room into the hallway. Resident #5 then proceeded to push the resident backwards from the outside of his room to the outside of another room, a distance of approximately 16 feet. Resident #5 did not have the assistance of his walker to return to his room. c. On 3/15/07 at 10:50 a.m., Resident #5 stated, "The staff knows that the other residents come in here uninvited because they have come and taken them out. Both males and females have come in." d. On 3/16/07 at 9:12 a.m., the Director of Nursing stated that [Resident #4's] behavior of wandering had "not been identified" prior to the survey by the staff, Minimum Data Set Coordinator or the interdisciplinary care plan team. She further stated that a new Minimum Data Set and Plan of Care which identified the problem of wandering with care planned interventions had been developed the evening of 3/15/07 after they had been informed by the surveyor the 3/15/07 events between [Resident #4] and [Resident #5]." 5. Resident #6 had diagnoses of Encephalopathy, Alzheimer's and Depression. The Minimum Data Set dated 3/2/07 documented the resident had moderately impaired cognitive skills for daily decision-making, behavioral symptom of wandering occurred one to three days in the last seven days which was easily altered and wheeled self in wheelchair as primary mode of locomotion. a. As of 3/19/07 at 5:00 p.m., after complete	F 224		

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 ______	C 03/19/2007

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 224	Continued From page 11	F 224		

review of the clinical record, there was no plan of care with interventions that addressed wandering for this resident.

6. Resident #2 had a diagnosis of Dementia. The Annual Minimum Data Set dated 12/15/06 documented the resident had short and long-term memory problems, was moderately impaired in cognitive skills for daily decision making, had no behavior symptoms of wandering, required limited to total dependence on the staff for the performance of activities of daily living, and utilized a wheelchair as the primary mode of transportation.

a. The Social Services Progress Notes dated 3/13/07 documented, " [Resident #1's family member] states another black woman [Resident #2] was back in her [family member's] room this a.m. and was trying to fight her and [the family member's sister] had to pull her [Resident #2] out of the room. [LPN #1]. "

b. On 3/15/07 at 4:30 p.m., the Director of Nursing [DON] after reviewing the Plan of Care [POC] stated, "The POC was revised on 3/14/07 and did not include identification of the problem or any interventions relative to this resident wandering in and out of other residents' rooms. " We are in the process of developing interventions for the identified issues today."

7. Resident #7 had diagnoses of Cerebral Vascular Accident and Dementia. The Quarterly Minimum Data Set dated 1/15/07 documented the resident had short and long-term memory problems, was moderately impaired in cognitive skills for daily decision making, had behavioral symptoms of wandering 1 to 3 days that was

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 ______	C 03/19/2007

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 224	Continued From page 12	F 224		

easily altered, and required supervision for performance of activities of daily living.

a. On 3/19/07 at 2:35 p.m., the Director of Nursing stated, "[Resident #7] is ambulatory and wanders into other residents' rooms. No care plan was developed for this resident until 3/18/07 with interventions related to wandering behavior."

8. Nursing employees throughout the facility were interviewed to ascertain whether any residents in the facility wandered uninvited into other residents rooms. Their individual responses were as follows:

a. On 2/15/07 at 3:00 p.m., C.N.A. #1 (Certified Nursing Assistant #1) stated, "[Resident #3 and Resident #2]. They go in and out of rooms. We try to keep them out but can't always."

b. On 2/15/07 at 3:05 p.m., C.N.A. #2 stated, "[Resident #6 and Resident #3] go into other's rooms. They are not supposed to. We can't always keep them out."

c. On 2/15/07 at 3:10 p.m., C.N.A. #3 stated, "[Resident #3 and Resident #2] go into other residents rooms. We go get her out and try to lead her another way. We can't really keep them out."

d. On 2/15/07 at 3:20 p.m., LPN #1 (Licensed Practical Nurse #1) stated, "[Resident #2 and Resident #3] wander. When we see them go in or are in other residents rooms, we get them out."

e. On 2/15/07 at 3:25 p.m., C.N.A. #4 stated, "[Resident #7, Resident #3, and Resident #2]. We take them out of the wrong room to the

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 ______	C 03/19/2007

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 224	Continued From page 13	F 224		

correct room. Sometimes I take them for a walk or give them a magazine."

f. On 2/15/07 at 3:30 p.m., RN #1 (Registered Nurse #1) stated, "Yes, we have residents who wander in and out of other resident's rooms. [Resident #3] when she is up and [Resident #2]. We try to redirect them. If they've already gone into another resident's room, we go in and bring them back out."

g. On 2/15/07 at 3:35 p.m., C.N.A. #5 stated, "[Resident #3, Resident #6 and Resident #2] go into other residents rooms. I check on them. When they're in another's room, I get them out. Other than us watching nothing keeps them out of other folk's rooms."

h. On 2/15/07 at 3:44 p.m., C.N.A. #6 stated, "[Resident#3, Resident #2 and Resident #6]. We try to keep them where we are. Of course, we watch but they do get in other rooms frequently."

9. The inservice form dated 3/12/07 documented topics covered: "Annual Abuse Policy and Procedure per [Name Given], Attorney General's Office. [Given name], C.N.A. Supervisor discussed c (with) staff stop sign on [Resident #1's] door and redirect other residents away from room." Personnel who attended the inservice were asked if the C.N.A. Supervisor presented any discussion at this meeting as the Administrator indicated in an interview with surveyors on 3/16/07 at 11:08 a.m.:

a. On 3/19/07 at 10:30 a.m., LPN #2 stated, "No".

b. On 3/19/07 at 10:33 a.m., C.N.A. #8 stated, "No".

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 ____	C 03/19/2007

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 224	Continued From page 14 c. On 3/19/07 at 10:37 a.m., C.N.A. #9 stated, "No". d. On 3/19/07 at 10:42 a.m., LPN #3 stated, "No". e. On 3/19/07 at 10:45 a.m., Housekeeper #1 stated, "No". f. On 3/19/07 at 10:48 a.m., C.N.A. #11 stated, "No". g. On 3/19/07 at 10:51 a.m., C.N.A. #12 stated, "No". h. On 3/19/07 at 11:14 a.m., the C.N.A. Supervisor stated, "I did not provide an inservice with [Given Name], Attorney General's Office on 3/12/07. The Director of Nursing told me to make sure that [Resident #3] was not allowed in any resident's room and to redirect her back to the 300 hall. I talked to the 100 hall aides only. At 3:00 p.m., I talked to the 100 hall aides. I did not talk to 11-7. On the 13th I put a sheet up after the [Resident #2] happening." 10. On 3/15/07 at 4:00 p.m., the Director of Nursing stated, "Most C.N.A. (Certified Nursing Assistant) staff have been inserviced regarding [Resident #2 and Resident #3], not about other wandering residents. LPN's (Licensed Practical Nurses) and RN's (Registered Nurses) have not attended the inservices." a. The signature form dated 3/13/07 documented the at the top of the page, "ALL C.N.A.'s PLEASE SIGN," and further documented "1. Know where [Resident #3 and Resident #2] are at all times. Keep them out of other patients rooms. 2. Any	F 224		

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 ____	C 03/19/2007

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 224	Continued From page 15 bed alarm is to be answered immediately." b. The inservice dated 3/13/07, topic (Resident #2 and 3) documented, "1. Please redirect [Resident #3 and Resident #2] on 100 hall. 2. Do not let them enter [Resident #1's] room or any other resident's room. Pay attention to alarms going off. Respond. 3. Take [Resident #3] back to her hall." 11. On 3/19/07 at 10:10 a.m., a focused group meeting of four cognitively alert and oriented residents selected by the facility met to discuss the possibility of wandering residents in the facility. The group was asked if uninvited residents came into their respective rooms, whether the same residents entered uninvited each time and if the facility had been aware of these uninvited guests. Three of the four responded that a female resident had entered their rooms. These three indicated that the staff was aware of the resident intrusions. Only one of the three residents commented regarding to any negative feelings related to the wanderers and that was because she was not fully clothed on one occasion when the wanderer entered her room. She stated that she had not informed the staff of the wanderers entrance when she was unclothed.	F 224		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #12430 was substantiated, all or in	F 324		

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 ______	C 03/19/2007

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 324	Continued From page 16	F 324		

part, with these findings.

A. Based on observation, record review and interview the facility failed to ensure protection for wandering residents and the residents affected by wanderers as evidenced by the facility's failure to identify wandering behaviors and to develop/implement interventions to decrease the risk of resident to resident aggression and resident anxiety resulting from the intrusions of wandering cognitively impaired residents for 5 of 5 (Resident #2, 3, 4, 6 and 7) case mix residents who had episodes of wandering. The failed practice resulted in actual harm [fear] for 1 case mix resident [Resident #1] and had the potential to affect all 77 residents as identified by the Roster Sample Matrix received from the Administrator on 3/14/07 at 3:00 p.m. The findings are:

1. As of 3/19/07 at 5:00 p.m., there was not a policy or procedure available for review relative to the care of the wandering resident.

a. On 3/16/07 at 9:12 a.m., the Director of Nursing stated: "A list [of wanderers] is being developed based on the Minimum Data Set so the staff can be trained. The list is not currently prepared."

b. On 3/19/07 at 3:45 p.m., the Director of Nursing stated "We do not have a policy or procedure specific to caring for the wandering resident."

2. Resident #1 had diagnoses of Hypertension, Anxiety, Dementia, Arthritis, Mental Status Change [Lethargy], Depression, Coronary Artery Disease, and Dizziness. The Quarterly Minimum

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 ______	C 03/19/2007

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 324	Continued From page 17 Data Set dated 2/16/07 documented the resident had problems with short-term memory, modified independence in cognitive skills for daily decision making, required supervision and limited assistance with the performance of activities of daily living, was unable to maintain balance while standing without physical help during the test for balance, and had no falls within the past 30 days or the past 31-180 days. a. An Incident/Accident Report dated 3/12/07 at 10:00 a.m., received from the Administrator on 3/14/07 at 1:45 p.m., documented, "Description of Incident (Who, What, When, Where and Why): Resident [Resident #1] was laying in bed resting and another female resident entered room and began pulling on resident's clothes. Resident became very upset crying and shaking. Both residents were hitting @ [at] each other." 1) An "OLTC Witness Statement Form", no date or time, completed by the Maintenance Supervisor and attached to the Incident/Accident Report documented, "As I was walking down 100 hall when I heard [Resident #1] screaming down the hallway. So I go and ask her what as wrong. She stated someone was in her room and she seemed very agitated (or mad). So I held her hand to steady her because she seemed unsteady, and I called for a nurse. [LPN #1] came to the room 114 as I was calling and removed [Resident #3] from the room." 2) An "OLTC Witness Statement Form" dated 3/14/07 at 14:05 [2:40 p.m.] completed by Licensed Practical Nurse #1 [LPN] and attached to the Incident/Accident Report documented, "When I went down the hall, this resident [Resident #1] was standing outside of room with	F 324		

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 ______	C 03/19/2007

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 324	Continued From page 18 Maintenance Man, shoes off and she was crying stating 'I'm going to get that N_ _ _ _.' When I asked her what happened she said 'I was laying down and she came in my room and pulling at me see my clothes. She ripped a button off my blouse. I got the w/c [wheelchair] and laid her [Resident #1]down in bed trying to calm her down. A CNA [Certified Nursing Assistant] stayed /c [with] her. I called [Resident #1's physician] to try to get her something for her nerves. He ordered Ativan 0.5 mg. X 1 only. I reported to [Director of Nursing] and we put up a stop sign at doorway and CNA's were instructed to keep wanderers from going to her /r [resident] room." 3) On 3/15/07 at 9:00 a.m., Resident #1 was interviewed and stated, "A big black woman came into my room the other day and I couldn't get her out of here. I saw her coming in the door and told her to stop. She just kept on coming in. I can't stand or walk very well but I scooted to the end of my bed and I got in my chair [wheelchair] and went toward her telling her to get out of my room. She was in a wheelchair. Her chair is bigger than mine. She's tall and real black. When I got to the door I saw a man at the desk and hollered for him. He came running. He took her on down the hall. I told him to let me hit her and she wouldn't come back. He told me, No, he would take care of her." Resident #1 stated, "this has happened about 5 times before." Resident #1 stated, "I don't know her name". The resident was asked if she was hurt from the encounter. Resident #1 stated, "I was just scared and now I have trouble sleeping because I'm afraid she will come back while I'm in the bed and I couldn't get away from her. She tore buttons off my blouse. I don't like to fight, but I will if I have to. I'm tired of her coming in my room."	F 324		

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 ______	C 03/19/2007

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 324	Continued From page 19	F 324		

b. On 3/14/07 at 1:40 p.m., the Social Director stated that on "Monday [3/12/07] [Resident #1's family member] had a meeting with me and the Administrator and asked what we were going to do about her being attacked and she was not going to leave the building until she knew where the woman [Resident #3] was so Resident #1 could sleep in peace. The Administrator said we would re-direct and a stop sign was put up. The family member said, [Administrator's name] that will not work. Is that all you're going to do? The Administrator told her we can't keep her [Resident #3] in her room without violating her rights."

On 3/16/07 at 11:08 a.m., the Administrator was interviewed and stated, "On 3/12/07 [Social Director] came to me and said [Resident #1's] [Family member] wanted to meet with me and would not leave the building until she did. She was upset about [Resident #3] coming into [Resident #1's] room. I went to the Activities room to meet with [family member]. [Resident #1's family member] wanted to know what we were going to do about [Resident #1's] safety - her words that were written on the Grievance Form documented [Resident #1] was attacked. I told her that I thought the term " Attacked " was a little strong because it is not in [Resident #3's] nature to be violent. I agreed that [Resident #1] might have been scared when she awakened and someone was pulling on her clothing but I disagreed with it being called an attack. I saw that the Stop Sign was up, the [family member] stated that was not going to stop anybody. I told her that it might not but it was a first step and that I would also have the CNA supervisor inform all the CNA's that if they saw [Resident #3] going down the hallway to divert her and I would also

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 ______	C 03/19/2007

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 324	Continued From page 20	F 324		

have the RN and the nursing staff do the same with [Resident #3]. I asked her what else do you think I should do? She [the family member] stated, "I don't know what else you could do." I told her, I can not put a lock on her [Resident #3's] door as it would be a violation of State regulations and I could not interfere with [Resident #3's] rights to be out and about in the facility."

c. On 3/14/07 at 1:30 p.m., the Administrator stated, "On Monday [3/12/07] [Resident #3] went down the 100 hall and into [Resident #1's] room. [Resident #3] is in a wheelchair and is self-mobile. She goes in and out of residents' rooms. The staff removed her. We have found her several times in other rooms - 2 to 3 times in the last 2 weeks. [Resident #3] got hold of [Resident #1's] shirt and pulled on her shirt. It woke her up. She was scared really bad. After the incident the "Stop Sign" was put up." The Administrator further stated, "On Tuesday morning [3/13/07] [Resident #2] went into [Resident #1's] room." The Administrator was asked if the "Stop Sign" was up and he stated, "I don't know. [Resident #1] didn't like the stop sign and would take it down, fold it and put it up in the drawer. [Family Member] was in the facility on Tuesday, the alarm went off and no one was responding. [Resident #1] was sitting on the side of her bed fussing with [Resident #2] who was in a wheelchair in [Resident #1's] room. The [family member] turned the alarm off, pushed [Resident #2] out into the hallway, and left the facility." The Administrator was asked if any action had been taken regarding the alarm going off and no one responding. The Administrator stated, "Not to my knowledge."

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 ______	C 03/19/2007

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 324	Continued From page 21 d. A "Resident Grievance/Complaint Form" dated 3/12/07 documented the date of incident as occurring on 3/12/07 at 9:30 a.m. and signed by the Administrator and the Resident's family member was received from the Administrator on 3/16/07 at 11:19 a.m. The section of the form, "Describe the nature of the grievance/complaint (be specific)" documented, "Another resident came into [Resident #1's] room this a.m. while she was going to sleep and grabbed her shirt and pulled 2 buttons off of shift - resident was screaming and bed alarm going off - no one came to help her. Family wants to know what we are going to do about preventing this from happening again. The stop sign we put across the door will not prevent her from coming into room - also has had a cough for a month and a half - nothing done - family wants answers now. This is the second time she has been attacked by this woman in the w/c [wheelchair]. 'Mom is afraid to go to sleep.' The back of the form documented, "Will speak /c [with] CNA Supervisor and DON [Director of Nursing] to inform staff to divert [Resident #3] from 100 hall. CNA to do inservice. DON placed notice in 24 hr. [hour] report book." e. On 3/16/07 at 10:10 a.m., the Director of Nursing [DON] was interviewed and asked, "When [Resident #3] entered the room of [Resident #1] on 3/12/07 and physically touched [Resident #1] was [Resident #1] scared"? The DON stated: " Yes, she was scared. The daughter reported she was scared." The DON stated that LPN #1 had interviewed the resident and had documented her fear in the Nurse's Notes and on the OLTC Witness Statement. The DON was asked what interventions were employed on 3/12/07 to protect Resident #1 and	F 324		

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 ______	C 03/19/2007

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 324	Continued From page 22	F 324		

to comfort her anxiety? The DON stated, "The residents were initially separated. Then a magnetic "Stop Sign" banner was put in place across the doorway to deter all wandering residents from entering the room. The doctor was notified and an order was received to administer a one time dose of Ativan 0.5 mg. PO for anxiety. On 3/12/07 at 11:50 a.m. Nurse ' s Notes document the resident was calmer at that time."

The DON was asked, "Have you or your staff interviewed other cognitive residents regarding the wanderers and do any of these residents have any anxiety"? The DON stated, "Yes, we began interviewing cognitive residents on 3/15/07 regarding wanderers. I interviewed 3 cognitive residents on the 100 hall that collaborated that other residents have come into their rooms, it was a nuisance, but not distressing. No other residents have been interviewed at this point."

f. On 3/19/07 at 1:30 p.m., Resident #1 was asked if the Stop Sign was helping. The resident stated, "The stop sign has helped, but I'm still afraid. When I lay down, I can't know to get out. I'm afraid to go to sleep. She's mean. When she comes in she goes to ramming into things and when I tell her to get out she won't leave. Last time I sat up and slid to the end of my bed to get her out and she started fighting."

g. On 3/19/07 at 11:52 a.m., the DON was asked if she had interviewed other cognitively non-impaired residents. The DON stated, "I interviewed [Resident #4 and Resident #4's wife], [Resident #1], and [Resident #1's roommate, a non-case mix resident]. I have not interviewed the whole building yet."

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 ______	C 03/19/2007

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 324	Continued From page 23	F 324		

h. The DON was asked what interventions were put in place after the incident on 3/12/07 to protect Resident #1 and to comfort her anxiety [when Resident #2 wandered into her room]? The DON stated, "We began shift-to-shift inservices for the staff to re-direct [Resident #3] and [Resident #2] from the 100 hall - do not let residents go into [Resident #1's] or other residents' rooms, pay attention to alarms going off and respond to the alarms, and take [Resident #3] back to her hall and inservices are still ongoing."

The DON was asked what interventions were put in place to protect Resident #1 and to comfort her anxiety? The DON stated, "Inservices continued and increased monitoring was employed."

The DON was asked what interventions were put in place to protect Resident #1 and to comfort her anxiety [when Resident #2 again entered the resident's room]? The DON stated, " Inservices continued and monitoring of [Resident #1 ' s] level of anxiety was continued to be monitored."

2. Resident #3 had a diagnosis of Dementia. The Minimum Data Set dated 12/1/07 documented the resident had moderately impaired cognitive skills for daily decision-making, behavioral symptom of wandering occurred one to three days in the last seven days which was not easily altered and wheeled self in a wheelchair as the primary mode of locomotion.

a. The plan of care dated 12/1/06 and updated 3/8/07 documented, " Problem, behavioral symptoms ... Approach ... Rsd (Resident) wanders hallways in w/c (wheelchair) ... The plan

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 ____	C 03/19/2007

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 324	Continued From page 24	F 324		

of care also identified a Problem, Res (Resident) propels self in wc (wheelchair) grasping/pulling on anything within reach to assist c (with) locomotion," no corresponding interventions. A new Plan of care dated 3/14/07 documented, a " Problem, R [Resident] often roams facility and often gets in other R's rooms. Freq. (Frequent) monitoring of whereabouts to prevent going into other rooms uninvited ... Approach, documented as "R grabs and pulls at handrails and objects to assist in propelling around facility."

b. The facility's Incident/Accident Report dated 3/12/07 at 10:00 a.m., documented, a description of incident as "Res went into another Res room and began pulling and hitting on other R (Resident). No apparent injury to [Resident #3] as told to me. Resident was grabbing and reaching for any object within reach. She was roaming as she usually does anywhere without a purpose direction. Did not witness Resident grabbing. Resident reported [Resident #3] grabbed her clothing." The other investigative findings section documented, "[Resident #3] observed grabbing at objects and roaming about building. Resident has never been known to be aggressive c (with) anyone before. The steps to prevent reoccurrence section documented, "try heading R off when going down other hallways."

c. The Social Services Progress Notes dated 3/12/07 [no time] documented, "was reported to me that res went into 114-b and grabbed onto res blouse. Spoke c [with]other family. Stop sign across doorway will hopefully keep other res from coming into 114-b. Will continue to redirect as needed."

d. On 3/15/07 at 11:00 a.m., the Director of

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 ______	C 03/19/2007

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 324	Continued From page 25 Nursing stated the 3/14/07 plan of care was developed on 3/14/07 "after [surveyors] were here for the survey in February." The Director of Nursing was asked what interventions were put in place to protect other residents from those residents that wander into their rooms and protect the residents that wander into residents room that might do harm. She responded "I can't tell you approaches." e. On 3/15/07 at 10:49 a.m., Resident #3 was in the 400 hall day room lodged between the wall and dining room table. She was unable to maneuver the wheelchair to exit the area. She was observed until 11:06 a.m. when C.N.A. # 7 (Certified Nursing Assistant #7) removed her from this area to the 300 Hallway and allowed her be self mobile in her wheelchair. 3. Resident #5 had diagnoses of Atrial Fibrillation, Coronary Artery Disease, Parkinson's Disease and Hypertension. The Minimum Data Set dated 12/20/06 documented the resident had independent cognitive skills for daily decision-making, required supervision for walking in room and in the corridor, required the assistance of a cane, walker or crutch for locomotion. 4. Resident #4 had diagnoses of Dementia, Organic Brain Syndrome and Cerebrovascular Accident. The Minimum Data Set dated 12/5/06 documented the resident had moderately impaired cognitive skills for daily decision making and no behavioral symptom of wandering. a. As of 3/15/07 at 8:30 a.m., the plan of care dated 6/6/06 and updated 12/5/06, did not document a problem of wandering.	F 324		

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 ______	C 03/19/2007

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 324	Continued From page 26	F 324		

b. On 3/15/07 at 8:40 a.m., the resident was observed in a wheelchair in Resident #5's room. Resident #5 pushed Resident #4's wheelchair backwards from his room into the hallway. Resident #5 then proceeded to push the resident backwards from the outside of his room to the outside of another room, a distance of approximately 16 feet. Resident #5 did not have the assistance of his walker to return to his room.

c. On 3/15/07 at 10:50 a.m., Resident #5 stated, "The staff knows that the other residents come in here uninvited because they have come and taken them out. Both males and females have come in."

d. On 3/16/07 at 9:12 a.m., the Director of Nursing stated that [Resident #4's] behavior of wandering had "not been identified" prior to the survey by the staff, Minimum Data Set Coordinator or the interdisciplinary care plan team. She further stated that a new Minimum Data Set and Plan of Care which identified the problem of wandering with care planned interventions had been developed the evening of 3/15/07 after they had been informed by the surveyor the 3/15/07 events between [Resident #4] and [Resident #5]."

5. Resident #6 had diagnoses of Encephalopathy, Alzheimer's and Depression. The Minimum Data Set dated 3/2/07 documented the resident had moderately impaired cognitive skills for daily decision-making, behavioral symptom of wandering occurred one to three days in the last seven days which was easily altered and wheeled self in wheelchair as primary mode of locomotion.

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 ____	C 03/19/2007

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 324	Continued From page 27	F 324		

a. As of 3/19/07 at 5:00 p.m., after complete review of the clinical record, there was no plan of care with interventions that addressed wandering for this resident.

6. Resident #2 had a diagnosis of Dementia. The Annual Minimum Data Set dated 12/15/06 documented the resident had short and long-term memory problems, was moderately impaired in cognitive skills for daily decision making, had no behavior symptoms of wandering, required limited to total dependence on the staff for the performance of activities of daily living, and utilized a wheelchair as the primary mode of transportation.

a. The Social Services Progress Notes dated 3/13/07 documented, " [Resident #1's family member] states another black woman [Resident #2] was back in her [family member's] room this a.m. and was trying to fight her and [the family member's sister] had to pull her [Resident #2] out of the room. [LPN #1]. "

b. On 3/15/07 at 4:30 p.m., the Director of Nursing [DON] after reviewing the Plan of Care [POC] stated, "The POC was revised on 3/14/07 and did not include identification of the problem or any interventions relative to this resident wandering in and out of other residents' rooms. " We are in the process of developing interventions for the identified issues today."

7. Resident #7 had diagnoses of Cerebral Vascular Accident and Dementia. The Quarterly Minimum Data Set dated 1/15/07 documented the resident had short and long-term memory problems, was moderately impaired in cognitive

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 ______	C 03/19/2007

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 324	Continued From page 28	F 324		

skills for daily decision making, had behavioral symptoms of wandering 1 to 3 days that was easily altered, and required supervision for performance of activities of daily living.

a. On 3/19/07 at 2:35 p.m., the Director of Nursing stated, "[Resident #7] is ambulatory and wanders into other residents' rooms. No care plan was developed for this resident until 3/18/07 with interventions related to wandering behavior."

8. Nursing employees throughout the facility were interviewed to ascertain whether any residents in the facility wandered uninvited into other residents rooms. Their individual responses were as follows:

a. On 2/15/07 at 3:00 p.m., C.N.A. #1 (Certified Nursing Assistant #1) stated, "[Resident #3 and Resident #2]. They go in and out of rooms. We try to keep them out but can't always."

b. On 2/15/07 at 3:05 p.m., C.N.A. #2 stated, "[Resident #6 and Resident #3] go into other's rooms. They are not supposed to. We can't always keep them out."

c. On 2/15/07 at 3:10 p.m., C.N.A. #3 stated, "[Resident #3 and Resident #2] go into other residents rooms. We go get her out and try to lead her another way. We can't really keep them out."

d. On 2/15/07 at 3:20 p.m., LPN #1 (Licensed Practical Nurse #1) stated, "[Resident #2 and Resident #3] wander. When we see them go in or are in other residents rooms, we get them out."

e. On 2/15/07 at 3:25 p.m., C.N.A. #4 stated,

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 ______	C 03/19/2007

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 324	Continued From page 29	F 324		

"[Resident #7, Resident #3, and Resident #2]. We take them out of the wrong room to the correct room. Sometimes I take them for a walk or give them a magazine."

f. On 2/15/07 at 3:30 p.m., RN #1 (Registered Nurse #1) stated, "Yes, we have residents who wander in and out of other resident's rooms. [Resident #3] when she is up and [Resident #2]. We try to redirect them. If they've already gone into another resident's room, we go in and bring them back out."

g. On 2/15/07 at 3:35 p.m., C.N.A. #5 stated, "[Resident #3, Resident #6 and Resident #2] go into other residents rooms. I check on them. When they're in another's room, I get them out. Other than us watching nothing keeps them out of other folk's rooms."

h. On 2/15/07 at 3:44 p.m., C.N.A. #6 stated, "[Resident#3, Resident #2 and Resident #6]. We try to keep them where we are. Of course, we watch but they do get in other rooms frequently."

9. The inservice form dated 3/12/07 documented topics covered: "Annual Abuse Policy and Procedure per [Name Given], Attorney General's Office. [Given name], C.N.A. Supervisor discussed c (with) staff stop sign on [Resident #1's] door and redirect other residents away from room." Personnel who attended the inservice were asked if the C.N.A. Supervisor presented any discussion at this meeting as the Administrator indicated in an interview with surveyors on 3/16/07 at 11:08 a.m.:

a. On 3/19/07 at 10:30 a.m., LPN #2 stated, "No".

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 ______	C 03/19/2007

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 324	Continued From page 30 b. On 3/19/07 at 10:33 a.m., C.N.A. #8 stated, "No". c. On 3/19/07 at 10:37 a.m., C.N.A. #9 stated, "No". d. On 3/19/07 at 10:42 a.m., LPN #3 stated, "No". e. On 3/19/07 at 10:45 a.m., Housekeeper #1 stated, "No". f. On 3/19/07 at 10:48 a.m., C.N.A. #11 stated, "No". g. On 3/19/07 at 10:51 a.m., C.N.A. #12 stated, "No". h. On 3/19/07 at 11:14 a.m., the C.N.A. Supervisor stated, "I did not provide an inservice with [Given Name], Attorney General's Office on 3/12/07. The Director of Nursing told me to make sure that [Resident #3] was not allowed in any resident's room and to redirect her back to the 300 hall. I talked to the 100 hall aides only. At 3:00 p.m., I talked to the 100 hall aides. I did not talk to 11-7. On the 13th I put a sheet up after the [Resident #2] happening." 9. On 3/15/07 at 4:00 p.m., the Director of Nursing stated, "Most C.N.A. (Certified Nursing Assistant) staff have been inserviced regarding [Resident #2 and Resident #3], not about other wandering residents. LPN's (Licensed Practical Nurses) and RN's (Registered Nurses) have not attended the inservices." a. The signature form dated 3/13/07 documented the at the top of the page, "ALL C.N.A.'s PLEASE SIGN," and further documented "1. Know where	F 324		

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 ____	C 03/19/2007

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 324	Continued From page 31	F 324		

[Resident #3 and Resident #2] are at all times. Keep them out of other patients rooms. 2. Any bed alarm is to be answered immediately."

b. The inservice dated 3/13/07 documented, "1. Please redirect [Resident #3 and Resident #2] on 100 hall. 2. Do not let them enter [Resident #1's] room or any other resident's room. Pay attention to alarms going off. Respond. 3. Take [Resident #3] back to her hall."

10. On 3/19/07 at 10:10 a.m., a focused group meeting of four cognitively alert and oriented residents selected by the facility met to discuss the possibility of wandering residents in the facility. The group was asked if uninvited residents came into their respective rooms, whether the same residents entered uninvited each time and if the facility had been aware of these uninvited guests. Three of the four responded that a female resident had entered their rooms. These three indicated that the staff was aware of the resident intrusions. Only one of the three residents commented regarding to any negative feelings related to the wanderers and that was because she was not fully clothed on one occasion when the wanderer entered her room. She stated that she had not informed the staff of the wanderers entrance when she was unclothed.

B. Based on observation, record review and interview the facility failed to ensure that interventions were consistently implemented in order to prevent falls and to reduce the risk of injuries from falls for 1 (Resident #1) of 1 case-mix residents who was identified to be at risk for falls and has a chair alarm. This failed practice had the potential to affect 4 residents in

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 ______	C 03/19/2007

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 324	Continued From page 32	F 324		

the facility who had a chair alarm and who were at risk for falls as identified by the Roster Sample Matrix received from the Administrator on 3/14/07 at 3:00 p.m. The findings are:

Resident #1 had diagnoses of Hypertension, Anxiety, Dementia, Arthritis, Mental Status Change [Lethargy], Depression, Coronary Artery Disease, and Dizziness. The Quarterly Minimum Data Set dated 2/16/07 documented the resident the resident had modified independence in cognitive skills for daily decision making, required supervision to limited assistance with the performance of activities of daily living, was unable to maintain balance while standing without physical help during the test for balance, and had no falls within the past 30 days or the past 31-180 days.

a. An Incident/Accident Report dated 1/15/07 at 1405 [2:05 p.m.] documented, "Resident was found lying beside bed by CNA. Resident was sitting up with hand to her head and blood covering hand and rag she was holding. Upon closer inspection resident has a laceration aprox. [approximately] 3 cm [centimeters] long on rt [right] side of head. Area looks to be clotting off but when touched area started to bleed a little. Wet rag with ice applied. [Ambulance] notified of transport." The "Incident/Accident Report: Follow Up - Final Disposition" documented, "To ER [Emergency Room] with 5 staples to laceration on l [left] side of head." The "Incident/Accident Report: Steps to Prevent Reoccurrence" documented, "W/C [wheelchair] alarm."

b. Plan of Care entry dated 1/16/07 documented, "Bed/w/c alarm. Received 5 staples to r [right] side of forehead." A Plan of Care entry dated

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 ______	C 03/19/2007

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 324	Continued From page 33 3/7/07 documented, "At risk for falls d/t [due to] dementia. "Chair/bed alarm." c. An Incident/Accident Report dated 3/6/07 at 1440 [2:40 p.m.] documented, "Summoned to room per CNA. Resident sitting on floor in front of chair and w/c [wheelchair] in front of her. /R [resident] stated she had gotten in the chair across room and went to get into w/c pulled on the handles of w/c as she was getting up and went to floor. She hit back of left side of head on table of refrig. [refrigerator]" The "Incident/Accident Report: Steps to Prevent Reoccurrence" documented, "Encourage /r [resident] to use CL [call light] for assist. Chair/bed alarm continue to alert staff of self". d. On 3/16/07 at 8:40 a.m., Resident #1 was in her room in a wheelchair. The resident's body alarm was not attached. The body alarm was observed attached to the head of the bed - not on the resident or the wheelchair. e. On 3/16/07 at 9:10 a.m., Resident #1 was visiting with a family member . The family member stated she had arrived at about 8:45 a.m. and found her [Resident #1] in the restroom without assistance. The family member stated that she had observed the resident's body alarm attached to the head of the bed. The family member stated, "I worry about her falling when getting out of the wheelchair to use the bathroom. The alarm would alert them that she is getting out of her chair. One of the staff came by while she was in the bathroom and had one of the CNA's come in and assist her in the bathroom and put her alarm on her." f. On 3/19/07 at 1:30 p.m., the resident was in	F 324		

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 ______	C 03/19/2007

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 324	Continued From page 34 bed. The body alarm was not attached to the resident's bed or to the resident. The body alarm was attached to the back of the resident's wheelchair.	F 324		
F 490 SS=G	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #12430 was substantiated, all or in part, with these findings. Based on observation, record review and interview the facility failed to prevent neglect as evidenced by the facility's failure to develop and implement written policies and procedures to ensure protection for wandering residents and the residents affected by wanderers for 5 of 5 (Resident #2, 3, 4, 6 and 7) case mix residents who had episodes of wandering. The failed practice resulted in actual harm [fear] for 1 case mix resident [Resident #1] and had the potential to effect all 77 residents as identified by the Roster Sample Matrix received from the Administrator on 3/14/07 at 3:00 p.m. The findings are: 1. As of 3/19/07 at 5:00 p.m., there was not a policy or procedure available for review relative to the care of the wandering resident. a. On 3/16/07 at 9:12 a.m., the Director of Nursing stated: "A list [of wanderers] is being	F 490		

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 ______	C 03/19/2007

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 490	Continued From page 35	F 490		

developed based on the Minimum Data Set so the staff can be trained. The list is not currently prepared."

b. On 3/19/07 at 3:45 p.m., the Director of Nursing stated "We do not have a policy or procedure specific to caring for the wandering resident."

2. Resident #1 had diagnoses of Hypertension, Anxiety, Dementia, Arthritis, Mental Status Change [Lethargy], Depression, Coronary Artery Disease, and Dizziness. The Quarterly Minimum Data Set dated 2/16/07 documented the resident had problems with short-term memory, modified independence in cognitive skills for daily decision making, required supervision and limited assistance with the performance of activities of daily living, was unable to maintain balance while standing without physical help during the test for balance, and had no falls within the past 30 days or the past 31-180 days.

a. An Incident/Accident Report dated 3/12/07 at 10:00 a.m., received from the Administrator on 3/14/07 at 1:45 p.m., documented, "Description of Incident (Who, What, When, Where and Why): Resident [Resident #1] was laying in bed resting and another female resident entered room and began pulling on resident's clothes. Resident became very upset crying and shaking. Both residents were hitting @ [at] each other."

1) An "OLTC Witness Statement Form", no date or time, completed by the Maintenance Supervisor and attached to the Incident/Accident Report documented, "As I was walking down 100 hall when I heard [Resident #1] screaming down the hallway. So I go and ask her what as wrong.

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 ____	C 03/19/2007

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 490	Continued From page 36 She stated someone was in her room and she seemed very agitated (or mad). So I held her hand to steady her because she seemed unsteady, and I called for a nurse. [LPN #1] came to the room 114 as I was calling and removed [Resident #3] from the room." 2) An "OLTC Witness Statement Form" dated 3/14/07 at 14:05 [2:40 p.m.] completed by Licensed Practical Nurse #1 [LPN] and attached to the Incident/Accident Report documented, "When I went down the hall, this resident [Resident #1] was standing outside of room with Maintenance Man, shoes off and she was crying stating 'I'm going to get that N_ _ _ _.' When I asked her what happened she said 'I was lying down and she came in my room and pulling at me see my clothes. She ripped a button off my blouse. I got the w/c [wheelchair] and laid her [Resident #1] down in bed trying to calm her down. A CNA [Certified Nursing Assistant] stayed /c [with] her. I called [Resident #1's physician] to try to get her something for her nerves. He ordered Ativan 0.5 mg. X 1 only. I reported to [Director of Nursing] and we put up a stop sign at doorway and CNA's were instructed to keep wanderers from going to her /r [resident] room." 3) On 3/15/07 at 9:00 a.m., Resident #1 was interviewed and stated, "A big black woman came into my room the other day and I couldn't get her out of here. I saw her coming in the door and told her to stop. She just kept on coming in. I can't stand or walk very well but I scooted to the end of my bed and I got in my chair [wheelchair] and went toward her telling her to get out of my room. She was in a wheelchair. Her chair is bigger than mine. She's tall and real black. When I got to the door I saw a man at the desk and hollered for	F 490		

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 ______	C 03/19/2007

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 490	Continued From page 37	F 490		

him. He came running. He took her on down the hall. I told him to let me hit her and she wouldn't come back. He told me, No, he would take care of her." Resident #1 stated, "This has happened about 5 times before." Resident #1 stated, "I don't know her name". The resident was asked if she was hurt from the encounter. Resident #1 stated, "I was just scared and now I have trouble sleeping because I'm afraid she will come back while I'm in the bed and I couldn't get away from her. She tore buttons off my blouse. I don't like to fight, but I will if I have to. I'm tired of her coming in my room."

b. On 3/14/07 at 1:40 p.m., the Social Director stated that on "Monday [3/12/07] [Resident #1's family member] had a meeting with me and the Administrator and asked what we were going to do about her being attacked and she was not going to leave the building until she knew where the woman [Resident #3] was so Resident #1 could sleep in peace. The Administrator said we would re-direct and a stop sign was put up. The family member said, [Administrator's name] that will not work. Is that all you're going to do? The Administrator told her we can't keep her [Resident #3] in her room without violating her rights."

On 3/16/07 at 11:08 a.m., the Administrator was interviewed and stated, " On 3/12/07 [Social Director] came to me and said [Resident #1's] [Family member] wanted to meet with me and would not leave the building until she did. She was upset about [Resident #3] coming into [Resident #1's] room. I went to the Activities room to meet with [family member]. [Resident #1's family member] wanted to know what we were going to do about [Resident #1's] safety - her words that were written on the Grievance

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 ____	C 03/19/2007

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 490	Continued From page 38 Form documented [Resident #1] was attacked. I told her that I thought the term " Attacked " was a little strong because it is not in [Resident #3's] nature to be violent. I agreed that [Resident #1] might have been scared when she awakened and someone was pulling on her clothing but I disagreed with it being called an attack. I saw that the Stop Sign was up, the [family member] stated that was not going to stop anybody. I told her that it might not but it was a first step and that I would also have the CNA supervisor inform all the CNA's that if they saw [Resident #3] going down the hallway to divert her and I would also have the RN and the nursing staff do the same with [Resident #3]. I asked her what else you think I should do. She [the family member] stated, "I don't know what else you could do." I told her, I can not put a lock on her [Resident #3's] door as it would be a violation of State regulations and I could not interfere with [Resident #3's] rights to be out and about in the facility." c. On 3/14/07 at 1:30 p.m., the Administrator stated, "On Monday [3/12/07] [Resident #3] went down the 100 hall and into [Resident #1's] room. [Resident #3] is in a wheelchair and is self-mobile. She goes in and out of residents' rooms. The staff removed her. We have found her several times in other rooms - 2 to 3 times in the last 2 weeks. [Resident #3] got hold of [Resident #1's] shirt and pulled on her shirt. It woke her up. She was scared really bad. After the incident the "Stop Sign" was put up." The Administrator further stated, "On Tuesday morning [3/13/07] [Resident #2] went into [Resident #1's] room." The Administrator was asked if the "Stop Sign" was up and he stated, "I don't know. [Resident #1] didn't like the stop sign	F 490		

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 ____	C 03/19/2007

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 490	Continued From page 39 and would take it down, fold it and put it up in the drawer. [Family Member] was in the facility on Tuesday, the alarm went off and no one was responding. [Resident #1] was sitting on the side of her bed fussing with [Resident #2] that was in a wheelchair in [Resident #1's] room. The [family member] turned the alarm off, pushed [Resident #2] out into the hallway, and left the facility." The Administrator was asked if any action had been taken regarding the alarm going off and no one responding. The Administrator stated, "Not to my knowledge." d. A "Resident Grievance/Complaint Form" dated 3/12/07 documented the date of incident as occurring on 3/12/07 at 9:30 a.m. and signed by the Administrator and the Resident's family member was received from the Administrator on 3/16/07 at 11:19 a.m. The section of the form, "Describe the nature of the grievance/complaint (be specific)" documented, "Another resident came into [Resident #1's] room this a.m. while she was going to sleep and grabbed her shirt and pulled 2 buttons off of shift - resident was screaming and bed alarm going off - no one came to help her. Family wants to know what we are going to do about preventing this from happening again. The stop sign we put across the door will not prevent her from coming into room - also has had a cough for a month and a half - nothing done - family wants answers now. This is the second time she has been attacked by this woman in the w/c [wheelchair]. 'Mom is afraid to go to sleep.' The back of the form documented, "Will speak /c [with] CNA Supervisor and DON [Director of Nursing] to inform staff to divert [Resident #3] from 100 hall. CNA to do inservice. DON placed notice in 24 hr. [hour] report book."	F 490		

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 ______	C 03/19/2007

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 490	Continued From page 40	F 490		

e. On 3/16/07 at 10:10 a.m., the Director of Nursing [DON] was interviewed and asked, "When [Resident #3] entered the room of [Resident #1] on 3/12/07 and physically touched [Resident #1] was [Resident #1] scared"? The DON stated: " Yes, she was scared. The daughter reported she was scared." The DON stated that LPN #1 had interviewed the resident and had documented her fear in the Nurse's Notes and on the OLTC Witness Statement. The DON was asked what interventions were employed on 3/12/07 to protect Resident #1 and to comfort her anxiety. The DON stated, " The residents were initially separated. Then a magnetic "Stop Sign" banner was put in place across the doorway to deter all wandering residents from entering the room. The doctor was notified and an order was received to administer a one time dose of Ativan 0.5 mg. PO for anxiety. On 3/12/07 at 11:50 a.m. Nurse ' s Notes document the resident was calmer at that time."

The DON was asked, "Have you or your staff interviewed other cognitive residents regarding the wanderers and do any of these residents have any anxiety"? The DON stated, "Yes, we began interviewing cognitive residents on 3/15/07 regarding wanderers. I interviewed 3 cognitive residents on the 100 hall that collaborated that other residents have come into their rooms, it was a nuisance, but not distressing. No other residents have been interviewed at this point."

f. On 3/19/07 at 1:30 p.m., Resident #1 was asked if the Stop Sign was helping. The resident stated, "The stop sign has helped, but I'm still afraid. When I lay down, I can't know to get out.

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 ____	C 03/19/2007

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 490	Continued From page 41 I'm afraid to go to sleep. She's mean. When she comes in she goes to ramming into things and when I tell her to get out she won't leave. Last time I sat up and slid to the end of my bed to get her out and she started fighting." g. On 3/19/07 at 11:52 a.m., the DON was asked if she had interviewed other cognitively non-impaired residents. The DON stated, "I interviewed [Resident #4 and Resident #4's wife], [Resident #1], and [Resident #1's roommate, a non-case mix resident]. I have not interviewed the whole building yet." h. On 3/16/07 the DON the was asked what interventions were put in place since the incident on 3/12/07 to protect Resident #1 and to comfort her anxiety [when Resident #2 wandered into her room]? The DON stated, "We began shift-to-shift inservices for the staff to re-direct [Resident #3] and [Resident #2] from the 100 hall - do not let residents go into [Resident #1's] or other residents' rooms, pay attention to alarms going off and respond to the alarms, and take [Resident #3] back to her hall and inservices are still ongoing." The DON was asked what interventions were put in place to protect Resident #1 and to comfort her anxiety. The DON stated, "Inservices continued and increased monitoring was employed The DON was asked what interventions were put in place to protect Resident #1 and to comfort her anxiety [when Resident #2 again entered the resident's room]. The DON stated, " Inservices continued and monitoring of [Resident #1 ' s] level of anxiety was continued to be monitored."	F 490		

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 ______	C 03/19/2007

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 490	Continued From page 42	F 490		

2. Resident #3 had a diagnosis of Dementia. The Minimum Data Set dated 12/1/07 documented the resident had moderately impaired cognitive skills for daily decision-making, behavioral symptom of wandering occurred one to three days in the last seven days which was not easily altered and wheeled self in a wheelchair as the primary mode of locomotion.

a. The plan of care dated 12/1/06 and updated 3/8/07 documented, " Problem, behavioral symptoms ... Approach ... Rsd (Resident) wanders hallways in w/c (wheelchair) ... The plan of care also identified a Problem, Res (Resident) propels self in wc (wheelchair) grasping/pulling on anything within reach to assist c (with) locomotion," no corresponding interventions. A new Plan of care dated 3/14/07 documented, a " Problem, R [Resident] often roams facility and often gets in other R's rooms. Freq. (Frequent) monitoring of whereabouts to prevent going into other rooms uninvited ... Approach, documented as "R grabs and pulls at handrails and objects to assist in propelling around facility."

b. The facility's Incident/Accident Report dated 3/12/07 at 10:00 a.m., documented, a description of incident as "Res went into another Res room and began pulling and hitting on other R (Resident). No apparent injury to [Resident #3] as told to me. Resident was grabbing and reaching for any object within reach. She was roaming as she usually does anywhere without a purpose direction. Did not witness Resident grabbing. Resident reported [Resident #3] grabbed her clothing." The other investigative findings section documented, "[Resident #3] observed grabbing at objects and roaming about building. Resident has never been known to be

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 ____	C 03/19/2007

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 490	Continued From page 43	F 490		

aggressive c (with) anyone before. The steps to prevent reoccurrence section documented, "try heading R off when going down other hallways."

c. The Social Services Progress Notes dated 3/12/07 [no time] documented, "was reported to me that res went into 114-b and grabbed onto res blouse. Spoke c [with] other family. Stop sign across doorway will hopefully keep other res from coming into 114-b. Will continue to redirect as needed."

d. On 3/15/07 at 11:00 a.m., the Director of Nursing stated the 3/14/07 plan of care was developed on 3/14/07 "after [surveyors] were here in February." The Director of Nursing was asked what interventions were put in place to protect other residents from those residents that wander into their rooms and protect the residents that wander into residents room that might do harm. She responded "I can't tell you approaches."

e. On 3/15/07 at 10:49 a.m., Resident #3 was in the 400 hall day room lodged between the wall and dining room table. She was unable to maneuver the wheelchair to exit the area. She was observed until 11:06 a.m. when C.N.A. # 7 (Certified Nursing Assistant #7) removed her from this area to the 300 Hallway and allowed her be self mobile in her wheelchair.

3. Resident #5 had diagnoses of Atrial Fibrillation, Coronary Artery Disease, Parkinson's Disease and Hypertension. The Minimum Data Set dated 12/20/06 documented the resident had independent cognitive skills for daily decision-making, required supervision for walking in room and in the corridor, required the assistance of a cane, walker or crutch for

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 ______	C 03/19/2007

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 490	Continued From page 44 locomotion. 4. Resident #4 had diagnoses of Dementia, Organic Brain Syndrome and Cerebrovascular Accident. The Minimum Data Set dated 12/5/06 documented the resident had moderately impaired cognitive skills for daily decision making and no behavioral symptom of wandering. a. As of 3/15/07 at 8:30 a.m., the plan of care dated 6/6/06 and updated 12/5/06, did not document a problem of wandering. b. On 3/15/07 at 8:40 a.m., the resident was observed in a wheelchair in Resident #5's room. Resident #5 pushed Resident #4's wheelchair backwards from his room into the hallway. Resident #5 then proceeded to push the resident backwards from the outside of his room to the outside of another room, a distance of approximately 16 feet. Resident #5 did not have the assistance of his walker to return to his room. c. On 3/15/07 at 10:50 a.m., Resident #5 stated, "The staff knows that the other residents come in here uninvited because they have come and taken them out. Both males and females have come in." d. On 3/16/07 at 9:12 a.m., the Director of Nursing stated that [Resident #4's] behavior of wandering had "not been identified" prior to the survey by the staff, Minimum Data Set Coordinator or the interdisciplinary care plan team. She further stated that a new Minimum Data Set and Plan of Care which identified the problem of wandering with care planned interventions had been developed the evening of 3/15/07 after they had been informed by the	F 490		

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 ______	C 03/19/2007

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 490	Continued From page 45 surveyor the 3/15/07 events between [Resident #4] and [Resident #5]." 5. Resident #6 had diagnoses of Encephalopathy, Alzheimer's and Depression. The Minimum Data Set dated 3/2/07 documented the resident had moderately impaired cognitive skills for daily decision-making, behavioral symptom of wandering occurred one to three days in the last seven days which was easily altered and wheeled self in wheelchair as primary mode of locomotion. a. As of 3/19/07 at 5:00 p.m., after complete review of the clinical record, there was no plan of care with interventions that addressed wandering for this resident. 6. Resident #2 had a diagnosis of Dementia. The Annual Minimum Data Set dated 12/15/06 documented the resident had short and long-term memory problems, was moderately impaired in cognitive skills for daily decision making, had no behavior symptoms of wandering, required limited to total dependence on the staff for the performance of activities of daily living, and utilized a wheelchair as the primary mode of transportation. a. The Social Services Progress Notes dated 3/13/07 documented, " [Resident #1's family member] states another black woman [Resident #2] was back in her [family member's] room this a.m. and was trying to fight her and [the family member's sister] had to pull her [Resident #2] out of the room. [LPN #1]. " b. On 3/15/07 at 4:30 p.m., the Director of Nursing [DON] after reviewing the Plan of Care	F 490		

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 ______	C 03/19/2007

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 490	Continued From page 46	F 490		

[POC] stated, "The POC was revised on 3/14/07 and did not include identification of the problem or any interventions relative to this resident wandering in and out of other residents' rooms. " We are in the process of developing interventions for the identified issues today."

7. Resident #7 had diagnoses of Cerebral Vascular Accident and Dementia. The Quarterly Minimum Data Set dated 1/15/07 documented the resident had short and long-term memory problems, was moderately impaired in cognitive skills for daily decision making, had behavioral symptoms of wandering 1 to 3 days that was easily altered, and required supervision for performance of activities of daily living.

a. On 3/19/07 at 2:35 p.m., the Director of Nursing stated, "[Resident #7] is ambulatory and wanders into other residents' rooms. No care plan was developed for this resident until 3/18/07 with interventions related to wandering behavior."

8. Nursing employees throughout the facility were interviewed to ascertain whether any residents in the facility wandered uninvited into other resident ' s rooms. Their individual responses were as follows:

a. On 2/15/07 at 3:00 p.m., C.N.A. #1 (Certified Nursing Assistant #1) stated, "[Resident #3 and Resident #2]. They go in and out of rooms. We try to keep them out but can't always."

b. On 2/15/07 at 3:05 p.m., C.N.A. #2 stated, "[Resident #6 and Resident #3] go into other's rooms. They are not supposed to. We can't always keep them out."

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 ______	C 03/19/2007

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 490	Continued From page 47	F 490		

c. On 2/15/07 at 3:10 p.m., C.N.A. #3 stated, "[Resident #3 and Resident #2] go into other resident ' s rooms. We go get her out and try to lead her another way. We can't really keep them out."

d. On 2/15/07 at 3:20 p.m., LPN #1 (Licensed Practical Nurse #1) stated, "[Resident #2 and Resident #3] wander. When we see them go in or are in other residents rooms, we get them out."

e. On 2/15/07 at 3:25 p.m., C.N.A. #4 stated, "[Resident #7, Resident #3, and Resident #2]. We take them out of the wrong room to the correct room. Sometimes I take them for a walk or give them a magazine."

f. On 2/15/07 at 3:30 p.m., RN #1 (Registered Nurse #1) stated, "Yes, we have residents who wander in and out of other resident's rooms. [Resident #3] when she is up and [Resident #2]. We try to redirect them. If they've already gone into another resident's room, we go in and bring them back out."

g. On 2/15/07 at 3:35 p.m., C.N.A. #5 stated, "[Resident #3, Resident #6 and Resident #2] go into other resident ' s rooms. I check on them. When they're in another's room, I get them out. Other than us watching nothing keeps them out of other folk's rooms."

h. On 2/15/07 at 3:44 p.m., C.N.A. #6 stated, "[Resident#3, Resident #2 and Resident #6]. We try to keep them where we are. Of course, we watch but they do get in other rooms frequently."

9. The inservice form dated 3/12/07 documented topics covered: "Annual Abuse Policy and

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 ______	C 03/19/2007

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 490	Continued From page 48	F 490		

Procedure per [Name Given], Attorney General's Office. [Given name], C.N.A. Supervisor discussed c (with) staff stop sign on [Resident #1's] door and redirect other residents away from room." Personnel who attended the inservice were asked if the C.N.A. Supervisor presented any discussion at this meeting as the Administrator indicated in an interview with surveyors on 3/16/07 at 11:08 a.m.:

a. On 3/19/07 at 10:30 a.m., LPN #2 stated, "No".

b. On 3/19/07 at 10:33 a.m., C.N.A. #8 stated, "No".

c. On 3/19/07 at 10:37 a.m., C.N.A. #9 stated, "No".

d. On 3/19/07 at 10:42 a.m., LPN #3 stated, "No".

e. On 3/19/07 at 10:45 a.m., Housekeeper #1 stated, "No".

f. On 3/19/07 at 10:48 a.m., C.N.A. #11 stated, "No".

g. On 3/19/07 at 10:51 a.m., C.N.A. #12 stated, "No".

h. On 3/19/07 at 11:14 a.m., the C.N.A. Supervisor stated, "I did not provide an inservice with [Given Name], Attorney General's Office on 3/12/07. The Director of Nursing told me to make sure that [Resident #3] was not allowed in any resident's room and to redirect her back to the 300 hall. I talked to the 100 hall aides only. At 3:00 p.m., I talked to the 100 hall aides. I did not talk to 11-7. On the 13th I put a sheet up after the [Resident #2] happening."

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 ______	C 03/19/2007

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 490	Continued From page 49 10. On 3/15/07 at 4:00 p.m., the Director of Nursing stated, "Most C.N.A. (Certified Nursing Assistant) staff have been inserviced regarding [Resident #2 and Resident #3], not about other wandering residents. LPN's (Licensed Practical Nurses) and RN's (Registered Nurses) have not attended the inservices." a. The signature form dated 3/13/07 documented at the top of the page, "ALL C.N.A.'s PLEASE SIGN," and further documented "1. Know where [Resident #3 and Resident #2] are at all times. Keep them out of other patient ' s rooms. 2. Any bed alarm is to be answered immediately." b. The inservice dated 3/13/07 documented, "1. Please redirect [Resident #3 and Resident #2] on 100 hall. 2. Do not let them enter [Resident #1's] room or any other resident's room. Pay attention to alarms going off. Respond. 3. Take [Resident #3] back to her hall." 11. On 3/19/07 at 10:10 a.m., a focused group meeting of four cognitively alert and oriented residents selected by the facility met to discuss the possibility of wandering residents in the facility. The group was asked if uninvited residents came into their respective rooms, whether the same residents entered uninvited each time and if the facility had been aware of these uninvited guests. Three of the four responded that a female resident had entered their rooms. These three indicated that the staff was aware of the resident intrusions. Only one of the three residents commented regarding to any negative feelings related to the wanderers and that was because she was not fully clothed on one occasion when the wanderer entered her	F 490		

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 ______	C 03/19/2007

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 490	Continued From page 50 room. She stated that she had not informed the staff of the wanderers entrance when she was unclothed.	F 490		