

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

PRINTED: 04/11/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045376</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/28/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHERWOOD NURSING &amp; REHABILITATION CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>245 INDIAN BAY DRIVE SHERWOOD, AR 72120</b>	
(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 176 SS=E	<p><b>483.10(n) SELF ADMINISTRATION OF DRUGS</b></p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that before residents were allowed to self-administer medication the interdisciplinary team determined that it would be a safe practice, and failed to provide accurate re-assessments quarterly or as needed to confirm that the residents remained appropriate for self-administration of medication for 2 (Residents #6 and #15) of 3 (Residents #3, #6, and #15) case mix residents that self administered medications. This failed practice had the potential to affect 4 residents who self administered medications as documented on a list provided by the Director of Nursing on 3/28/08. The findings are:</p> <p>1. Resident #15 had diagnoses of Major Depression, Vascular Dementia, Depression with Suicidal Ideation. The Annual Minimum Data Set (MDS) dated 2/5/08 documented the resident had modified independent cognitive skills for daily decision making, adequate vision with no visual limitations/difficulties and no visual appliances, had repetitive health complaints and repetitive anxious complaints/concerns up to 5 days a week..</p> <p>a. The Social History and Initial Assessment form dated 11/1/06 documented " poor" under the Vision heading.</p>	F 176		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	Continued From page 1  b. The Mental Status Questionnaire form dated 5/9/07 documented a score of 10 of 10 items, resulting in 0 errors. Under the scoring system, 0 had no value. 1 to 2 errors = intact mental function.  c. The Competence to Self Administer Medication form dated 5/9/07 was filled out and signed by, LPN (Licensed Practical Nurse) #4 and the form documented the resident wishing to self administer Lotramene (Lotrisone) Cream. Medication was to be located in the inside drawer of the night table. The resident to read the label. The resident to administer, resident to measure and resident to prepare. The resident was documented as demonstrating proper technique to apply medication to the skin. The resident was to dispose of equipment. Nurse to document by asking if resident applied, and summary was "At this time, the resident competent to perform the task. Will evaluate quarterly."  d. Telephone Order dated 9/19/07 at 1700 hours documented, "Can self administer Duoneb updraft, Lotrisone cream [and] TAO (triple antibiotic ointment)."  e. The Competence to Self Administer Medication form dated 9/20/07 was completed and signed by LPN #4. The form documented that the medications the patient wishes to self administer were Lotrisone Cream and TAO, the Medications will be located in the top drawer, that the resident will read the label, no other equipment is necessary, the resident demonstrates proper technique, and no measuring is necessary. The resident will prepare the medication, the resident voices	F 176		

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F 176	Continued From page 2 understanding and demonstrates proper technique, the nurse will dispose of the empty container, and the nurse will document. "At this time, resident is found competent to perform the task. Will evaluate quarterly and prn (as needed)."  f. The Competence to Self Administer Medication form dated 9/20/07 documented, that the Duoneb updrafts to be kept on the med cart, for the nurse to read and fill the updraft container, for the nurse to read the increments, and the nurse to prepare the medication. The resident demonstrates proper technique of turning the machine on/off, bagging, nurse to change tubing per protocol, nurse to dispose of equipment, and nurse to document on the MAR (Medicine Administration Record). "At this time, the resident found competent to perform task. Will evaluate quarterly and prn " Signed by LPN #4. As of 3/28/08 this was the most recent Competence to Self Administer Medication assessment in the clinical record.  g. A Mental Status Questionnaire form dated 9/20/07 documented that the resident had one answer in error out of ten. On the scoring scale of the instrument, 1-2 errors = "intact mental function. "  h. The Arkansas Department of Health and Human Services Evaluation of Medical Need Criteria (Form DHHS-703) dated 12/21/07 and signed by the MD (medical doctor), and a RN (registered nurse) documented reason for Hospitalization, "Major Depression, severe with suicidal ideation, recurrent episode. " Transferring "Bed to chair with help of another person or persons. Vision, "limited" was checked	F 176			

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F 176	Continued From page 3 and "other - macular degeneration" was filled in.  i. On 3/26/08 at 4:07 p.m., the resident stated that he cannot read anymore and seldom uses the phone because he cannot see well enough. The resident was asked about the updraft mouthpiece that was lying unbagged on the night stand. The resident stated that "A guy comes in at 5 a.m. ... to get it (updraft) ready for me to use at my convenience. I do it (updraft) when the nurse sets it up. " The resident was asked how many times a day was the updraft set up. The resident stated, "In the morning, then about 4:30-ish, and at bedtime ...3 times a day." The resident was then asked if anyone had given him a refresher course in the use of the updraft machine, the resident stated, "No...I have no problems with the updraft."  j. On 3/27/08 at 11:24 a.m., the resident retrieved 2 containers from the night stand. One container was a tube of Clotrimazole 1.0 - 10.5 % cream/gm (gram) and a container of Ketoconazole 2% shampoo. The resident stated that he was unable to read the label of the Clotrimazole because he had macular degeneration. The directions on both labels were in large print. The resident stated that the nurse originally provided education for the use of both medications, but had not since then.  k. On 3/27/08, at 5:00 p.m., the clinical record was reviewed and no interdisciplinary note was found in the chart indicating that an interdisciplinary team was involved in the assessment allowing the resident to self administer medications. The 2/05/08 RAPs (Resident Assessment Protocols) summary did	F 176			

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F 176	<p>Continued From page 4</p> <p>not have "Visual Function" triggered and the care plan contained no vision-related problems, goals, or approaches. The Care plan dated 2/06/08 also contained no self-medication problems, goals, or approaches.</p> <p>l. On 3/27/08 at 5:30 p.m. the ADON (Assistant Director of Nursing) stated, "I wasn't aware that [Resident #15] had a problem seeing until you said this".</p> <p>m. On 3/28/08 at 3:10 p.m., the DON (Director of Nursing) stated that she did not know that [Resident #15] had any vision problems.</p> <p>2. Resident #6 had diagnoses of Chronic Obstructive Pulmonary Disorder, Fibromyalgia, Dementia, Cerebral Infarct, CVA (Cardiovascular Accident) with Right hemiparesis, Chronic Urinary Tract Infection, Depression, Shortness of Breath, Chronic Cellulites, and Shingles. The Annual MDS dated 1/28/08 documented the resident had modified independent cognitive skills for daily decision making, was usually able to understand, had impaired vision which was corrected with glasses, required extensive assistance of two or more people with bed mobility, was dependent with transfers, and locomotion with the assist of one staff member, had full loss of limitations in range of motion on one side, was able to perform tasks/activities but was very slow, and was unable to lie flat due to shortness of breath. .</p> <p>a. A Competence to Self Administer Medication form dated 5/9/07 documented, patient's wish to self administer Duoneb updraft, and the nurse to read the label, put the medication in the updraft machine, measure and fill the container.. The form also documented that the resident</p>	F 176			

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F 176	Continued From page 5 demonstrated proper technique of turning the machine on and off, bagging the inhaler. (inhaler), nurse to change the tubing per protocol, Nurse to dispose of equipment, and nurse to document on the Med Sheet. Evaluator summary documented, "At this time, the resident competent to perform task, will evaluate quarterly and as needed. Signed by LPN #4.  b. A Physician's Telephone Order dated 5/9/07 documented that the resident can self administer Duoneb updraft; nurse will keep on cart and fill container as ordered. The order was signed 5/23/07.  c. A Nurse's Note dated 9/10/07 documented, "Mental function remains intact, resident con't. (continues) to be found competent to self admin. Medication' will review qtr (quarterly) [and] prn (as needed). Signed by LPN #4.  d. The Care Plan dated 1/28/08 documented the problem as the resident is safe to self administer, goal resident will successfully self administer updraft treatments without complications during the next 90 days. Approaches include the Interdisciplinary Team met and determined resident is mentally and physically capable of self administration of updraft tx's (Treatments), resident demonstrates and verbalizes competency quarterly and prn, medication to be held in med cart, medication to be signed off/out by nurse post administration, re-evaluate quarterly and prn. As of 3/28/07 no documentation was found in the clinical record regarding the Interdisciplinary Team meeting, or quarterly or prn assessments since 9/10/07.  e. Physician's Orders sheet for March 2008	F 176			

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F 176	Continued From page 6 documented, " Duoneb updraft, po qd prn "resident can self administer; nurse will keep meds on cart and fill container as ordered."  f. On 3/25/08 at 1:13 p.m. the resident was in bed with the head of bed elevated about 40 degrees. The resident turned the updraft machine on to give a breathing treatment. At 1:17 p.m. the resident turns the updraft off and returns mouth piece to area near the machine.  g. On 3/25/08 at 4:53 p.m., the resident activated the call light. When CNA (Certified Nursing Assistant) #2 responded, the CNA immediately asked the resident, "Need your updraft?" The resident stated, "It's unplugged." The CNA stated, "Let me plug it in." [The Updraft comes on after it is plugged in]. The resident stated, "Thank you," and proceeds with the updraft treatment.  h. On 3/26/08 at 2:16 p.m., CNA #6 stated that when she assisted the resident #6 with changes or had to put the head of the bed down or if the resident #6 has trouble breathing the resident will use the updraft. On an average, the resident uses the updraft about 2 times a shift. The machine is in the residents room all the time and the resident puts the mouthpiece in the Ziploc (plastic) bag at times. If not, the CNAs do it for the resident.  i. On 3/28/08 at 1:13 p.m. CNA #7 stated that the resident uses the updraft about 2 times on a 7 to 3 shift. "[Resident #6] starts it, lets it run for a few minutes, and turns it off."  j. The Medication Administration Record for March 2008 documented, administration of Duoneb Update PO QD prn ... resident can self	F 176			

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F 176	Continued From page 7 administer; nurse will keep meds on cart and fill container as ordered ... Dates were filled in with nurses' initials 3/1 through 3/6, 3/8 through 3/19, and 3/22. Blocks were not filled in for 3/7, 3/20, 3/21, and 3/23 through 3/28, which is the date it was copied by surveyor at 2:10 p.m.  k. On 3/28/08 at 2:42 p.m., the resident declined to answer surveyor's questions for the day after the second attempt. The mouthpiece for the resident updraft machine was sitting in the top drawer of the resident's bedside table. The opening of the mouthpiece was aimed upward and it was not covered or bagged.  l. On 3/28/08 at 2:45 p.m., the resident significant other stated that the resident uses the updraft 3 to 4 times per day, but a waiver was signed so the resident could use the updraft alone.	F 176			
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that medication administration was completed per physician orders and manufacturers recommendation for administration for 1 case mix residents (Residents #6) of 3 (Resident #6, #7, and #15) case mix residents who had physician orders for self administered medications, and failed to ensure that ice cream was served during	F 282			

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F 282	Continued From page 8 lunch and supper for 1 (Resident #7) of 1 (Resident #7) case mix residents that had Physician's Orders for ice cream at lunch and supper. The failed practices had the potential to affect 4 residents in the facility that had physician's order for self administration of medication as documented on a list provided by the Director of Nurses on 3/28/08 at 11:15 a.m., and 7 residents in the facility with physician's orders for ice cream to be served with lunch and supper as documented on a list provided by the Director of Nurses on 3/28/08 at 11:15 a.m. The findings are:  1. Resident #6 had a diagnosis of Chronic Obstructive Pulmonary Disorder. The Annual MDS dated 1/28/08 documented the resident had modified independent cognitive skills for daily decision making, was usually able to understand , had impaired vision which was corrected with glasses, had full loss of limitations in range of motion on one side, was able to perform tasks/activities but was very slow, and was unable to lie flat due to shortness of breath.  a. The Care Plan dated 1/28/08 documented the problem as the resident is safe to self administer, goal resident will successfully self administer updraft treatments without complications during the next 90 days. Approaches include the Interdisciplinary Team met and determined resident is mentally and physically capable of self administration of updraft tx's, resident demonstrates and verbalizes competency quarterly and prn, medication to be held in med cart, medication to be signed off/out by nurse post administration, re-evaluate quarterly and prn.  b. Physician's Orders sheet for March 2008 for	F 282		

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F 282	<p>Continued From page 9</p> <p>Duoneb updraft, po (by mouth) qd (every day) prn (as needed) "Resident can self administer; nurse will keep meds on cart and fill container as ordered."</p> <p>c. On 3/25/08 at 1:13 p.m., the resident was in bed with the head of bed elevated about 40 degrees. The resident turned the updraft machine on to give a breathing treatment.</p> <p>d. On 3/25/08 at 1:17 p.m., the resident turned the updraft off and returned the mouth piece to area of machine.</p> <p>e. On 3/25/08 at 4:53 p.m., the resident activated the call light. When the CNA (Certified Nursing Assistant) #2 responded, the CNA immediately asked the resident, "Need your updraft?" The resident stated, "It's unplugged." The CNA stated, "Let me plug it in.". The resident stated, "Thank you," and proceeded with the updraft treatment.</p> <p>f. On 3/26/08 at 2:16 p.m., CNA #6 stated that when she assisted the resident with changes or had to put the head of the bed down or if the resident had trouble breathing, the resident would use the updraft machine. The CNA also stated that the resident uses the updraft machine about 2 times a shift. The machine is in the resident's room all the time and the resident puts the mouthpiece in the Ziploc (plastic) bag at times. If not, the CNAs does it for the resident.</p> <p>g. On 3/28/08 at 1:13 p.m., CNA #7 stated that the resident uses the updraft about 2 times on a 7 to 3 shift. The CNA stated that [Resident #6] "starts it, lets it run for a few minutes, and turns it off."</p>	F 282			

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F 282	Continued From page 10  h. On 3/28/08 at 2:45 p.m., the resident's significant other stated that [Resident #6] uses the updraft 3 to 4 times per day, but had signed a waiver so that the updraft machine could be used without assistance.  i. The Medication Administration Record for March 2008 documented administration of Duoneb Update PO (as needed) QD (every day) prn ... resident can self administer; nurse will keep meds on cart and fill container as ordered. The MAR documented that the medication had been administered one time on 3/1 through 3/6, 3/8 through 3/19, and 3/22, indicated by the nurse initials. Blocks that were not filled in for 3/7, 3/20, 3/21, and 3/23 through 3/28, indicated by no nurse initials.  j. On 3/28/08 at 2:45 p.m., the resident's significant other stated that [Resident #6] uses the updraft 3 to 4 times per day, and had signed a waiver so that the updraft machine could be used without assistance.  2. The web page, < <a href="http://www.webmd.com/drugs/drug-21156-DuoNeb+Inhl.aspx?drugid=21156&amp;drugname=DuoNeb+Inhl">http://www.webmd.com/drugs/drug-21156-DuoNeb+Inhl.aspx?drugid=21156&amp;drugname=DuoNeb+Inhl</a> > documented:  "How to use DuoNeb Inhl ... This medication is used with a special machine called a nebulizer. Consult your healthcare professional for how to properly use the nebulizer and read the manufacturer's instructions. ... Inhale this medication into your lungs using the nebulizer and mouthpiece/face mask, usually 4 times a day or as directed by your doctor. ... Each treatment should last about 5-15 minutes. Rinse your mouth	F 282		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045376</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/28/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHERWOOD NURSING &amp; REHABILITATION CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>245 INDIAN BAY DRIVE SHERWOOD, AR 72120</b>		
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F 282	Continued From page 11 after treatment to prevent dry mouth and throat irritation. ... Use this medication exactly as prescribed. Remember to use it at the same times each day. ... Dosage is based on your medical condition and response to therapy. "  3. Resident #7 had a diagnosis of Weight Loss unintended. The quarterly MDS dated 12/18/07 documented the resident had independent cognitive skills for daily decision making and had no weight change in the last 30 days.  a. A Physician's Order dated 9/7/07 documented Diet Mechanical Soft- Ice Cream With Lunch and Supper.  b. On 3/25/08 at 12:20 p.m. the resident was observed eating lunch. There was no ice cream on the lunch tray,  c. On 3/25/08 at 5:28 p.m., the supper tray was brought to the resident. There was no ice cream on the supper tray.  d. On 3/25/08 at 6:10 p.m., the resident was asked about the ice cream. The resident stated,"I would eat ice cream if they gave it to me."  e. The Resident ' s clinical record documented the weight for March 2008 as 181.8 pounds. The weight documented for February 2008 was 187.2. This was a 2.8 percent weight loss for 1 month.	F 282			
F 309 SS=E	483.25 QUALITY OF CARE  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309			

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F 309	Continued From page 12 and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure that catheter tubing was secured for 2 (Resident #10 and #13) of 2 (Resident # 10 and #13) case mix residents that had indwelling urinary catheters. This failed practice had the potential to affect 4 residents in the facility that had indwelling urinary catheters as documented by a list provided by the Director of Nursing on 3/28/08 at 11:15 a.m. The findings are.  1. Resident # 10 had a diagnosis of bladder spasms. The annual Minimum Data Set (MDS) dated 12/24/07 documented the resident had moderately impaired cognitive skills for daily decision making, and had an indwelling catheter.  a. On 3/25/07 at 12:00 p.m., Certified Nursing Assistant (CNA) #3 and CNA #4 performed catheter care for the resident. The tape on the catheter to secure it to the resident's leg had come loose. The catheter tubing was not secured in any way. The catheter tubing was under the resident's right leg. The resident's groin area and the catheter insertion site was cleansed, but the catheter tubing was not cleansed. The resident was turned over to a side laying position, with the catheter unsecured, and was found to have bowel incontinence. After the CNAs had finished cleansing the resident, they removed the tape that was stuck to the catheter. The CNAs then lifted the resident up in bed while the catheter was still unsecured.	F 309			

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F 309	Continued From page 13  b. On 3/25/07 at 3:50 p.m., CNA #5 was asked to check the resident's catheter. The CNA pulled back the covers on the resident's bed. The catheter tubing was not taped or secured in any way. CNA # 5 stated, "Have this hall every day, don't know why it's not taped. I don't think it is suppose to be taped, is it?"  c. The Overall Plan of Care dated 12/24/08 documented, "Indwelling Catheter: Risk For Complications ... Son doesn't want catheter strap wants silk tape to secure catheter to leg."  d. The Catheter Care, Urinary Procedure provided by the Director of Nursing on 3/28/08 at 11:15 p.m. documented, "Clean catheter tubing starting at the urethra opening and clean in direction of catheter bag."  2. Resident #13 had a diagnosis of Chronic Urinary Tract Infection. the Quarterly MDS dated 1/3/08 documented the resident had moderately impaired cognitive skills for daily decision making.  a. On 3/24/08 at 3:12 p.m., the Director of Nursing was asked to assess the resident to make sure the foley catheter was secured. A portion of a catheter strap was present on the catheter tubing, but the catheter tubing was not secured in any way. The catheter tubing was coiled up under a blanket.	F 309		
F 322 SS=E	483.25(g)(2) NASO-GASTRIC TUBES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea,	F 322		

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F 322	<p>Continued From page 14</p> <p>vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure Percutaneous Enteral Gastrostomy (PEG) tube placement was checked before administering a bolus feeding and/or medication administration for 1 (Resident #5) and failed to ensure to administer bolus feeding per gravity for 2 (Residents #5 and 12) of 4 (Residents #2, #5, #9, and #12) case mix residents who received their nutrition and/or medications through a PEG tube. This failed practice had the potential to affect 8 residents in the facility who had a PEG tube as documented on the Residents Census and Conditions of Residents form dated 3/24/08. The findings are:</p> <p>1. Resident #5 had diagnosis of Gastrostomy Status and Hypokalemia. The Quarterly Minimum Data Set (MDS) dated 2/22/08 documented the resident had severely impaired cognitive skills for daily decision making, was totally dependent on staff for all of the activities of daily living, and had a feeding tube.</p> <p>a. The Physician order sheet for March 2008 documented for Jevity 1.5 two cans bolus BID at 8:00 a.m. and 8:00 p.m., and 1 can bolus at 12:00 p.m., and 5:00 p.m.. ... flush G-Tube with 200 cc (cubic centimeters) H2O (water) Q (every) 4 hours ... flush with 60 cc H2O before and after meds.</p> <p>b. On 3/25/08 at 11:55 a.m., LPN (Licensed</p>	F 322		

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F 322	<p>Continued From page 15</p> <p>Practical Nurse) # 2 accessed the resident's PEG tube and flushed with 60cc of water followed by her medications dissolved in 15cc's of water followed by 1 can of Jevity 1.5 feeding supplement thinned with approximately 200cc's of water and flushed with 60cc of water again to clear the tube. LPN #2 did not check the PEG tube for placement before initiating the flushing of the tube. LPN #2 made no attempt to gravity feed the medication or feeding supplement. A plunger was used with the feeding syringe and pushed in approximately 25 seconds.</p> <p>2. Resident #12 had diagnoses of Gastrostomy Status, Vitamin B12 Deficiency, and Anemia. The Quarterly MDS dated 12/26/07 documented the resident was severely impaired in cognitive skills for daily decision making, was bedfast, and required extensive assistance for all activities of daily living, and had a tube feeding.</p> <p>a. The Physician order sheet for March 2008 documented for jevity 1.5 via pump 40 cc [per] HR (hour) ... flush [with] 200 cc H2O Q 8 HRs and flush with 60 cc H2O before and after meds.</p> <p>b. On 3/27/08 at 11:15 a.m., LPN #3 crushed the resident ' s medicine and dissolved them in water. The LPN checked for tube placement and flushed the PEG tube with 60cc of water, then administered the medications followed by 60cc of water quickly with the plunger in the feeding syringe. LPN #3 did not attempt to gravity feed.</p> <p>3. According to Stat Facts the Clinical Pocket Reference for Nurses, Copyright 1996 by F. A. Davis Company documented on page 195 Tube Feeding, Nasogastric or Gastrostomy. #8. Place bulb syringe into the end of the tube and pour</p>	F 322		

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F 322	Continued From page 16 formula slowly into the syringe barrel, keeping it full to prevent air from seeping into the stomach. #9. Regulate rate of formula administration by adjusting the height of the syringe. Allow the formula to flow by gravity.	F 322			
F 323 SS=E	4. The facility Policy and Procedure entitled 'Enteral Feedings, Checking Tube Placement', documented under Procedure #6. Tube placement will be verified at least once per shift or prior to administering intermittent feedings or medications via the tube.  483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that doors were free of gouges with splinters. This failed practice had the potential to affect 4 of 24 residents on 400 Hall based on the resident list received from Director of Nursing on 03/24/08. The facility failed to ensure a residents full body weight was not supported by the axilla and the back of a residents pants during a transfer to prevent the potential for injury for 1 (Resident #2) of 4 case mix residents (Residents #12, #4, #6, and #9) who required assistance with transfers. This failed practice had the potential to affect 18 residents in the facility that required the assistance of 2 staff members for transfers as	F 323			

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F 323	Continued From page 17 identified on a list provided by the Director of Nursing on 3/28/08 at 11:00 a.m. The facility also failed to ensure that a bottle of sore throat spray was not left by the door in a resident's room. This failed practice had the potential to affect 13 residents who were cognitive impaired/confused and mobile per ambulation or wheel chair according to a list provided by the Director of Nursing on 3/28/08 at 11:15 a.m. The findings are:  1. On 2/25/08 at 9:40 a.m., the door to room #414 and room # 406 on the 400 hall, had splinters in the gouge areas located on the left side of the both doors approximately 18 inches from the floor and 1 1/2 inches in length.  2. Resident #2 had diagnoses of Encephalopathy, Alzheimer ' s Dementia, and Osteoporosis. The Quarterly Minimum Data Set (MDS) dated 10/19/08 documented the resident had severe impaired cognitive skills of daily decision making, required, limited assistance of one person for transfers, bed mobility, and activities of daily living, had partial loss and limitations in range of motion in legs and feet on both sides and had repetitive physical movements was exhibited up to 5 days a week.  a. On 3/27/08 at 12:40, LPN #1 and CNA #1 performed a transfer for the resident from a wheelchair to the bed. The two staff members stood on either side of the resident, placing their arms under the residents armpits then grabbing the waist band of the residents pants and then lifting the resident full body weight during the transfer. The left lateral aspect of the resident's left lower extremity made contact with the bed rail that had been lowered for the transfer. As CNA	F 323			

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F 323	Continued From page 18 #1 left the room, the CNA verbally acknowledged that she had performed the transfer inappropriately.  b. The facility ' s Policy and Procedure entitle ' Transfer Activities Policy ' documented, "Do not support the patient under the arms as this prevents the patient from using his/her unaffected extremity."  3. On 3/25/08 at 12:50 p.m. a bottle of Top Care Sore Throat Spray was on the bedside table next to the door of room 200. The label on the bottle documented, " In case of overdose, get medical help or contact a Poison Control Center right away."	F 323		
F 325 SS=G	483.25(i)(1) NUTRITION  Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure nutritional interventions that were implemented to maintain nutritional parameters were assessed for its effectiveness and/r revised for 1 (Resident #8) of 4 (Resident's #1, #2, #3, and #9) residents who	F 325		

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F 325	Continued From page 19 experienced severe weight loss. This failed practice resulted in actual harm to Resident #8 who had a severe weight loss and had the potential to affect 17 residents in the facility who had an unplanned significant weight loss as documented on the Resident Census and Conditions of Residents form dated 3/24/08. The findings are:  1. Resident #8 had diagnoses of Unintended Weight Loss, Vitamin D Deficiency, and Anemia. The Quarterly Minimum Data Set dated 3/3/08 documented the resident was moderately impaired in cognitive skills for daily decision making and required limited assistance for activities of daily living, requires supervision with meals and had weight loss of 5% in last 30 days or 10% in last 180 days.  a. The care plan dated 12/03/07 and revised 3/3/08 documented, " Problem: Resident is at risk for weight loss [due to] Dementia ... Approaches ... Megace as ordered ... monthly weights as ordered ... Monitor appetite and record % of amount eaten at all meals ... "  b. The Physician's order sheet for March 2008 documented Megace 400 mg Liquid give 10cc PO (by mouth) AC (before meals)".  c. The Dietary Progress Notes dated 1/10/08 documented by the Registered Dietician (RD) documented the nutritional parameters of this resident as needing 1339 KCal (Kilo Calorie) to maintain weight, 41-51 grams of protein and 1538 cc (cubic centimeters) fluid daily. The RD observed a meal with no chewing or swallowing problems and documented that the resident received Megace. The RD recommended that	F 325			

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F 325	Continued From page 20 the resident's diet be changed to Super Cal and to provide help with feeding.  d. The facility Weight audit form dated March 2008 documented that the resident had experienced a 19.16% weight loss in the last 6 months, and a 6.29% weight loss in the last month..  e. The facility Weekly weight form for this resident documented weekly weights for January 2008 thru March 2008. Week one for each month documented the residents weight as: January 2008; weight was 115.4, February 2008; weight was 110.2 and March 2008; weight was 106.3 and today ' s weight 3/28/08 103.9. This is a 9.9 % weight loss in the last three months.  f. The Dietary progress note date 1/10/08 documented, To [change] diet to Super Cal and provide help [with] feeding.  g. A Physician order date 1/11/08 documented to change diet to Super Cal.  h. The Meal Consumption record for January 2008 documented the resident was eating on an average less than 50% of her meals. In February 2008 approximately the same was consumed. In March 2008 an average of approximately 25% was consumed at each meal. On 3/25/08 during the 12:00 meal observations, the resident ate 10% or less at noon and nothing for supper. The Meal Consumption form for January 2008 had 12 spaces without documentation. The Meal Consumption form for February 2008 had 13 spaces without documentation and the Meal Consumption form for March 2008 had 17 spaces unaccounted for through 3/26/08.	F 325			

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F 325	Continued From page 21  i. A Dietary Progress Notes dated 2/27/08 documented by the RD documented a 3.58% weight loss from January to February. The RD recommendation was for staff to discuss with any family to see if they had some suggestions.  j. A Dietary Progress Notes dated 3/14/08 documented by the RD documented a 6.29% weight loss from February to March. The RD recommended that a tube feeding be considered if the resident continues to refuse to eat.  k. On 3/26/08 at 3:00 p.m., the dietician was asked if the resident received a snack, she stated, no, if she isn't on my list she doesn't get one.  l. On 3/27/08 at 1:35 p.m., the Director of Nursing (DON) was asked if the weight loss of the resident had been discussed at their weight loss meetings this month. The DON stated, "Yes, but it wasn't documented". The DON was asked if she had spoken to the family about a feeding tube. The DON stated, "I privately talked to the family in January about a feeding tube. At that time they did not want a feeding tube because they thought she would come around again after she got to feeling better". The DON was asked have you talked to the family since 3/14/08 about a feeding tube. The DON stated, "No, I haven't talked to them about that since January".  m. On 3/28/08 at 1:55 p.m., after review of the clinical record, no documentation was found to indicate that the family had been consulted about the resident's likes and dislikes. There was no	F 325			

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F 325	Continued From page 22 documentation of a reassessment to see if the interventions put in place were successful, and no further interventions documented since 1/10/08.	F 325		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. medication pass, record review and interview the facility failed to follow Physician ' s orders to ensure residents were free of significant medication errors for 1 (Resident #3) case mix resident of 5 residents observed during the medication pass . This failed practice had the potential to affect 77 residents currently receiving medications in the facility as identified by the DON on 3/28/08. The findings are:  1. Resident #3 had diagnosis of Coronary Artery Disease, Arrhythmia, Myocardial infarction, and Hypertension.  a. A Discharge Medication sheet for [hospital] dated 3/21/08 documented for Coumadin 1 mg (milligram) PO (by mouth) Daily - Nursing Home to Monitor PT/INR (Protime/ International ratio) daily.  b. On 3/25/08 during record review following observation of the 8:00 a.m. medication pass the omission of the Coumadin order was discovered. The handwritten admission orders dated 3/21/08 omitted the Coumadin order.  c. On 3/25/08 the ADON (Assistant Director of	F 333		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045376</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/28/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHERWOOD NURSING &amp; REHABILITATION CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>245 INDIAN BAY DRIVE SHERWOOD, AR 72120</b>		
(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 333	Continued From page 23 Nursing) verbally acknowledged writing the admission orders and the omission of the order for Coumadin 1 mg in error. The Medication Administration Record for March 2008 did not document an order for the administration of Coumadin and had not been administered to the resident on 3/21/08, 3/22/08, 3/23/08 and 3/24/08.	F 333			
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure food was palatable and hot and cold foods served at an acceptable temperature for the residents. This failed practice had the potential to affect 75 residents in the facility who take meals from the kitchen. The findings are.  1. On 3/26/08 the menu documented Chili for all residents. At 10:30 a.m., the Chili had been prepared and had been placed on the back burner of the stove simmering under low heat. Cook #1 was asked why the Chili had been prepared so early if it was to be served for the scheduled 12:00 meal. She said, " We have to hurry up and get it done so we can feed the	F 364			

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F 364	<p>Continued From page 24</p> <p>heads in the special dining room at 11:00. "</p> <p>2. On 3/26/08 at 11:48 a.m., Cook #1 blended food for the pureed diets and prepared food from the stove and placed it on steam table #1 at 12:06 p.m.</p> <p>Three carts were served from the steam table, the Bistro Dining rooms 1 and 2 and a third cart for residents who eat in their rooms. The first Bistro cart was sent out at 12:18 p.m., the second Bistro cart went out of the kitchen at 12:28 p.m., and the third cart left the kitchen at 12:41 p.m.</p> <p>3. On 3/26/08 at 12:41 p.m., 1 CNA (Certified Nursing Assistant) was assigned to serve the trays from the third cart. This cart contained food for all residents who eat in their rooms.</p> <p>4. On 3/26/08 at 1:08 p.m., the last tray was removed from the cart and the temperature of the food was tested with the facility's thermometer. The Chili was 125 degrees, the Baked Potato was 120 degrees wrapped in foil. The foods when they were on the steam table when checked at 12:06 p.m. was: the Chili was 205 degrees and the baked Potato was 200 degrees. The jello was partially melted and the bowl of salad was warm. The Dietary Manager said that she started placing hot bricks in the bottom of the food cart to keep the food warm but it melts the Jello.</p> <p>5. On 3/27/08 at 7:16 a.m., at the breakfast meal, the temperature of the on the steam table was eggs were 165 and hot cereal was 171 degrees. At 8:08 a.m., the temperature of the hot cereal on the test tray was 99 and the eggs were 87 degrees.</p>	F 364			

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F 364	Continued From page 25  4. On 3/27/08 after review of the Resident Council Meeting minutes documented the following:  a. The Resident Council Meeting Minutes for January 10, 2008 documented that the resident complaints about the food was as follows:  The eggs and oatmeal are cold.  Sometime the food is barely touched.  Why can't we get hot food if we choose to eat in our room. It's our choice if we want to eat in our room.  They would like the Dietary Manager to meet with them.  b. The Resident Council Meeting Minutes for 2/14/08 documented that the resident complaints about the food was as follows:  The food is still not warm, and the Toast is only warm bread.  Resident commented that they wanted Cobblers more often.  5. On 3/25/08 at 9:15 a.m., during the Residents Group Meeting 9 alert and oriented residents complained that the food was late and cold and that they were having too many sandwiches. They also said that the warm bricks that were placed at the bottom of the food cart to keep the food warm also gets the cold food warm.  6. On 3/25/08 at 1:30 p.m., the Dietary Manager	F 364			

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F 364	Continued From page 26 was asked if she had met with the residents concerning their complaints on cold food and late meals. She said she had met with them. She said she placed warm bricks at the bottom of the food cart that transport trays to residents rooms. She said she started cooks preparing soups from scratch and she said she would try to get some to the sandwiches.  7. On 3/27/08 at 10:15 a.m., the Administrator was asked if she had been informed about the cold food and the late meals and what had she done about it. She said Yes, I told [Dietary Manager ' s name] that she needed to get the food out to the residents hot. The Administrator was again asked what she had done to see that the food was served timely and hot to the residents in their rooms. She said, I told [CNA supervisor ' s name] that she needed to see to it that the food got out hot to the residents.	F 364		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that raw meat was not stored above other foods and dietary staff did not take their breaks and eat in the storage area of the kitchen to prevent the potential for contamination of products stored there. The failed practice had the potential to affect 71 residents who take their meals from the kitchen as identified by the Dietary Roster dated	F 371		

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F 371	Continued From page 27 3/25/08. The findings are.  1. On 3/24/08 at 2:00 p. m. during the initial tour 2 large zip lock bags of raw chicken was stored on the third shelf in the walk in cooler above a pan of bacon.  2. On 2/24/08 at 2:10 p.m., 3 chairs were in the storage room. On the shelf next to the chairs was an open can of Sprite, and an open package of peanut butter snack crackers with 2 uneaten crackers left in the package.  3. On 3/26/08 at 2:45 p.m., the Dietary Manager was asked if the dietary staff eat and take their breaks in the storage room. She said Yes.	F 371			