

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

PRINTED: 06/02/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/21/2008
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NAME OF PROVIDER OR SUPPLIER SHERWOOD NURSING & REHABILITATION CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 245 INDIAN BAY DRIVE SHERWOOD, AR 72120
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(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
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{F 282} SS=D	<p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that a resident received fortified foods as per physician orders for 1 (Resident # 6) of 3 case mix residents (Resident #1, 6 and 9) who had physician orders for fortified foods and were at risk for weight loss. The failed practice had the potential to affect 8 residents in the facility that had dietary orders for fortified foods and were at risk for weight loss according to a list provided by the Director of Nursing (DON) on 5/21/08. The findings are:</p> <p>1. Resident #6 had diagnosis of Alzheimer's Dementia, Diabetes Mellitus, Vitamin Deficiency, and Osteoporosis. The annual MDS dated 4/29/08 documented that resident had severely impaired cognitive skills for daily decision making, had a weight loss (of 5% in last 30 days or 10 % in last 180 days) and had a therapeutic diet.</p> <p>a. The Resident's Overall Plan of Care dated 4/29/08 documented, "Resident at risk for weight loss ... Has lost weight in the last 30 - 180 days ... Rsd (resident) will not have further weight loss during this plan of care. ... Approach #10 ... Super potatoes with lunch and supper."</p> <p>b. A Physician's Telephone Order dated 5/8/08</p>	{F 282}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 282}	Continued From page 1 documented, "1- D/C (discontinue) small portions/Resume [regular no concentrated sweets] diet. 2 - Add super potatoes [at] lunch [and] supper." c. The supper meal card dated 5/20/08 documented the resident was to receive large portions and super potatoes. d. On 5/20/08 at 5:15 p.m., during the supper meal the resident was served, 2 pieces of fried fish, french fries, 2 hush puppies, tomato slices, tomato juice, Health Shake and iced tea. The resident did not receive super (fortified) potatoes and did not receive a dessert. The resident was picking at her food and resistant to being fed. She drank her juice with ease from a straw. The meal card and tray was shown to the DON (Director of Nursing) and she stated, "I'll go get some." The DON went to the kitchen and brought a dish of super potatoes and then went back to get a dish of the fruit cocktail that was served for dessert.	{F 282}			
{F 323} SS=D	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, record review and interview the facility failed to ensure supervision	{F 323}			

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{F 323}	Continued From page 2 was provided during the administration of an updraft treatment for one (Resident # 9) of 4 case mix resident (Residents # 4, # 5, # 9 and # 10) that had physician order for nurse to administer an updraft treatment. The failed practice had the potential to affect 13 residents in the facility that had physician orders for updraft treatments according to a list provided by the Director of Nursing on 5/21/08. The findings are: 1. Resident # 9 had diagnoses of Cancer of Prostate and COPD (Congestive Obstructive Pulmonary Disease). The Significant Change Minimum Data Set dated 5/3/08 documented the resident had severely impaired cognitive skills for daily decision making, and received oxygen therapy. a. A Physician order dated 5/2/08 documented, Duoneb 2.5/0.5 updraft q (every) 4 hours while awake and a physician order dated 4/9/08 documented, DC ' d (discontinued) self administration of meds (medications), Nurse to administer. b. On 5/19/08 at 3:23 p.m., the resident was sitting in a wheelchair, with the updraft machine on and the mouthpiece with positioned in the resident ' s mouth. There was not a nurse in the room or the hallway. At 3:28 p.m., the resident leaned forward and laid the mouth piece on the over bed table and turned the updraft machine off. The resident was asked how often the updraft was used. The Resident stated, "4 times a day." The resident was asked if the Nurse helped during the updraft treatment. The Resident stated, "I do it by myself." The resident was asked if he used all the medication during the treatment. The resident stated, "No I don't use it	{F 323}			

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{F 323}	Continued From page 3 all, I use it later. I turn the machine on by myself." c. On 5/19/08 at 3:45 p.m., the Assistant Director of Nursing checked the chamber of the Updraft Machine, and there was clear fluid left in the chamber. The clear substance was measured, and the chamber contained approximately 2.0 ml (milliliters) of clear substance. The manufacturers label documented that the Duoneb dose is 3 ml. d. On 5/19/08 at 3:50 p.m., the 3-11 LPN (Licensed Practical Nurse) # 1 stated that she had not put the medication in the updraft. The LPN stated that the resident ' s updraft was due at 4:00 p.m. LPN #1 was then asked when the last scheduled updraft was due to be administered for the resident. LPN # 1 stated, " 12:00 p.m. "	{F 323}			