

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

PRINTED: 08/08/2006
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 C 07/28/2006
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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F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>Complaint #11821, unsubstantiated.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and record review, the</p>	F 164		

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 164	Continued From page 1 facility failed to ensure privacy was provided during a body audit for 1 (Resident #7) of 3 case mix residents on the 100 Hall (Resident #1, 4 and 7) who required assistance with dressing. This failed practice had the potential to affect 21 residents who resided on the 100 Hall as identified by the Director of Nursing on 7/27/06. The findings are: Resident #7 had a diagnosis of Cerebral Vascular Accident with Right Hemiparesis. The Quarterly Minimum Data Set dated 6/9/06 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive assistance of one person for dressing. a. On 7/25/06 at 2:52 p.m., a body audit was conducted. CNA (Certified Nursing Assistant) #1 removed the resident's top, exposing the residents bare chest and arms. The curtain was not drawn. LPN (Licensed Practical Nurse) #1 came into the room to apply a medicated ointment to the resident's skin. The LPN drew the curtain around the resident after seeing the resident was exposed.	F 164			
F 170 SS=C	483.10(i)(1) MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to ensure the mail was delivered on Saturdays. This failed practice had the potential to affect all 73	F 170			

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F 170	Continued From page 2 residents. The findings are: 1. On 7/25/06 at 2:00 p.m., during the group interview, the group stated that they did not receive mail on Saturdays. 2. On 7/25/06 at 6:00 p.m., the Administrator stated the mail was delivered on Monday through Friday and was held in the post office over the weekend to be delivered on Monday.	F 170			
F 246 SS=B	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the table height was below the level of the chest at meal time for 1 (Resident #2) of 4 case mix residents (Resident #1, 2, 7 and 16) who ate their meals in wheelchairs. This failed practice had the potential to affect 18 residents who ate their meals in a wheelchair as identified by the facility's nurse consultant on 7/27/06. The findings are: Resident #2 had diagnoses of Chronic Lymphatic Leukemia, Weight loss and Generalized Weakness. The Quarterly Minimum Data Set dated 6/17/06 documented the resident was moderately impaired in cognitive skills for daily decision making and required limited assistance	F 246			

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F 246	Continued From page 3 of one person for eating. a. On 7/25/06 at 5:33 p.m., 7/26/06 at 5:24 p.m. and 7/27/06 at 7:22 a.m. the resident was sitting in a wheelchair in the dining room at the assist table on the left side of dining room which borders the 300 hall eating her meal. The resident had to raise her arms and reach up approximately 4 to 6 inches to reach her food. The resident's chin was approximately 2 inches from the table top.	F 246			
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure window screens were attached and in good repair, resident equipment was not rusted, the glass in doors was not cracked, thresholds, floors and air vents were not dirty, baseboards were attached to the wall, water faucets did not drip, chairs were clean and floor tiles were not cracked. This failed practice had the potential to affect all 73 residents. The findings are: On 7/24/06 at 10:00 a.m., the following observations were made: a. On the Exterior-100-Hall, Resident Room #114 had one window screen which was bowed at the bottom and partially detached from the window. b. Exterior-200-Hall:	F 253			

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F 253	Continued From page 4 1) Resident Room #200 had one window screen that was bowed at the top and partially detached from the window. 2) Resident Room #205 had one detached window screen and one window screen with an "L" shaped 1 by 3 inch tear in the window. c. Exterior-300-Hall: 1) Resident Room #307 had one detached window screen with the frame broken on the right bottom corner. 2) Resident Room #309 had one partially detached window screen. d. Exterior-400-Hall, in Resident Room #401 and #402 there was a partially detached window screen in each room. e. On the exterior of the dinning room there was 1 partially detached window screen. f. On the 400 Hall at 10:50 a.m.: 1) In the whirlpool room (servicing the #300 and #400 hall) there was a whirlpool lift that had a rusted area at the bottom covering a 1 1/2 by 3 inch area. A commode lift had rust on the front left leg approximately 1/4 thick. 2) The window to the right of the glass exit door had a six inch circular crack on the bottom. The metal threshold of the exit door also had dirty build up across the door's width. g. On the 300 Hall:	F 253			

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F 253	Continued From page 5 1) The exit door had scuff marks six inches below the knob and nine inches from the floor across the width of the door. The molding to the baseboard was concave with dirt and debris underneath. 2) Resident Room #306 had a brownish-gray dirt and wax build up on the floor, in front of the door extending 3 tiles by 5 tiles. 3) The baseboard molding on the right and left entrances to the day room between #300 and #400 hall were detached at the corners. 4) The metal threshold of the exit door had dirt a build up of dirt across the width of the door. h. On the 200 Hall: 1) The shower/bath room servicing the #100 and #200 hall and a dripping faucet which could not be stopped. The first shower on the left, entering from the #200 hall was stained with a brownish-yellow substance across the floor, extending the width of the floor. A commode lift had rust stains on the two rear legs. 2) The baseboard to the left of Resident Room #202 was concave and had dirt and debris underneath. 3) Resident Room #204 had dirt and wax build up at the entrance, 2 tiles by 3 tiles in size. 4) The dining room entrance had one 12 by 12 inch pink, cracked floor tile with a missing 1/2 inch corner and the door jambs had dirt build up on all sides.	F 253			

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F 253	Continued From page 6 i. In the Dinning Room: 1) There were eleven chairs that were stained/spotted with a grayish brown substance. 2) The exit door facing the #200 hall had a pink streak ten inches below the middle hinge and had scuff marks nine inches up the door extending the width of the door. 3) There were two scuff marks (one 7 inches and one 12 inches long) on the wall with the sign which read "Never, Never, Never Give Up". 4) The plastic corner molding to the left of the air conditioning (AC) closet was missing an "L" shaped 3 by 4 inch piece. 5) The door air vents on the two AC closets were covered with dust and dirt. 6) The kitchen door underneath the clock had scuff marks and was dirty. The walls on both sides of the door were scraped and had scuff marks. 7) The red-colored baseboards through out the dinning room were scraped, exposing the light surface underneath.	F 253			
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced	F 323			

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F 323	Continued From page 7 by: Based on observation the facility failed to ensure there were no sharp/jagged edges on doors, walls and furniture and metal hangers were not left in the shower rooms. These failed practices had the potential to affect 15 residents who were independent for mobility in a wheelchair on 300 Hall, 4 residents who routinely sat at the table in the Dayroom between 200 and 300 Halls and 26 residents who were taken into the 300/400 shower room in a chair as documented by the Administrator on 7/26/06. The findings are: 1. On 7/25/06 at 10:30 a.m., the whirlpool room on the 400 Hall had one 2 by 8 inch piece of ceramic tile missing from the bottom right side of the first shower stall, exposing a sharp/jagged edge. 2. On 7/25/06 at 11:27 a.m. the day room between 300 and 400 hall had a table in it which had a 12 inch sharp/jagged area underneath the top surface. 3. On 7/25/06 at 11:29 a.m., in Resident Room #306 there were sharp/jagged edges on the hinge side of the door. 4. Resident #16 had diagnoses of Alzheimer's and Dementia with Behaviors. The Admission Minimum Data Set dated 6/30/06 documented the resident was severely impaired in cognitive skills for daily decision making, wandered and required extensive assistance with all activities of daily living. a. The Incident Accident report dated 7/11/06 at 6:30 a.m., documented the resident was in the	F 323			

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F 323	Continued From page 8 shower room sitting in a wheel chair with a coat hanger hanging out of her left pierced ear. Licensed Practical Nurse #1 assisted in removing the coat hanger without difficulty and there was no bleeding. There was no apparent injury. b. An inservice dated 7/11/06 conducted for all Certified Nursing Assistants on safety hazards documented, "Be certain residents do not enter shower rooms unless accompanied by staff and keep all dangerous items locked or out of reach of residents. Wire hangers should be put away in closet or hung on clothes rack." c. On 7/25/06 at 10:50 a.m., there were two wire coat hangers on a metal hanging rod on the back wall of the 300 and 400 shower room.	F 323		
F 324 SS=E	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: Based on observation, record review and interview, the facility failed to ensure transfers were conducted in a manner to prevent the potential for injury for 2 (Resident #4 and 8) of 4 case mix residents (Residents #1, 4, 9 and 5) who required 2 staff to transfer from wheelchairs. This failed practice had the potential to affect 13 residents in wheelchairs who required two staff to transfer as identified by the nurse consultant on 7/26/06. The findings are: 1. Resident #4 had diagnoses of Osteoarthritis,	F 324		

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F 324	<p>Continued From page 9</p> <p>Parkinson's Disease, Dementia With Behaviors and Hypertension. The Quarterly Minimum Data Set (MDS) dated 6/20/06 documented the resident was moderately impaired in cognitive skills for daily decision making, required limited assistance of one person for transfers, was occasionally incontinent of bladder and usually continent of bowel.</p> <p>On 7/26/06 at 9:09 a.m., the resident was in the bathroom sitting on the commode. After the resident was cleaned up CNA (Certified Nursing Assistant) #1 and 4 stood the resident up by each placing an arm under each of the resident's arms. The resident bent over at the waist and CNA #4 grabbed the back of the resident's pants to steady the resident, then the CNA's pivoted the resident around and sat her down into the wheelchair. The CNA's were asked if they ever used a gait belt when they transferred residents. Both CNA's replied yes. They were also asked if they were suppose to use a gait belt and they said yes.</p> <p>2. Resident #8 had diagnoses of Hypertension, Osteoarthritis, Cardiac Dysthymia, and Dementia. The Quarterly MDS dated 6/2/06 documented the resident was severely impaired in cognitive skills for daily decision making and had limited use of both legs and partial loss of voluntary movement.</p> <p>a. On 7/25/06 at 9:30 a.m., CNA #2 and 3 lifted the resident out of her wheelchair by placing their arms under the resident's arms and lifting the resident up and rotating her to the bed without using the gait belt.</p> <p>b. On 7/26/06 at 2:00 p.m., the Nurse Consultant stated their policy was to use the gait belt when they were transferring residents.</p>	F 324			

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F 324	Continued From page 10	F 324			
F 441 SS=E	<p>c. The facility's Transfer Policy documented that the equipment required was a wheel chair, clean gloves, blanket, and gait belt.</p> <p>483.65(a) INFECTION CONTROL</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation the facility failed to ensure an ice machine was free of mold/mildew. This failed practice had the potential to affect all 73 residents. The findings are:</p> <p>1. On 7/25/06 at 10:50 a.m., the ice machine by the facility vending machines (in short hallway off of Hall 300) had a black, mold/mildew-like substance over the upper left inside corner at the lid hinge and in front of the ice chute. The black substance, that was easily removed with napkin, covered an area that measured approximately 3-4 inches x 1-1.5 inches and was directly over the ice in the machine.</p> <p>2. On 7/28/06 at 9:04 a.m., Registered Nurse #1 stated that all residents received ice from the ice</p>	F 441			

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F 441	Continued From page 11 machine.	F 441			
F 463 SS=E	<p>483.70(f) RESIDENT CALL SYSTEM</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure the call lights in the resident showers were functioning. This failed practice had the potential to affect 35 residents who used the 100 and 200 hall shower/bath room and 18 residents who routinely received specialized rehab in the rehab room according to a list provided by the Nurse Consultant on 7/26/06 and 7/28/06. The findings are:</p> <p>On 7/25/06 at 11:30 a.m., the following observations were made:</p> <p>a. On the 400 Hall, the call light in the therapy room bathroom was not functioning outside of the bathroom, or outside of the therapy room.</p> <p>b. On the 200 Hall:</p> <p>1) The call light in the shower room toilet stall was wrapped around the hand rail 4 1/2 times and in the on position, but the lights to 100 or 200 halls were not functioning.</p> <p>2) The call light in the first shower from the left (entering from 200 hall) was in the on position,</p>	F 463			

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F 463	<p>Continued From page 12 but the lights to 100 or 200 halls were not functioning.</p> <p>3) The call light in the second shower from the left (entering from 200 hall) was in the off position. When the call light was put in the on position, the lights to 100 or 200 halls did not light up.</p> <p>4) The call light in the third shower from the left (entering from 200 hall) was in the off position. When the call light was put in the on position, the lights to 100 or 200 halls did not light up.</p> <p>5) The call light behind the whirlpool tub was in the off position. When the call light was put in the on position, the lights to 100 or 200 halls did not light up.</p> <p>c. The call light communication board at the nurse's station did not sound or light ("100 C/B 200" on the board) to indicate that a call light had been activated in the shower room.</p> <p>d. On 7/25/06 at 11:45 a.m., the maintenance supervisor stated that he changed the bulbs to the 100 and 200 hall lights but that the bulbs were not the problem.</p> <p>e. On 7/25/06 at 12:05 p.m., the maintenance log was reviewed with the maintenance supervisor. There was no documentation that the call system had been routinely checked. The Maintenance Supervisor stated he had been employed with the facility since 7/17/06 and that prior to 7/17/06, Maintenance worker #1 was in the position for two weeks because the original maintenance supervisor left on 6/3/06. The Maintenance Supervisor was asked to provide evidence of the</p>	F 463			

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

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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 C 07/28/2006
NAME OF PROVIDER OR SUPPLIER SHERWOOD NURSING & REHABILITATION CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 463	Continued From page 13 most recent call light check in the facility. The maintenance supervisor stated, "I could probably get that from the 2005 records." As of 4:40 p.m. no further documentation had been provided. f. On 7/26/06 at 9:30 a.m., the RN (Registered Nurse) Consultant #1 was asked if a record of recent call light checks had been located. The consultant provided "Monthly Maintenance Inspection Checklists" dated 1/30/04, 2/12/04 and 4/9/04. There was no further documentation of routine checks to determine the call light functioning status as of 7/28/06.	F 463			