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

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 10/29/2008

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 #13977 was unsubstantiated. Complaint #13998 was substantiated, all or in part, with a deficiency cited at F246.	F 000		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an assessment was completed prior to the application of a restraint to determine medical necessity, to determine the least restrictive device needed and to obtain a physician's order for the restraint prior to its use for 1 (Resident #4) of 2 case mix residents (Resident's #1 and #4) who used a physical restraint. The failed practice had the potential to affect 15 residents with restraints according to a list provided by the Registered Nurse Consultant on 10/28/08 at 7:50 a.m. The findings are: Resident #4 had diagnoses of Dementia and generalized weakness. The Minimum Data Set dated 8/7/08 documented the resident had moderate impairment cognitive skills for daily decision making, required extensive assistance of one person for transfers, had an unsteady balance while standing and had no functional limitation in range of motion. a. On 8/25/08 at 2:00 p.m., a Nurse's Notes documented, "Summoned to therapy room. Upon	F 221		

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 221	Continued From page 1 entering R (resident) lying on floor. DON (Director of Nursing) applying pressure to forehead. Therapist stated she was sitting in the G/C (Geri chair) and leaned forward. As PT/OT (Physical Therapist/Occupational Therapist) went to intercept, resident hit floor causing hematoma to forehead and hit right shoulder." b. A Nurses note dated 8/28/08, time [10:00 a.m.] documented, " ... Up in [wheel chair with] lap top. ... " c. A Nurses note dated 9/30/08 documented, "12N (12:00 p.m.) clarification order [received]/noted for lap tray while [up] in w/c (wheel chair) to reduce attempts to arise unassisted [related to] generalized weakness [and] dementia ... " d. On 10/28/08 at 11:55 a.m., the Director of Nursing stated, "We placed a lap tray on her wheelchair on 8/25/08." The Director of Nursing further stated, "There was no order for the lap tray or an assessment at that time." e. As of 10/29/08 at 4:00 p.m., after review of the clinical record, there was not a restraint assessment available for review. f. The facility ' s policy and procedure entitled, "Restraints, Application" documented, "Note ... follow state regulations for use of restraints in long term care facilities ... General Documentation Guidelines ... section 2. The following may be documented in the patient's medical record: b. Pre Restraining Assessment performed. ..." g. 10/28/08 at 11:20 a.m., resident in therapy	F 221		

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F 221	Continued From page 2 sitting in wheel chair with lap tray in place.	F 221		
F 246 SS=E	483.15(e)(1) ACCOMMODATION 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: Complaint #13998 was substantiated, all or in part, with these findings. Based on observation and interview the facility failed to ensure that a resident preferences of time and needs were reasonably accommodated when getting a resident out of bed in the morning for two (Resident #5 and Resident #6) of six (Residents #1 through #6) case mix residents. This failed practice had the potential to affect all 80 residents as listed on the Roster Sample Matrix dated 10/28/08 at 7:50 a.m. The findings are: 1. On 10/28/08 during the Initial Tour of the facility between the times of 5:05a.m. and 5:35a.m., 17 of the facility's residents had been awakened and dressed. 2. On 10/28/08 at 5:35 a.m., CNA #1 was interviewed and stated, "We start getting residents up at 5:00 a.m. 3. On 10/28/08 at 5:38 a.m., CNA #2 was interviewed and stated, "We start getting	F 246		

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F 246	Continued From page 3 residents up at 4:45 a.m." 4. On 10/28/08 at 5:41 a.m., CNA #3 was interviewed and stated, "We get residents up starting at 5:00 a.m." 5. Resident #5 had diagnoses of Ventral Hernia, Colitis, Resection of Villous Adenoma, Seizure Disorder, Glaucoma and Decreased Visual Acuity, Cataract, Status Post Pneumothorax, Fractured Hip, Vascular Dementia, Fractured Right Fibula, Fractured Right Tibia, Below Knee Amputation, Altered Pain Level, Osteoporosis, Degenerative Joint Disease, Hypertension, and Pain. The Quarterly Minimum Data Set dated 9/12/08 documented the resident to have short and long-term memory problems, had moderately impaired cognitive skills for daily decision making, required extensive assistance of one or more persons for the performance of bed mobility, transfers, dressing, toileting, personal hygiene, and bathing and was awake most of the time during the morning, afternoon and evening. a. On 10/28/08 at 5:22 a.m., during the Initial Tour the resident was observed sitting up in a wheelchair in her room with a CNA brushing the resident's hair. b. On 10/28/08 at 7:26 a.m., the resident was in the Dining Room in a wheelchair. The resident was at a table and appeared to be sleeping. c. On 10/28/08 at 9:52 a.m., the resident was in a wheelchair on the 100 hallway, snoring, and had her left arm dangling at the side of the wheelchair. The resident was observed for a three minute period with no change. Employees and other residents were walking by. The Director of	F 246		

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F 246	Continued From page 4	F 246		

Activities walked by and stated, "She is sleeping."

d. On 10/28/08 at 11:30 a.m., the resident was in the Dining Room in a wheelchair. The resident appeared to be asleep. The resident's left arm was draped over the wheel of the wheelchair, her eyes were closed and her head was dropped down almost to her chest.

6. Resident #6 had diagnoses of Hypertension, Hypothyroidism, Bladder Incontinence, Dementia with Depression, Anemia, and Deep Vein Thrombosis of the Left Lower Extremity. The Initial Minimum Data Set dated 8/8/08 documented the resident had independent cognitive skills for daily decision making, required set-up help with all activities of daily living, and was awake all or most of the time during the afternoon and evening.

a. On 10/28/08 at 5:40 a.m., during the Initial Tour the resident was observed sitting on the side of the bed with his walker in front of him.

b. On 10/29/08 at 8:42 a.m. the resident the resident stated, "They get me up between four and five every morning - I don't necessarily like to get up that early - I would like to get up about seven."

7. On 10/28/08 at 12:36 p.m. the Director of Nursing (DON) was asked if there was a schedule or a list that informed the staff of the times to start get residents up in the morning. The DON stated, "There is no list of certain times to start getting residents up in the morning that I'm aware of. Residents should be gotten up based on their preferences and needs."