

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

PRINTED: 11/22/2006
FORM APPROVED
OMB NO. 0938-0391

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| 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 11/07/2006 |
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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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| F 000 | INITIAL COMMENTS Complaint #12113 was substantiated (all or in part) with deficiencies cited at F157, F225, F226 and F309. | F 000 | | |
| F 157 SS=E | 483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. | F 157 | | |

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| 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 157 | <p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #12113 was substantiated (all or in part) with these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure the family/responsible party was notified of an injury for 1 (Resident #1) of 5 case mix residents who sustained injuries of unknown origin (Residents #1 through #5). The failed practice had the potential to affect 67 residents who were cognitively impaired, as documented on the Roster/Sample Matrix provided by the Minimum Data Set (MDS) Coordinator on 10/30/06 at 1:45 p.m. The findings are:</p> <p>Resident #1 had diagnoses of Dementia, Hemiplegia and Right Cerebrovascular Accident (CVA). The Quarterly Minimum Data Set dated 10/20/06 documented the resident was moderately impaired in cognitive skills for daily decision making, had short and long term memory problems, required total assistance with all activities of daily living, was incontinent of bowel and bladder and had partial loss of voluntary range of motion in the legs and feet.</p> <p>a. The Overall Plan of Care dated 7/19/06 and updated 10/20/06 documented: "...10/17/06 Scratches to ABD [abdomen]."</p> <p>b. Nurse's Notes dated 10/17/06 at 12:15 a.m. documented: "Summoned to room per CNA [Certified Nursing Assistant], approximately 6" [6-inch] red, raised, scratch to right lower quad [quadrant] of abdomen noted going up and down; Also approximately 4 inch red, raised scratch</p> | F 157 | | | |

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| F 157 | Continued From page 2 going crosswise to the lower right quad of abdomen. Resident states, 'That big girl scratched me.' Appears to be fingernail scratch. Zero discomfort noted. V/S [vital signs] 122/68, 70, 97.2, 18. Paperwork faxed to [Physician]. Will notify family in a.m. [morning]." There was no documentation in the Nurse's Notes to indicate the resident's family was notified the following morning. c. On 10/31/06 at 2:55 p.m., the Director of Nursing (DON) and the Registered Nurse (RN) Consultant were interviewed. The DON stated, "Scratches were reported to me." When shown the Nurses' Notes and Incident/Accident documentation regarding the resident's family not being notified and asked when the family was informed of the scratches, the DON stated, "I don't know at this time." d. The facility's policy and procedure titled, "Incident and Accident Investigating and Reporting," documented: "...Policy: All incidents and accidents will be reported (immediately or as soon as practicable) to the Administrator and Director of Nursing... As soon as practicable, the attending physician and family representative will be notified of the incident or accident..." | F 157 | | | |
| F 225 SS=E | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a | F 225 | | | |

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| F 225 | <p>Continued From page 3</p> <p>court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #12113 was substantiated (all or in part) with these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure an injury of unknown origin was investigated to rule out abuse for 1 (Resident #1) of 5 case mix residents</p> | F 225 | | |

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| F 225 | <p>Continued From page 4</p> <p>(Residents #1 through #5). The failed practice had the potential to affect 67 residents who were cognitively impaired, as documented on the Roster/Sample Matrix provided by the Minimum Data Set (MDS) Coordinator on 10/30/06 at 1:45 p.m. The findings are:</p> <p>Resident #1 had diagnoses of Right Femoral Neck Fracture, Deep Vein Thrombosis and Dementia. The Quarterly Minimum Data Set dated 10/20/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, had short and long term memory problems, required total assistance with all activities of daily living, was incontinent of bowel and bladder and had partial loss of voluntary movement in the legs and feet.</p> <p>a. The Overall Plan of Care dated 7/19/06 and updated on 10/20/06 documented: "10/17/06 Scratches to ABD [abdomen]."</p> <p>b. Nurse's Notes dated 10/17/06 at 12:15 a.m. documented: "...Summoned to room per CNA, approximately 6" [6 inch] red, raised, scratch to right lower quad [quadrant] of abdomen noted going up and down. Also approximately 4 inch red, raised scratch going crosswise to the lower right quad of abdomen. Resident states 'that big girl scratched me.' Appears to be fingernail scratch. Zero discomfort noted. V/S [vital signs] 122/68, 70, 97.2, 18. Paperwork faxed to [physician]. Will notify family in a.m. [morning]." There was no documentation that an investigation of the scratches and the resident's statement was initiated at this time.</p> <p>c. An Incident/Accident Report dated 10/17/06 documented: "...Patient's condition before</p> | F 225 | | | |

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| F 225 | Continued From page 5 incident: Alert x's [times] 1 and disoriented x's 2. Description of Incident: Summoned to room per CNA. Resident had approximately 6 inch scratch on right lower abdomen and approximately 4 inch scratch also. Resident stated, 'big girl scratched me.' Scratch is red in color... Description of Incident by Person Injured: 'I don't know what happened.' ...Other Investigative Findings (if applicable): Scratches inconsistent with fingernails. Steps to Prevent Reoccurrence: Inservice CNA regarding length of nails and jewelry. Follow Up (Final Disposition) [section not completed]." There was no documentation of any further follow up or investigation to determine the cause of the scratches or to determine the identity of the "big girl" mentioned in the resident's initial statement. d. On 10/31/06 at 2:55 p.m., the DON and the Registered Nurse (RN) Consultant were interviewed. The DON stated, "Scratches were reported to me. I assessed it and I didn't think they were consistent with fingernail scratches. The resident told me she didn't know how they happened." When asked if she investigated further by interviewing prior shifts of their knowledge about the scratches, the DON stated, "No, I didn't." When asked if she interviewed other alert and oriented residents, the DON stated, "No." | F 225 | | | |
| F 226 SS=E | 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. | F 226 | | | |

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| F 226 | <p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #12113 is substantiated (all or in part) with these findings.</p> <p>Based on observation, interview, and record review the facility failed to ensure their policy and procedures for abuse prohibition were implemented, as evidenced by failure to ensure an injury of unknown origin was investigated to rule out abuse for 1 (Resident #1) of 5 case mix residents (Residents #1 through #5). The failed practice had the potential to affect 67 residents who were cognitively impaired, as documented on the Roster/Sample Matrix provided by the Minimum Data Set (MDS) Coordinator on 10/30/06 at 1:45 p.m. The findings are:</p> <p>Resident #1 had diagnoses of Right Femoral Neck Fracture, Deep Vein Thrombosis and Dementia. The Quarterly Minimum Data Set dated 10/20/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, had short and long term memory problems, required total assistance with all activities of daily living, was incontinent of bowel and bladder and had partial loss of voluntary movement in the legs and feet.</p> <p>a. The Overall Plan of Care dated 7/19/06 and updated on 10/20/06 documented: "10/17/06 Scratches to ABD [abdomen]."</p> <p>b. Nurse's Notes dated 10/17/06 at 12:15 a.m. documented: "...Summoned to room per CNA, approximately 6" [6 inch] red, raised, scratch to right lower quad [quadrant] of abdomen noted going up and down. Also approximately 4 inch</p> | F 226 | | | |

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| F 226 | <p>Continued From page 7</p> <p>red, raised scratch going crosswise to the lower right quad of abdomen. Resident states 'that big girl scratched me.' Appears to be fingernail scratch. Zero discomfort noted. V/S [vital signs] 122/68, 70, 97.2, 18. Paperwork faxed to [physician]. Will notify family in a.m. [morning]."</p> <p>There was no documentation that an investigation of the scratches and the resident's statement was initiated at this time.</p> <p>c. An Incident/Accident Report dated 10/17/06 documented: "...Patient's condition before incident: Alert x's [times] 1 and disoriented x's 2. Description of Incident: Summoned to room per CNA. Resident had approximately 6 inch scratch on right lower abdomen and approximately 4 inch scratch also. Resident stated, 'big girl scratched me.' Scratch is red in color... Description of Incident by Person Injured: 'I don't know what happened.' ...Other Investigative Findings (if applicable): Scratches inconsistent with fingernails. Steps to Prevent Reoccurrence: Inservice CNA regarding length of nails and jewelry. Follow Up (Final Disposition) [section not completed]." There was no documentation of any further follow up or investigation to determine the cause of the scratches or to determine the identity of the "big girl" mentioned in the resident's initial statement.</p> <p>d. On 10/31/06 at 2:55 p.m., the DON and the Registered Nurse (RN) Consultant were interviewed. The DON stated, "Scratches were reported to me. I assessed it and I didn't think they were consistent with fingernail scratches. The resident told me she didn't know how they happened." When asked if she investigated further by interviewing prior shifts of their knowledge about the scratches, the DON stated,</p> | F 226 | | | |

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| F 226 | Continued From page 8 "No, I didn't." When asked if she interviewed other alert and oriented residents, the DON stated, "No." e. The facility's policy and procedure titled, "Incident and Accident Investigating and Reporting," documented: "...Policy: All incidents and accidents occurring in this Facility or its premises will be investigated and reported to the Administrator and Director of Nursing. 1. All incidents and accidents will be reported (immediately or as soon as practicable) to the Administrator and Director of Nursing. ...Treatment will be provided as ordered by the physician. The Charge Nurse or Designee, will conduct an immediate investigation of the incident or accident; complete the appropriate sections of the Incident and Accident Reporting form; and sign the form... If patient neglect, abuse, or misappropriation of property is reported, the Administrator and the Director of Nursing will conduct an immediate investigation. The investigation should address the following: a. Whether an incident has occurred. b. To what extent the patient was mistreated and by whom. c. The measures needed to protect patients from further incidents, according to the Abuse Investigation & Reporting Nursing Facility Policy. d. Description of the incident by the person injured. e. Other investigative findings. f. Steps to protect all staff and employees. g. Other corrective actions, including a change in policy, and; h. Follow up observations and disposition of any outstanding issues. 11. The investigation process should include interviews with appropriate persons and may include interviews with: Facility employees, The patient, The patient's roommate, Other patients, Family members, Visitors in the facility, or other persons | F 226 | | | |

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| F 226 | Continued From page 9 who may have knowledge of the incident. 13. The facility will complete its investigation within 5 days of the incident or accident's discovery and written investigation reports will be reviewed, initialed, and dated by the Administrator and the DON..." | F 226 | | | |
| 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 and plan of care. This REQUIREMENT is not met as evidenced by: Complaint #12113 was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure 1 (Resident #5) of 1 case mix resident who experienced skeletal fractures and/or had physician orders for as-needed pain medication was assessed for pain and provided with physician-ordered pain management. The failed practice had the potential to affect 49 residents who were confused and non-interviewable, as identified by the Director of Nursing during initial rounds on 10/30/06. The findings are: Resident #5 had diagnoses of Alzheimer's Dementia, Osteoporosis, Patella Fracture and Mental/Behavior Disturbance. | F 309 | | | |

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| F 309 | <p>Continued From page 10</p> <p>a. Nurse's Notes dated 10/13/06 documented: "...bruising noted to left leg, swollen, warm to touch, [physician] called, waiting on return call..." At 10:15 a.m., the Nurse's Notes documented a physician order was received to obtain a mobile x-ray of the resident's left hip and knee.</p> <p>b. An Incident/Accident Report dated 10/13/06 documented: "...purple/yellow/green bruise to back of left leg. Knee swollen, warm... to hospital for evaluation. Lt. [left] Fx. [fracture] knee immobilizer. Follow up appointment with orthopedic."</p> <p>c. Nurses' Notes dated 10/13/06 at 2:20 p.m. documented: "[Physician] notified of x-ray results, Fx tibial plateau and Fx. inferior patella, new order: send to [hospital name], report called, [ambulance service] notified."</p> <p>d. Nurses' Notes dated 10/13/06 at 8:30 p.m. documented: "...resident back to facility, received by other nurse... No distress noted... new order Lortab 7.5/500 one tablet every 4-6 hours PRN [as needed]. Call and schedule follow up appointment Monday 10/16/06..."</p> <p>e. There was no documentation in the Nurses' Notes from 10/13/06 through 10/16/06 that pain assessments were completed. Only one entry, dated 10/16/06 at 12:00 a.m., documented vital signs.</p> <p>f. The October 2006 Physician Orders sheet documented an order (originally dated 4/26/06) for Vicodin 5/500 one tablet per mouth every 6 hours as needed for pain. A physician's telephone order dated 10/13/06 at 10:00 p.m. documented: "Lortab 7.5/500 one tablet every 4</p> | F 309 | | | |

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| 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 11/07/2006 |
| 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 309 | <p>Continued From page 11 to 6 hours PRN Pain. Follow up appointment (schedule) on Monday 10/16/06."</p> <p>g. Patient Education Materials dated 10/13/06 from the hospital documented: "...[Resident's name] has been given the following patient education materials: Injury and Illness... PATELLA FRACTURE... You have a FRACTURE (break) of the patella bone "kneecap." This causes pain, swelling and sometimes bruising. Depending on the severity of the fracture, this will take four weeks or longer to heal (a minimum of four weeks/or at least four weeks to heal). A knee brace, has been applied."</p> <p>h. The Quarterly Minimum Data Set (MDS) dated 10/26/06 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for transfers, exhibited socially inappropriate behavioral symptoms in the previous 7 days.</p> <p>The Resident's Overall Plan Of Care updated 10/26/06 documented: "...Fracture Left knee immobilizer to be in place. Check every shift for skin integrity. Administer meds [medication], as ordered by physician." The Plan of Care did not address the need to assess and treat the resident's pain.</p> <p>i. As of 11/7/06, there was no documentation on the October 2006 or November 2006 Medication Administration Records (MAR's) that any pain medication was administered to the resident from 10/13/06 through 11/7/06.</p> <p>j. On 11/6/06 at 3:30 p.m., the following interview was conducted with the Director of Nursing (DON):</p> | F 309 | | | |

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

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| F 309 | Continued From page 12 Surveyor: "As a nurse, how would you assess a resident for pain?" DON: "Ask resident if they had pain. If unable to answer, observe any grimacing, facial expressions, abdominal breathing and moaning." Surveyor: Whose responsibility is it to assess the resident for pain?" Relevance? DON: "The LPN on the floor." Surveyor: "How do you interpret a PRN pain medication order?" DON: "As needed, based on your assessment." Surveyor: "Do you think that [resident] experienced any pain and needed pain medication?" DON: "Yes, I'm sure she did have pain and should have gotten some medication." | F 309 | | | |