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	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Nursing & Rehabilitation Center, Inc	245 Indian Bay Drive Sherwood, AR 72120

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interview, and facility document review, the facility failed to ensure two staff assisted in transferring a resident using a mechanical lift as required by the resident's closet care plan and manufacturer's recommendations, to prevent a fall for one (Resident #98) of one resident reviewed. This failed practice resulted in Resident #98 sustaining a laceration to the right eyebrow and an injury to the right eye, causing bleeding from the eye. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) situation was related to State Operation Manual, Appendix PP, 483.35 at a scope and severity of J. The IJ began on [DATE], after a review of a record provided by the Administrator regarding Certified Nursing Assistant (CNA) #1 performing a one-person transfer, using a mechanical lift, of Resident #98 who was care planned for a two-person mechanical lift transfer. Resident #98 fell during this transfer. The Administrator presented the nine-page Office of Long-Term Care (OLTC) Incident and Accident (I&A) Report Form 7734 and 762 as the facility investigation into a resident sustaining a fall from a mechanical lift. This IJ ended on [DATE] with the completion of staff re-education on proper use of mechanical lifts.The Administrator was notified of the Immediate Jeopardy (IJ), with an accepted plan of removal/correction of the facility's action developed prior to the state surveyors entering the building on [DATE] for the facility recertification survey on [DATE] at 11:20 AM. This failed practice will be cited as Past Non-Compliance (PNC) in accordance with Appendix Q. The findings include:On [DATE] at 8:00 AM, the facility filed an OLTC I&A Report 762 report. The report revealed that on [DATE] at 5:30 AM, CNA #1 transferred Resident #98 with a mechanical lift using a one-person transfer. Resident #98 fell from the lift, sustaining a severe head injury with laceration to the right eyebrow, and bleeding from the right eye. The resident complained of pain to the head and right shoulder. The resident was transferred to a local emergency room for further evaluation. The family member of Resident #98 said the resident died at the hospital five days following the incident, due to the injuries sustained during this fall. The family member reported Resident #98 sustained an orbital fracture because something, went through it ,and the resident sustained an injury to [pronoun] hip and shoulder.A review of Resident #98's Medical Diagnosis revealed diagnoses which included encephalopathy, altered mental status, heart failure, chronic pulmonary edema, intervertebral disc disorders in the lumbar region, shortness of breath, cognitive communication deficit, muscle wasting and atrophy, lack of coordination, ischemic cardiomyopathy, vitamin D deficiency, disorder of the eye and adnexa, cardiac pacemaker, chronic systolic congestive heart failure, type 2 diabetes, polyneuropathy, osteoarthritis, and lower back pain.A review of Resident #98's Care Plan, with an initiation date of [DATE], revealed an Activities of Daily Living self-care performance deficit related to activity intolerance and impaired balance, and diagnoses which include spinal stenosis, intervertebral disc (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	told CNA #1 they knew Resident #98 was already on the lift pad. That was when CNA #1 admitted they had tried to lift Resident #98 in the lift by themself. The nurse told me there was blood everywhere. I asked the nurse if she called the family and the nurse said yes. When I got here, the nurse told me [Resident #61] had witnessed the entire thing. [Resident #61] told me (the DON) [CNA #1] came in the resident's room with the lift and [Resident #61] had asked [CNA #]1 if they were going to get a second person to help them with the lift. Resident #61 said the staff member pulled the curtain and the next thing they knew Resident #98 was on the floor. The DON said when they first got the call, they (the DON) had told the staff to send CNA #1 home. The DON said they reviewed the camera, and CNA#1 never attempted to get another person to help them. The DON said at the time of the incident, Resident #98's care plan directed the staff to transfer with two-persons, using the mechanical lift. The DON said the resident's closet care plan indicated Resident #98 was to be transferred using the mechanical lift by two-persons and a purple sling. The DON said the purple sling was the one in the room. The DON said the two-person transfer had been in place ever since the DON had been at the facility, for nine years. The DON said they used one brand of lifts in the building and provided a copy of the manufacturer's guidelines.During a phone interview on [DATE] at 4:11 PM, LPN #12 said, I went down noticed [Resident #98] lying face down in blood. I called 911 and gave them a run-down of the situation. I told one of the CNAs to go get another nurse. The other CNA in the room noticed the blood and told the CNA to go and get me a pressure dressing. The police were the first ones on arrival. LPN #11 stopped the bleeding coming from Resident #98's head and the ambulance service showed up at that point. LPN #11 said they called the hospital to give them a run-down of the situation. LPN #11 said when they first walked in, they found Resident #98 face down, between the lift, and the sling was on lift, blood was coming out of (the resident's) eyeball. (The resident's) eyeball was in the socket, and the bleeding was coming from the eye. The eye was black and gushing blood. It looked like the blood was coming out the tears. It wasn't protruding, it was black and bleeding. Just above the eyebrow, there was an abrasion and there was some bleeding. The eye was black, and blood was pouring out of [Resident #98's] right eyeball. LPN #11 said when they first found [Resident #98], they were the nurse in the room. LPN #11 attempted to apply pressure to the wound and when LPN #12 came back from the treatment room with gauze, it was both of us after that. LPN #11 said they were not in the room once the ambulance service arrived. They (LPN #11) got a pressure dressing to stabilize Resident #98's wound. LPN #11 said they asked LPN #12 if it was okay for LPN #11 to step out to get the paperwork. LPN #11 said based on what they saw, [Resident #98's] head was facing the foot of the bed, lift above [the resident], CNA #1 said the resident fell out of bed and had fallen on [the resident's] face. LPN #11 said the scene did not add up. LPN #11 said Resident #98 was mostly immobile unless we moved them. LPN #11 said they told the CNA if [Resident #98] fell out of bed [the resident's] head would have been the other way. CNA #1 said they were trying to put the sling under the resident, but the sling was already attached to the lift. If the resident had fallen out of bed, the injuries would have been on the other side. LPN #11 said Resident #98 was able to talk to them, tell their name, report that their head was hurting, then started speaking more slowly and we had to do a sternal rub to get [the resident] alert. [Resident #98's] lips were a little cyanotic (appearing blue). Emergency Medical Services (EMS) had arrived and taken over at that point. LPN #11 said as far as they knew, the mechanical lift was the only kind they used. LPN #11 said the facility required two CNAs, at all times, to transfer a resident with a mechanical lift; it had always been that way. If they couldn't find somebody, they would come to get me or another nurse to assist. LPN #11 said as far as they were aware, the policy at the facility had always been two-person transfer with the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interviews, the facility failed to ensure proper hand hygiene was performed during perineal care for one (Resident #106) of one resident reviewed. The findings include: Review of Medical Diagnosis revealed Resident #106 to have diagnoses of congestive heart failure, COPD (Chronic Obstructive Pulmonary Disease), and atrial fibrillation [fluttering heart palpitations]. Review of the admission Minimum Data Set with an Assessment Reference Date of 10/31/2025 revealed a Brief Interview of Mental Status score of 06, which indicates severe cognitive impairment. The MDS also indicated Resident #106 was incontinent of bowel, and occasionally incontinent of bladder. During an observation on 12/08/2025 at 1:37 PM, CNA (certified nursing assistant) #16 and CNA #9 assisted Resident #106 into bed and removed Resident #106's pajama bottoms while wearing gloves. CNA #9 folded down the front of Resident 106's brief and wiped the resident's perineal area. Resident #106 assisted in rolling to the right-side and CNA #16 wiped down the buttocks area twice in one direction then applied cream to the buttocks after removing a wet brief. CNA #16 removed skin cream from the drawer to the left side of the bed without changing gloves or performing hand hygiene. CNA #16 placed a clean brief under Resident #106, the resident rolled to the back, and the brief was secured. While still wearing the same dirty gloves, CNA #9 and CNA #16 pulled up Resident #106's clean pajama bottoms, adjusted linens, touched the resident's bedrails, and then CNA #16 returned skin cream to the left bedside drawer. CNA #9 touched the bed rails and bed remote to lower the bed and raised Resident 106's head while wearing the same dirty gloves. CNA #9 removed their dirty gloves then, without performing hand hygiene, offered fluids to the resident and opened the drawer to the left side of the bed, that was previously opened with CNA #16's dirty gloves. During an interview on 12/08/2025 at 1:53 PM, CNA #9 and CNA #16 revealed the process used to provide good hand hygiene during perineal care was to wash their hands and put on gloves prior to performing perineal care. CNA #16 revealed hand hygiene should be performed during perineal care and confirmed that dirty gloves should have been removed and hands washed before touching resident's clean brief, clothing, bed controls, and before putting cream back in the bedside drawer. CNA #16 said this practice was concerning due to germs. During an interview on 12/10/2025 at 12:08 PM, the Director of Nursing [DON] said staff were expected to wash their hands and put on gloves during perineal care and expected to change their gloves and use hand sanitizer frequently during perineal care, such as before putting a clean brief or clothing on residents. The DON displayed concern regarding staff providing perineal care without changing their gloves and performed hand hygiene, because there would be a concern for maintaining infection control. The DON said, Staff are in-serviced on perineal care on hire, annually, and if I start to see UTIs (urinary tract infections) or infections. During an interview on 12/11/2025 at 5:00 PM, the Administrator said, My expectation for staff is hand hygiene will be performed during perineal care when moving from dirty to clean areas to prevent the risk of infection The Administrator confirmed they do not have a hand hygiene policy. A review of Nursing Return Demonstrations, dated 09/18/2025 and 11/11 /2025, revealed CNA #9 and (continued on next page)

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 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Nursing & Rehabilitation Center, Inc	245 Indian Bay Drive Sherwood, AR 72120

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #16 completed skills checkoffs that included personal care and hand hygiene. Review of a policy titled Perineal/Incontinence Care, revised 11/22/2016, revealed after providing perineal care staff should change out of dirty gloves, then place a clean brief under resident using barrier cream as indicated and replace the bedspread.