| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045256 | A. Building<br>B. Wing | 04/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sheridan Healthcare and Rehabilitation Center | 113 South Briarwood Drive<br>Sheridan, AR 72150 |

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 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>37925<br><br>Based on record review, interview, and facility policy review, the facility failed to protect a resident's right to be free from misappropriation of resident ' s property, as evidenced by a medication card of [Compound Narcotic Pain Medication], 5 milligrams (mg)/325 mg which contained 43 pills, was taken from a medication cart and the empty card was located in a dumpster behind the facility, for 1 (Resident #8) of 1 sampled resident reviewed for misappropriation of property.<br><br>The findings are:<br><br>Review of an OLTC (Office of Long-Term Care) Incident and Accident Report (I&A), with discovery date and time of 07/12/2024 at 6:45 PM revealed during the count of the [NAME] medication cart on Friday, 07/12/24 around 6:15 PM, between former Licensed Practical Nurse (LPN) #5 [outgoing nurse] and former Registered Nurse (RN) #6 [incoming nurse], there was a discrepancy in the narcotic book count and the number of actual 5 mg [Brand name Opioid] for Resident #8. During the investigation, former LPN #5 admitted to the Director of Nursing (DON), Administrator and former Assistant Director of Nursing (ADON) #8, there had been an issue on the secure unit that required her attention quickly, and she left the medication cart unlocked by accident. Former LPN #5 indicated the narcotic box was not locked unless you shut [the lid] with force or used the key, and the [medication] cart and [narcotic (narc)] box were not locked upon her return, but she did not think about anything being missing.<br><br>Review of Resident #8's Medical Diagnosis Screen revealed the resident had diagnoses that included osteoporosis (a bone disease which causes the bones to change), dementia (a condition which affects a person ability to think or perform daily activities), and cervicalgia (neck pain).<br><br>Review of a quarterly Minimum Data Set (MDS) with an Assessment Refence Date (ARD) of 07/16/2024, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 04, which indicated severely cognitively impaired and was dependent on staff for toilet and personal hygiene, shower/bathe self, upper and lower body dressing, and received scheduled pain medication and as needed pain medication or was offered and declined, frequently experienced pain which frequently limited the resident's day-to-day activities and was receiving a high-risk drug, opioid.<br><br>Review of a Care Plan report, dated 03/31/2025, revealed Resident #8 was on pain medication therapy and had interventions to administer analgesic medications, as ordered by physician, and observe side effects and effectiveness. The Care Plan report also revealed, the resident received opioid medication with interventions to administer medication, as ordered and monitor for signs and symptoms of a potential drug overdose.<br><br>(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 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #8's Electronic Medication Administration Record (eMAR) for 07/2024 revealed [Compound Narcotic Pain Medication] 5-325 mg give 1 tablet by mouth at bedtime for pain. Start date: 06/27/2024, hold 07/06/24 to 07/09/24. This medication was discontinued on 07/22/2024. The 07/2024 eMAR revealed a dose was administered at 8:00 PM from 07/09/2024 through 07/21/2024.<br><br>Review of the Narcotic Book, page 97, revealed on 07/11/24 at 8:27 PM, the balance was 47 [pills]. There was a blank line after this entry and then on 07/12/24 at 9:00 AM the balance reflected 4 [pills]. On 07/15/24 at 7:09 PM, the last pill was signed out of the narc log, and the remaining balance was zero.<br><br>Review of a written statement by former LPN #5 revealed, she noticed a card of [Name Brand Opioid] missing and the count was correct at the beginning of her shift, at 6:00 AM. At 6:43 PM, she called the DON and was instructed to stay at the facility. The DON, former ADON #8, Administrator, former RN #6, and former LPN #5 searched for the medication, and did not find it. The written statement by former LPN #5 indicated she had to go to the secured unit for an emergency. She wrote when she came back to the med cart, it was unlocked, and she did not count anything, because she did not think anything would be missing.<br><br>On 04/03/2025 at 10:35 AM, the DON was interviewed and stated former LPN #5 and former RN #6 were doing the shift change narcotic count and they noticed a card of [opioid pain medication] missing for Resident #8. The DON indicated she was notified immediately, and no staff left the building from that point forward. She stated she notified the former ADON #8 and the Administrator, after she was called. She stated the [med] cart, the med room, and all the [medication] carts were searched, but the missing medication was not found. The DON stated she and the former ADON #8, went out to the dumpsters out the east side entrance of the building and began to pull the bags out and go through each bag. She stated the [medication] card, that still had Resident #8's identifying information, was found and was empty. The DON stated she was made aware of the lock on the narcotic box, in the medication cart on the west hall nursing station, not working properly at the time of the investigation for the missing medication. She stated she was informed that it had been happening [lock not working properly] and that you either had to lock the narc box with a key or it [the lid] had to be slammed shut. She stated she could not recall if the nurses gave her a time frame as to when they noticed the issue with narc box lock.<br><br>Review of an Abuse, Neglect, Maltreatment and Investigation and Reporting policy, not dated, indicated the facility will endeavor to protect resident/elders from maltreatment, which means adult abuse, exploitation, neglect, physical abuse, sexual abuse and the misappropriation of resident/elders ' property. Misappropriation of resident/elder property is patterned or deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident/elder's belongings or money without the resident/elder's consent. |