

Department of Health & 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: 045256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Sheridan Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 113 South Briarwood Drive 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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Number of residents sampled: Number of residents cited: Based on record review, interview, and facility policy review, the facility failed to develop and implement dementia care needs on a person-centered comprehensive care plan for one (Resident #7) of one resident reviewed. The findings include: Review of Resident #7's admission Record revealed the facility admitted Resident #7 on 01/09/2026 with diagnoses that included vascular dementia, as well as severe agitation with an onset date of 03/05/2026. Review of Resident #7's admission Minimum Data Set (MDS) with an Assessment Reference Date of 03/31/2026, revealed Resident #7 had a Brief Interview for Mental Status score of 07. The score indicated Resident #7 had severe cognitive impairment. The MDS also revealed an active diagnosis of non-Alzheimer's dementia. Review of Resident #7's Care Plan, with a review date of 04/10/2026, revealed the care plan did not indicate a focus or interventions for dementia care. During an interview on 06/25/2026 at 5:45 PM, the Director of Nursing (DON) stated the MDS Coordinator was responsible for adding dementia care to residents' Care Plans. She stated Resident #7's care plan should have included dementia care so the staff could receive education for the proper training. She stated her expectation for residents with dementia was for their care plan to include dementia care. The DON stated the facility currently did not have a policy on care plans or dementia care. During an interview on 06/25/2026 at 5:51 PM, the MDS Coordinator reviewed Resident #7's admission MDS with an ARD on 03/31/2026 and confirmed there was an active diagnosis for non-Alzheimer's dementia. MDS #1 reviewed the care plan and confirmed there was no focus area for dementia care included. MDS #1 also stated when Resident #7 first came in [when the resident was admitted to the facility] there was no diagnosis for dementia.		

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, observations, interviews, and facility policy review, the facility failed to remove expired medications from active rotation to avoid administration for one (Resident #21) of one resident reviewed. Specifically, the facility failed to remove expired medication from active rotation for which Resident #21 had an active order and was receiving as needed. The findings include: Review of an admission Record indicated the facility admitted Resident #21 on 03/20/2025 with diagnoses that included ureter cancer and anorexia. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/18/2026, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. Review of an Order Summary Report revealed Resident #21 had a physician's order for a by-mouth antinausea medication to be given every six hours as needed for nausea/vomiting. Review of Resident #21's May Medication Administration Record (MAR) revealed the resident received one dose of the antinausea medication on 05/06/2026 at 10:27 AM, and one dose on 05/20/2026 at 6:44 PM. During a concurrent observation and interviews of the cottage medication cart an expired medication card was observed which contained an antinausea medication in pill form, prescribed for Resident #21. The expiration date was 03/20/2026. There were no additional, unexpired medication cards present for this medication in the medication cart. -Licensed Practical Nurse (LPN) #1 verified the medication did belong to Resident #21 and was expired as of 03/20/2026. -The Infection Preventionist stated she would order a new antinausea medication card for Resident #21. During an interview on 06/25/2026 at 1:13 PM, the Director of Nursing (DON) reported it was important residents were administered medications that were not expired to ensure the efficacy of the drug was what the medication says it was. She reported the primary nurses were expected to keep the medication carts up to date and remove any expired medications. A review of a facility policy titled Medication Storage in the Facility with an effective date of 01/01/2015 indicated the nurse will check the expiration date of each medication before administering it and no expired medications will be administered to a resident.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review observations, and interviews, it was determined that the facility failed to ensure lab specimen supplies were not expired and lab specimens were stored in a refrigerator 36 degrees Fahrenheit (F) to 46 degrees F and away from food items. The findings include: Review of an admission Record indicated Resident #44 was admitted to the facility on [DATE] with diagnoses which included fracture of upper end of left humerus (broken left arm), displaced intertrochanteric fracture of left femur (broken left hip), embolism, blood clot in the lower left leg and thrombophilia (an increased tendency for the blood to clot). Review of Resident #44's clinical orders revealed an order dated 04/08/2026 for an oral anticoagulation medication 7.5 mg, give one tablet by mouth one time a day every Monday, Wednesday and Saturday. The clinical orders revealed a second order dated 04/09/2026 for an oral anticoagulation medication 5 mg, give one tablet by mouth one time a day every Tuesday, Thursday and Sunday for anticoagulation. Resident #44's clinical orders included a lab order dated 06/03/2024 for PT/INR (a blood test to monitor a specific anticoagulant medication therapy to prevent blood clots) one time a day every month starting on the third for one day. During an observation of the East Medication Room on 06/24/2026 at 4:34 PM this surveyor observed all six of six light blue topped tubes available, were expired as of 05/31/2026. During an observation of the East Medication Room on 06/24/2026 at 4:41 PM this surveyor observed a small white refrigerator with a paper poster adhered to the door indicating LAB REFRIGERATOR For Urine and Stool and Blood Specimens only! An additional paper poster on the refrigerator side indicated STATE REGULATIONS Refrigerator Temperature Must Be 36-46 Degrees Fahrenheit To Comply With State Regulations Adjust Temperature Controls Accordingly! The thermometer inside the refrigerator indicated 20 degrees F. The freezer compartment in the upper right section of the refrigerator contained ice accumulation of greater than two inches on the inside as well as the outside of the freezer compartment. Ice cream was stored in both the refrigerator and freezer section of the lab refrigerator. During an interview on 06/25/2026 at 9:00 AM, the Assistant Director of Nursing (ADON) indicated she was responsible for ensuring lab supplies were not expired. She indicated at this time one resident, Resident #44, did require use of the blue tubes identified as expired to evaluate an anticoagulant medication's need for adjustment. She reported it was important that the tubes were not expired to ensure the resident's readings would be accurate. The ADON indicated nurses stored blood, urine, and stool samples in the lab refrigerator in the East Medication Room until the pharmacy picked up the lab specimens from the facility and delivered the specimens to the lab to be processed. She indicated the only lab refrigerator at the facility was in the East Medication Room and reported the lab refrigerator temperature should be between 36 to 46 degrees F. She verified the lab refrigerator should not be 20 degrees F and should not be used to store ice cream. She reported the (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	night nurse's responsibility for the lab refrigerator included nightly temperature check, defrost when needed and check the contents of the refrigerator. During an interview on 06/25/2026 at 9:40 AM LPN #2 reported she utilized the lab refrigerator on 06/24/2026 to store a resident's lab tubes containing blood. She reported that the pharmacy picked up the lab specimen around 11:15 AM on 06/24/2026. She reported she did not notice the temperature, nor the contents of the lab refrigerator when she placed the lab specimens inside the refrigerator. During an interview on 06/25/2026 at 9:49 AM LPN #1 reported only labs can be stored in a lab refrigerator. She reported 20 degrees F was not an appropriate temperature for a lab refrigerator and food items may not be stored in a lab refrigerator. During an interview 06/25/2026 at 2:51 PM, the Director of Nursing (DON) reported that the expectation of staff when monitoring the lab supplies for expiration dates was to discard immediately any supplies found to be out of date. The DON indicated it was important that lab specimens were stored at a proper temperature because if they were stored out of range, they could be inaccurate and it could affect the specimen. She reported lab specimens should not be stored in a lab refrigerator at 20 degrees F, and ice cream should not be stored in a lab refrigerator.		

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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 observations, record reviews, interviews, and facility policy reviews, it was determined that the facility failed to ensure infection control practices were followed during laundry activities to prevent the spread of infection for the facility residents and failed to ensure contact precautions were consistently implemented for one (Resident #5) of one resident reviewed. The findings include: Resident #5 On 06/22/2026 at 2:35 PM, this surveyor approached Resident #5's room and observed a contact precaution sign on the door and personal protective equipment (PPE) of different color gowns inside the pockets of an external hanging rack outside the door. The contact precautions signage indicated Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also put on gloves and gown before entry. - There was also a white three tier cabinet on the outside of the resident's room by the doorway. The top drawer contained two boxes of disposable gloves. The second and third drawers contained yellow disposable gowns. There were no yellow or red biohazard bag or disposable equipment in the any of the drawers or in the four pockets on the hanging rack outside the resident's door. This surveyor used hand sanitizer on both hands, put on a yellow disposable gown and gloves. -After knocking and entering the room, this surveyor observed Resident #5 sitting up on the bed with their back to the wall and feet over the side of the bed. Resident #5 was wearing a blue adult brief and a pair of burgundy warm up pants that were only on the left leg. Resident #5 was unable to answer this surveyor's questions and surveyor was preparing to remove the PPE and noted there were not any biohazard bags or biohazard containers in the resident's room or bathroom into which to dispose of the PPE. -This surveyor activated Resident #5's call light. After five minutes of the call light being activated, Certified Nursing Assistant (CNA) #5 pushed Resident #5's door open slightly and spoke to the resident. She then pushed Resident #5's door open further and entered the room without putting on PPE. After she entered the room, she observed this surveyor standing in the room by the bathroom door with PPE of a yellow gown and blue gloves on. Once she had stepped on Resident #5's fall mat, she turned around and exited the room. After she put on a yellow gown and gloves, she came back in the room and began assisting Resident #5 by repositioning the resident in bed. There was a urine drainage bag resting on top of the fall mat. After CNA #5 removed Resident #5's burgundy warm up pants from their legs and the urine drainage tubing, she removed Resident #5's adult brief and placed the brief in a small trash can in the room that had a clear trash liner. She stated the treatment nurse was going to come in and assist her with Resident #5. As she was waiting, she began picking up the white pieces of material Resident #5 had begun to shred from their adult brief off the floor and placed them in the regular small trash can that contained a clear liner. CNA #5 was asked if Resident #5 was on transmission-based precautions and she stated, I don't know because I am not assigned to [Resident #5] today. This surveyor informed the CNA she had activated the call light because there was no place to discard the surveyor's PPE. CNA #5 stated once she was finished assisting Resident #5 she would leave the room and get containers for the PPE. She removed her PPE and placed the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	items in the small trash can with the clear liner. She washed her hands in the bathroom and surveyor asked if she would have the Infection Preventionist (IP) come to the room after she exited. On 06/22/2026 at 2:50 PM, the IP came to Resident #5's door and stood outside the doorway. This surveyor, still donned in PPE, asked the IP if a resident was on contact precautions, should biohazard containers be in the room for disposal of contaminated items, and she stated there should be. The IP left and returned, put on PPE, and brought in two brown cardboard boxes. The IP placed a red biohazard bag in each box and placed both boxes in the resident's bathroom that was shared with the adjacent room. There were no lids over the boxes of flaps to close. This surveyor then was able to dispose of the PPE, wash hands, and exit the resident's room. Review of the admission record for Resident #5 revealed the facility initially admitted Resident #5 on 08/14/2024 with diagnoses which included a urinary tract infection, with an onset date of 06/16/2026. Review of the Physician's Orders for Resident #5 revealed contact isolation for ESBL (extended-spectrum-beta-lactamases) with a start date of 06/18/2026. Review of the Care Plan, with a completion date of 06/18/2026, for Resident #5 revealed a focus of isolation precautions contact isolation ESBL with the date initiated of 06/18/2026. Interventions included ensure isolation signage is posted, maintain contact isolation precautions when caring for resident and PPE will be readily available, all with the date initiated of 06/18/2026. During an interview on 06/24/2026 at 1:58 PM, CNA #6 stated Resident #5 was on precautions, but she could not recall the name of the type, and the staff were using the red bags for linen and red bags for trash because they did not have any yellow bags at this time. She stated she returned to work today, and the resident was on precautions but had not been on precautions on Sunday, 06/21/2026, when she was at work. CNA #6 then walked over to Resident #5's door and stated the resident was on contact precautions. During an interview on 06/24/2026 at 2:11 PM, the Treatment Nurse (Tx Nurse) stated she was familiar with the facility's protocol for residents on contact isolation. She stated the nurse who passes medication to the resident on contact isolation was responsible for putting the biohazard containers in the resident's room. During an interview on 06/24/2026 at 2:25 PM, the IP stated Resident #5 was placed on contact isolation on Thursday, 06/18/2026. She stated the protocol for staff to follow when a resident was placed on contact precautions was the nurse would place the order in the facility's computer system for the antibiotic, confirm the order, and initiate the isolation. She stated the nurse would put the isolation signage out, place PPE out and communicate with the CNAs. She stated the nurses were responsible for placing biohazard containers in the resident's room who was on isolation. She stated staff should not enter the room of a resident who is on contact precautions to turn off a call light. While this surveyor was interviewing the IP, Laundry Worker #7 entered the hallway with a laundry cart, removed hanging laundry from the laundry cart, entered Resident #5's room without sanitizing hands or putting on PPE, and then came out of the room with empty hangers and continued down the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hallway with the laundry cart. The IP was asked if the laundry worker should enter Resident #5's room to take laundry without putting on PPE and she stated, No. She stated the nurses communicate with the housekeeping and dietary staff when a resident is placed on contact precautions. She stated the Director of Nursing (DON) conducts in-services on infection control and she [the IP] will assist her. Laundry Personnel During a concurrent observation of the mobile laundry at the facility and interview with Laundry Supervisor on 06/24/2026 at 2:23 PM she reported she washed her hands with soap and water at the handwashing sink for infection control between clean and dirty activities and after removing personal protective equipment (PPE). The Laundry Supervisor reported washing, drying and folding multiple loads of laundry today and every day that she is working. The described handwashing sink was full of plastic clothes hangers covered by slings for a lift device. The Laundry Supervisor reported the slings had been across the sink since 9:30 AM. Upon inquiring about handwashing since 9:30 AM, the Laundry Supervisor was unable to provide an answer for how infection control was maintained in laundry. She denied use of hand sanitizer and hand sanitizer was not observed. During an interview on 06/25/2026 at 2:00 PM Laundry #3 indicated handwashing was important to keep residents from getting sicker than they already are. She reported for handwashing she used the sink in the mobile laundry using soap and water and added she sometimes uses hand sanitizer instead. During an interview on 06/25/2026 at 2:51 PM the DON indicated laundry staff should sanitize their hands in between touching dirty and clean laundry. She reported best practice for laundry was to sanitize hands between touching dirty and clean laundry and after removing gloves. During a follow up interview on 06/25/2026 at 6:02 PM, the DON stated contact precaution required gowns and gloves before entering the resident's room. She stated biohazard boxes were placed in the room for disposal of PPE, and the nurse was responsible for putting the biohazard boxes out for use. Review of the [Laundry Supervisor's] Infection Control Overview and Policy for Inservice Program with a signed date of 02/27/2026 indicated Preventing the spread of infection is the core of our environmental services department. The policy indicated employees should implement hand hygiene practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination and properly store, handle, process and transport (cover) linens to minimize possible contamination. It also indicated standard precautions for environmental employees included proper hand hygiene, Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situation that require hand hygiene after handling soiled or used linens, after removing gloves or aprons. Review of an Infection Prevention and Control policy with no revision date revealed for isolation protocol, a resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC (Centers for Disease Control and Prevention) guidelines. The policy also revealed for staff education, all staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program and all staff shall demonstrate competence in relevant infection control practices. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an in-service education report dated 06/2026, and conducted by the DON, indicated for residents on contact isolation, gown and gloves must be donned (put on) before entering room.		