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 degeneration: lumbar region, polyneuropathy. The care plan identified interventions/tasks of transfers for Resident #98 to be dependent upon staff with a mechanical lift to move between surfaces, as necessary.A review of Resident #98's Closet Care Plan, dated [DATE], (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	instructed staff to use the mechanical lift with two staff and the purple sling (different colored slings are used following an assessment of the resident to ensure a proper fit) while transferring Resident #98.A review of Resident #98's Minimum Data Set with an Assessment Reference Date of [DATE], revealed the resident was to be dependent on helper to do all the effort, or the assistance of two or more helpers was required to complete the activity of transfer to chair or bed. A review of the Manual/Electric Portable Patient Lift user manual for the mechanical lift used to transfer Resident #98 during the incident, identified lift transfer recommendations of two assistants to be used for all lifting preparation, transferring from, and transferring to procedures. It included a warning that indicated failing to follow this recommendation could result in death or serious injury.A review of trainings for CNA #1, dated [DATE], indicated CNA #1 was trained on the mechanical lift. This training was completed by CNA #2. CNA #2's written statement for this training was provided in the investigation file. A review of Resident #98's Progress Note, dated [DATE] at 10:28 AM, revealed the Director of Nursing (DON) documented Resident #98 sustained a witnessed fall on [DATE] at 5:30 AM, with a visible head injury with a laceration to the right eyebrow. Resident #98 complaints of pain to head and right shoulder were noted. Resident #98 was transferred to the emergency room (ER) for further evaluation. Resident #98 was oriented to person. In-serviced staff and checked off staff on mechanical lift transfers, CNA #1 was terminated.During a phone interview on [DATE] at 12:13 PM, the family member of Resident #98 said the facility called and initially reported that an accident had occurred when Resident #98 fell out of bed. Later, the DON called and said Resident #98 had been dropped from the lift when a staff member tried to transfer the resident using the lift with a one-person transfer, instead of the two-person transfer, that was required. The family member said Resident #98 was dropped from the lift, which they believed led to Resident #98's death. Resident #98's family member said when the resident fell, something went through the resident's orbital fracture of their eyeball, and the resident's hip was broken on the right side, according to what the local ER nurse had told them. The family member said Resident 98's roommate witnessed the incident. The family member said the DON did fill out the police report. The family member said Resident #98 had lived at the facility for 7-8 years. The family member said Resident #98 was sent to a local ER and the CNA that performed the improper transfer was let go at the time of the incident. During an interview on [DATE] at 11:44 AM, CNA #8 said they had worked at the facility for over a year. CNA #8 said they did not know of any resident care planned for a one-person assistance mechanical lift transfer and it was always supposed to be two-staff when transferring residents with the mechanical lift. CNA #8 said they had to wait for the second person to assist them with a lift transfer. CNA #8 said they had been in-serviced on transferring a resident with a mechanical lift a few months ago, and when they were hired. CNA #8 said they were trained on using the mechanical lift a few times a year. CNA #8 recalled a lift transfer where a resident was lifted using a mechanical lift with one-staff, and the resident was hurt really bad, it was awful, and it wasn't that staff wasn't trained. CNA #8 said the facility in-serviced everyone after it happened, but we were taught before we started working on the floor. CNA #8 said the accident could have been prevented, had the CNA that performed the lift gotten a nurse or someone to help them.During an interview on [DATE] at 12:45 PM, Resident #61, who was the roommate of Resident #98 and present at the time of the incident, said they observed CNA #1 come in with the lift. Resident #61 said, I told the CNA they needed to have two people to use the lift. Resident #61 reported CNA #1 said they were going to wait for the other CNA, but then CNA #1 pulled the privacy curtain. Resident #61 said they heard a loud noise, pulled the curtain back, and could see Resident #98's face and head lying in a pool of blood. Resident #61 said I heard Resident #98 when they fell. Resident #61 said they gave a statement when it happened. Resident #61 said, [Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON)] wrote it for me and I signed it. The CNA's name was [CNA #1] who dropped [Resident #98], but [CNA #1] told me their name was a different name, but it was not, that I knew the CNAs name and their name was [CNA #1]. The other CNA that was supposed to help [CNA #1] told [CNA #1] that (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	they would be right back to help and asked [CNA #1] to give them a couple minutes to finish something. But [CNA#1] did not wait for the other CNA, I don't know the other CNAs name. Resident #61 said I screamed for the nurse because [CNA#1] was just standing there. Resident #61 said CNA #1 finally went out to get the nurse, but the nurse was already coming in. Resident #61 said the nurse's name was [Licensed Practical Nurse #1] and they came in and helped Resident #98. Resident #61 said the ambulance and the Emergency Medical Technicians (EMTs) came in to help. Resident #61 said Resident #98 had lived here over 10 years, and they had been roommates since November of 2024. Resident #61 said they told CNA#1 they needed to get some help, and that they could not use the lift by themselves, and the sling was still on the lift when Resident #98 was on the floor. Resident #61 said the head part of the sling was not where it was supposed to be, it was upside down. Resident #61 said Resident #98 was not alert when the EMTs left the facility, and the whole side of Resident #98 face was blue. During an interview on [DATE] at 1:16 PM, CNA #2 said I did not see it (Resident #98's fall). I was on 300-Hall. I was doing orientation with another CNA. [CNA #1] came running and said [Resident #98] fell. I went to find a nurse. The nurse ran back there, and the nurse told me to get the other nurse. I had told [CNA#1] to go back in the room with the resident. [LPN #12] and [LPN #11] were the two nurses. I went down to [Resident #98's] room and peeked in. I saw [Resident #98] was on the floor and it was blood on the floor beside [Resident #98]. [Resident #98] was still talking at that time. It was a lot of blood beside [Resident #98's] head. I started talking to [CNA#1]. [CNA#1] told me they were getting [Resident #98] ready, and [Resident #98] fell out of the bed. I don't think that is what happened because where [Resident #98] fell was too far from the bed. The lift was 4-5 feet away from the bed. [Resident #98] was 1-2 feet from the lift. [CNA #1] did not say anything about using the lift. I just knew it was there. [Resident #98] went to ER and did not come back to the facility. I know [Resident #98] had a funeral because a staff member went to the funeral. During an interview on [DATE] at 12:19 PM, the LPN/ADON said the CNAs were all trained in competency on the mechanical lift. The CNAs did a skill check off during the first four days of orientation, and then every quarter they received a refresher training on tasks. The LPN/ADON said it was absolutely not okay for one person to transfer a resident using a mechanical lift. The LPN/ADON said a few months ago, according to investigation, an (unidentified) CNA attempted to use a mechanical lift alone, but that CNA had previously been instructed not to use a mechanical lift with one person. The LPN/ADON said the staff were retrained after the incident occurred.During an interview on [DATE] at 2:10 PM, the Director of Nursing (DON) said around 6:00 AM on [DATE], they were notified of the incident involving the lift transfer with Resident #98. The DON said the resident was already at the hospital by the time they were notified. The DON revealed they immediately went to the facility and completed the reportable to the OLTC. The DON said, I received a phone call from the nurse telling me to get up, you are fixing to be upset. CNA #1 initially said that Resident #98 rolled out of bed. The nurse said the resident already had the lift pad underneath them when they went to give the resident their meds about 20 minutes prior. The nurse said they asked CNA #1 again what happened. The nurse then said they 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 (continued on next page)

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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 mechanical lift. LPN #11 said they had never found anyone using a lift by themselves. LPN #11 revealed the facility provided in-services sporadically, the last one was after this incident, and staff were trained and had to give a return demonstration and do a skills check-off. LPN #11 said the Lead CNA and the ADON trained the CNAs. LPN #11 said the lift sling was about four feet off the floor following the incident, measured to the bottom of the sling. LPN #11 said they thought the sling was improperly placed on the resident, because of how it was on the lift and that it did not look right and the chair was not in place. I do not know for certain if it was upside down, but I do not recall the back where the handles are, I assume they were at the bottom. I remember looking at the lift sling and it did look like it was upside down. LPN #11 said CNA #1 was getting Resident #98 out of bed. The lift was out by the window, turned almost toward the door, it appeared the resident had fallen before the CNA could complete the turn. LPN #11 said from what they had witnessed in their time at the facility, there had always been a nurse and a CNA or two, to use a lift. During an interview on [DATE] at 8:45 AM, the DON said the monitoring sheets started on [DATE], after the incident occurred, and as a part of their plan of correction for conducting random checks of staff using the lift. The DON said the staff never know what hall or time I may pop in to check them using the lift. The DON said the monitoring sheets identified the date, time, lift used, condition/comments (this area is asking how the transfer was, not the condition of the lift), staff who (continued on next page)

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The Administrator said they believed the CNA just made a poor decision, CNA #1 did not want to wait for the help, the CNA #1 just did not ask for help thinking they could just do it by themself, knowing it was a 2-person. The Administrator said the facility trains employees properly for the safety of our residents and unfortunately CNA #1 made a judgement call, despite the training, and that CNA was terminated. The Administrator revealed they continued training and in-servicing for their staff. The Administrator said CNA #1 did not consider the consequences of their decision, and it changed the lives of a lot of people. The Administrator said CNA #1 put their resident in jeopardy by doing that. The Administrator said they trained their staff on hire, annually, and as needed on the use of the mechanical lift. The Administrator said their last training was immediately following the incident and revealed they were monitoring transfers. The Administrator said prior to that date, we did a check off upon hire, annually, and as needed, such as when staff hear concerns from the residents or if they find Incidents & Accidents with bruising they feel may come from the lift. The Administrator said they have had complaints in the past about the staff going too fast during a transfer, and those staff were in-serviced on compassion and taking their time during a lift. The Administrator said they ensured all their staff were trained, with return demonstration, following the incident and prior to returning to work by the DON, the Lead CNA, and the ADON. The Administrator said they put a system in place to monitor lift transfers, complete checkoffs with the staff, staff put signs on all mechanical lifts stating two-persons must use the lift at all times, and in-serviced staff that they will be terminated if they try to transfer with one person. The Administrator revealed they were monitoring through morning meetings, Quality Assurance and Performance Improvement (QAPI), and by involving the DON and the ADON through reviews of the written monitoring sheets and the staff verbally tell them about their monitoring. The Administrator said they developed an entire plan of correction or performance improvement plan following the incident, and they would continue with all new hires, annually, and as needed or necessary in training. The Administrator said the Quality Assurance team and the Medical Director (MD) were all made aware of the incident and the steps being taken to prevent it from recurring and they were involved. During an interview on [DATE] at 3:00 PM, the MD said their involvement at the facility was to take care of all the LTC patients, oversee the Nurse Practitioner, and to manage the Medicare patients and the Rehabilitation staff. The MD said they recalled the incident where a resident was injured following a fall from the mechanical lift and was transferred to the hospital and died a few days later. The MD said the resident was transferred to a hospital in [location] and they did not use that hospital, so they were not the treating physician at that hospital. During an interview on [DATE] at 3:41 PM, the Physician Assistant (PA) said they had worked at the facility since April of 2023. The PA said they recalled the incident when a resident sustained a fall from the mechanical lift, which occurred when staff was transferring a resident with the mechanical lift using a one-person to complete the transfer. The PA said it happened at about 5:00 AM. The PA was notified about the event. The PA said I was told the patient was in a lift and there was just one CNA that was with the resident and there was supposed to be two staff with the resident, and the resident fell out of the lift. I don't remember who they called to send the resident out. The resident hit their head, had a rib fracture, bleeding from their eye and had a subdural hematoma (a serious collection of blood that forms between the brain's surface and its tough outer covering (dura mater), (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:	(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 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.