STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045173	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SILVER OAKS HEALTH AND REHABILITATION	1875 OLD WIRE ROAD CAMDEN, AR 71701

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents / resident representatives were provided with the opportunity to formulate advanced directives other than code status, to enable them to make advance decisions regarding which measures should be provided or withheld in the event of their incapacitation for 4 (Residents #51, #43, #1, and #41) of 4 sampled residents. This failed practice had the potential to affect 16 residents who resided in the facility, according to the Census Action Form provided by the Business Office Manager dated 7/9/2020. The findings are: 1. Resident #51 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/5/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). a. As of 7/8/2020 at 12:30 p.m., the resident's clinical record contained no Advance Directive. b. On 7/8/2020 at 1:00 p.m., the Assistant Director of Nursing (DON) was asked if Resident #51 had an Advance Directive? She stated, Let me look. The ADON went through the resident's chart and stated, Well, I can't find it. c. On 7/8/2020 at 1:30 p.m., the Business Office Manager (BOM) brought in an Advanced Directive for Resident #51. The Business Office Manager stated, The resident was in the facility before (the facility's computerized clinical record system) charting was initiated, and it probably slipped through the cracks. 2. Resident #43 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/3/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). a. As of 7/8/2020 at 12:35 p.m., the resident's clinical record contained no Advance Directive. 3. Resident #1 had a [DIAGNOSES REDACTED]. a. As of 7/8/2020 at 12:40 p.m., the resident's clinical record contained no Advance Directive. 4. Resident #41 had a [DIAGNOSES REDACTED]. a. As of 7/8/2020 at 12:40 p.m., the resident's clinical record contained no Advance Directive.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a person-centered Care Plan was developed and implemented to meet the resident's needs and address the administration of Antidepressant Medications and the necessary monitoring requirements for potential adverse effects of an Antidepressant Medication to promote continuity of care for 1 (Resident #29) of 1 sampled residents. This failed practice had the potential to affect 41 residents who had physician's orders [REDACTED].#29 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/8/2020 documented the resident scored 15 (13-15 indicates cognitively Intact) on a Brief Interview for Mental Status (BIMS); required total assistance from two staff members for transfers and toilet use; and received Antidepressant Medications 7 out of the last 7 days. a. A physician's orders [REDACTED]. [MEDICATION NAME] Tablet 20 MG (milligrams) . Give 1 tablet by mouth one time a day for [MEDICAL CONDITION] . b. The resident's Comprehensive Care Plan with a revised date of 6/16/2020 contained no documentation related to the use of Antidepressant Medications. c. On 7/9/2020 at 8:15 a.m., the Assistant Director of Nursing was asked, Should Antidepressants be documented on the Care Plan? She stated, Yes. d. On 7/9/2020 at 8:30 a.m., the Minimum Data Set (MDS) Coordinator was asked, Is (Resident #29) on an Antidepressant? She stated, Yes. She was asked, Is her Antidepressant documented on the Care Plan? She stated, No. She went to the hospital and it went off and I didn't put it back on. She was asked, Should Antidepressants be documented on the Care Plan? She stated, Yes.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observation, record review, and interview, the facility failed to ensure the environment was free of hazards and mouthwash, nasal spray, and eye drops were stored in an appropriate secured location to prevent potential accidental ingestion for 2 (Residents #54 and #50) of 2 sampled residents. This failed practice had the potential to affect 33 residents who resided on the 300 Hall and 400 Hall, as documented on a list provided by the Assistant Director of Nursing on 7/6/2020 at 10:55 a.m. The findings are: 1. Resident #54 had a [DIAGNOSES REDACTED]. a. On 7/6/2020 at 11:30 a.m., a bottle of mouthwash was on the resident's over-the-bed table. (The Surveyor took a photograph of the bottle of mouthwash at this time.) b. On 7/7/2020 at 9:38 a.m., a bottle of mouthwash was on the resident's over-the-bed table. c. On 7/8/2020, during the 8:00 a.m. Medication Pass, a bottle mouthwash was on the resident's over-the-bed table. Licensed Practical Nurse (LPN) #1 was asked, Did you see the bottle of mouthwash on the resident's bedside table? He stated, No. I didn't notice it. He was asked if a bottle of mouthwash should be on the bedside table? He stated, No, ma'am. It's his, and it's in his room, but it probably shouldn't be out in the open like that. d. On 7/8/2020 at 9:00 a.m., the Assistant Director of Nursing (ADON) was asked for a Self-Administration of Medications Assessment for (Resident #54). She stated, Let me find it. He's been here so long I will have to search for it. e. On 7/9/2020 at 9:00 a.m., the Assistant Director of Nursing was asked, Should mouthwash be kept on an over-the-bed table? She stated, No. She was asked, What could happen if a confused resident drank the mouthwash? She did not answer. The Director of Nursing stated, It could make them sick. 2. Resident #50 had a [DIAGNOSES REDACTED]. a. A physician's orders [REDACTED]. [MEDICATION NAME] Propionate Suspension 50 MCG/ACT (micrograms per actuation) . 2 sprays in each nostril at bedtime for allergies [REDACTED]. b. On 7/6/2020 at 10:15 a.m., a bottle of [MEDICATION NAME] Nasal Spray with Resident #50's name on the pharmacy label and a bottle of Artificial Tears were on the resident's nightstand behind the television. (The Surveyor took a photograph of the nasal spray and the artificial tears at this time.) c. On 7/8/2020 at 7:50 a.m., Licensed Practical Nurse (LPN) #2 was asked, Does (Resident #50) have an order to have medications in his room? She stated, Not that I'm aware of. She was asked, Is there a reason why he would have medications in his room? She stated, There shouldn't be medications in his room. She was asked, What about nasal sprays and eye drops? She stated, No, they should not be in his room, but I don't give those on my shift. d. On 7/9/2020 at 9:00 a.m., the Assistant Director of Nursing was asked, Should medications be stored in a residents' room if they have not been assessed and Care Planned for self-administration of medications? She stated, No. e. A facility policy titled Storage of

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Medications provided by the Assistant Director of Nursing on 6/9/2020 at 10:51 a.m., documented, .2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure nebulizer masks were appropriately stored in a bag or covered container when not in use to prevent potential cross-contamination for 1 (Resident #54) of 1 sampled resident who required respiratory treatments; and the facility failed to empty / clean / replace a suction canister for 1 (Resident #9) of sampled resident who required suctioning. This failed practice had the potential to affect 11 residents who received nebulizer treatments, and 1 resident who required suctioning, as documented on the lists provided by the Assistant Director of Nursing on 7/9/2020 at 10:51 a.m. The findings are: 1. Resident #54 had a [DIAGNOSES REDACTED]. a. A Care Plan dated 2/10/18 documented, .Has altered respiratory status / difficulty breathing r/t (related to) [MEDICAL CONDITIONS] . [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) mg/ml (milligrams per milliliter) 3 ml (milliliters) inhale orally every 6 hours . b. A physician's orders [REDACTED]. [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML (milligrams per 3 milliliter) 3 ml (milliliters) . Inhale orally four times a day for SOB (shortness of breath) . c. On 7/6/2020 at 11:30 a.m., a nebulizer mask was hanging on the side of the resident's refrigerator and was not stored in a bag or covered container. (The Surveyor took a photograph of the nebulizer mask at this time.) d. On 7/7/2020 at 9:00 a.m., a nebulizer mask was hanging off of the side of the refrigerator and was not stored in a bag or covered container. e. On 7/8/2020 at 8:00 a.m., during of the 8:00 a.m. Medication Pass, a nebulizer mask hanging on the refrigerator in the resident's room and was not stored in a bag or closed container. Licensed Practical Nurse (LPN) #1 was unable to locate the resident's nebulizer medication on the Medication Cart. He stated, He may self-administer his updrafts. I'm not sure. I don't usually work this Cart (Medication Cart). Let me check on it and let you know. f. On 7/8/2020 at 8:03 a.m., the resident was asked, Do you give your own breathing treatment? He stated, Yes. He was asked, Where do you store the medicine? He stated, In that drawer over there. Why are you asking all these questions? g. On 7/8/2020 at 9:00 a.m., the Assistant Director of Nursing (ADON) was asked for the Self Administration of Medications Assessment for Resident #54. She stated, Let me find it. He's been here so long I will have to search for it. h. On 7/8/2020 at 12:20 p.m., the Director of Nursing stated, He did not have an assessment to self-administer his updrafts, but we are doing an assessment today. He puts the mask on the refrigerator like that. The MDS Coordinator stated, He was not out of medication this morning. I put more in the cart (Medication Cart). She was asked, Does he (the resident) keep nebulizer medication in his room? She stated, No. i. On 7/9/2020 at 9:00 a.m., the Assistant Director of Nursing was asked, Should a nebulizer mask be stored in a bag when not in use? She stated, Yes. j. A facility policy titled, Administering Medications Through a Small Volume (Handheld) Nebulizer provided by the Assistant Director of Nursing on 7/9/2020 at 10:51 a.m. documented, . 26. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it . 2. Resident #9 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 4/10/2020 documented the resident scored 15 on a BIMS; required suctioning; and required [MEDICAL CONDITION] care. a. A physician's orders [REDACTED].[MEDICAL CONDITION] .Monitor O2 (oxygen) sats (saturations) when suctioning . as needed . b. A Care Plan dated 1/21/2020 documented, .The resident has a [MEDICAL CONDITION] r/t (related to) Impaired breathing mechanics . Suction as needed and watch 02 (oxygen) sats (saturations) while suctioning . c. On 7/6/2020 at 11:30 a.m., a suction machine was on the resident's bedside table with a moderate amount of secretions in the canister. The suction machine was not covered or cleaned. d. On 7/7/2020 at 8:00 a.m., the suction machine was on the resident's bedside table with moderate amount of secretions in the canister. The resident was asked, When were you last suctioned? He stated, I have not been suctioned today. It's been a while. (The Surveyor took a photograph of the suction machine and cannister at this time.) e. On 7/8/2020 at 9:56 a.m., the suction machine canister had a moderate amount of secretions. (The Surveyor took a photograph of the suction machine and cannister at this time.) The resident was asked, When were you last suctioned? He stated, Last night. f. On 7/8/2020 at 10:05 a.m., Licensed Practical Nurse (LPN) #1 was asked, How often do the suction canisters get emptied or cleaned? He checked the computer and stated, I do not know the answer to that. Let me ask the DON (Director of Nursing) and get back with you. g. On 7/8/2020 at 12:35 p.m., LPN #1 was performing [MEDICAL CONDITION] care for Resident #9. The suction canister was empty. After completing [MEDICAL CONDITION] care, LPN #1 was asked, Did you ever find out how often you are supposed to empty or clean the suction canisters? He stated, We just do it as needed. We don't suction him very often. Maybe only once every month or so. h. On 7/9/2020 at 9:00 a.m., the Assistant Director of Nursing was asked, If a resident is only suctioned once a month or so, how often should the suction canister be cleaned or emptied or changed? She stated, As needed. She was asked, How would you determine when it is needed? She stated, If we suction a resident on our shift, we should change it at the end of the shift. i. A facility policy titled Suctioning the Upper Airway provided by the Assistant Director of Nursing on 6/9/2020 at 10:51 a.m. documented, .Steps in the Procedure . 33. Empty and rinse collection container if necessary or as indicated by facility protocol .