STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045173	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately for 3 (Resident #47, #10, and #87) of 5 residents reviewed for accuracy of MDS assessments. The findings include: Resident #47 Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2025, indicated Resident #47 had diagnoses which included schizophrenia, anxiety, and depression. The MDS also revealed a score of 13 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. Resident #47 received an antipsychotic medication. Further review of the MDS revealed it indicated Resident #47 did not have a serious mental illness and/or intellectual disability, or related condition. A Determination Letter, from the State Designated Professional Associates who complete preadmission screening and annual resident review (PASARR) level II assessments, dated 06/30/2020, indicated Resident #47 did not require specialized services related to their mental illness beyond the capabilities of a nursing home facility. During an interview on 06/04/2025 at 12:09 PM, the Administrator confirmed Resident #47 had a mental health diagnosis, was considered a PASARR level II by the State Designated Professional Associates, and the annual MDS dated [DATE] was coded incorrectly. The Administrator stated, The MDS should be coded correctly because it tells us what is going on with the resident, and the care that needs to be provided. During an interview on 06/04/2025 at 12:14 PM, the Director of Nursing (DON) confirmed Resident #47 had a mental health diagnosis, and the annual MDS dated [DATE] should be coded correctly to reflect that Resident #47 was considered a PASARR level II by the state PASARR process. Resident #10 Review of a quarterly MDS with an ARD of 04/25/2025, revealed Resident #10 had a BIMS score of 10, which indicated moderate cognitive impairment. Further review of the quarterly MDS indicated Resident #10 did not have a feeding tube while a resident of the facility. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Care Plan Report, revised 11/01/2024, revealed Resident #10 required tube feedings related to difficulty swallowing. Further review indicated Resident #10 was on Enhanced Barrier Precautions related to wounds and feeding tube. During an interview on 06/05/25 at 10:33 AM, the DON stated that Resident #10 had a feeding tube. The DON stated that the MDS was coded inaccurately. During an interview on 06/05/25 at 12:42 PM, the Administrator stated Resident #10 had a feeding tube which was not noted on the quarterly MDS. The Administrator stated the quarterly MDS was inaccurate. Resident #87 A review of the admission Record, indicated the facility admitted Resident #87 with diagnoses that included fracture of right and left rib, lower back vertebra, and left and right lower leg. The discharge MDS, with an ARD of 03/08/2025, revealed Resident #87 had a BIMS score of 15 which indicated the resident was cognitively intact. The MDS indicated discharge assessment with return not anticipated and that Resident #5 was discharged on 03/08/2025, to a short-term general hospital. A review of Resident #87's Care Plan, revised 03/10/2025, revealed the resident wished to be discharged home. The resident needed assistance and supervision with booking appointments, performing activities of daily living, cooking, cleaning and transportation. Interventions included to arrange a discharge conference with the resident, responsible party/support person to discuss issues related to discharge plans. Other interventions included establishing a pre-discharge plan with the resident, family, and caregivers, evaluating progress and revising plan as needed. A review of Order Summary, revealed Resident #87 may discharge home with medications on 03/08/2025, may have home health for continued physical and occupational therapy and nursing services through home health and a wheelchair. A review of Nursing Discharge Summary, dated 3/10/2025, revealed Resident #87 discharged from the facility on 03/08/2025 at 11:38 AM, to home or lesser level of care with medications and personal belongings. A review of Interventional Care Plan discharge instructions, dated 3/7/2025, revealed Resident #87 would be returning to the resident ' s home address. A review of Facility Initiated Transfer, dated 3/11/2025, revealed Resident #87 was transferred or discharged to other; which indicated home, assisted living, etc. A review of Progress Notes, dated 3/8/2025, revealed Resident #87 was discharged via wheelchair to private care with family member with all belongings including medications. The resident was in stable condition. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/2025 at 10:46 AM, the Administrator indicated there were two MDS Coordinators (MDSC) that worked at the facility. One MDSC completed long term care and the other MDSC completed short term care. The Administrator stated the facility had a morning start up meeting that the MDSC attended. The meeting covered admissions, discharges, review of medications, change of conditions and any behaviors. Resident #87 was a planned discharge home. The MDS indicated the resident discharged to a short-term acute hospital. From what I see the resident did go home. There was a discrepancy. They should have put that [Resident #87] went home. During the survey, the MDSCs were not available for interview. On 06/05/25 9:20 AM, review of a policy titled Certifying Accuracy of the Resident Assessment, indicated all personnel that completes any portion of the MDS must sign and certify the accuracy of that portion of the assessment they completed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, record review, and facility policy review, it was determined that the facility did not ensure that incontinence care was provided in a manner that promotes cleanliness and/or prevent infections for 1 (Resident #39) of 3 sampled residents reviewed for activities of daily living, and the facility did not ensure standards of practice were followed for 1 (Resident #39) of 2 sampled residents reviewed that received enteral feedings. Specifically, the head of Resident #39 ' s bed was lowered while the resident received enteral nutrition. The findings include: On 06/04/25 at 2:38 PM, while observing Certified Nursing Assistant (CNA) #3 and CNA #4 provide incontinence care to Resident #39, this surveyor observed CNA #4 clean the resident by cleaning from the back to front, wiping towards the resident ' s genitals. During an interview on 06/04/25 at 2:57 PM, CNA #4 stated she wiped down while the resident was on the right side. CNA #4 was standing behind the resident therefore the direction of down was toward the resident ' s genitalia. During an interview on 06/05/25 at 10:41 AM, the Director of Nursing (DON) stated staff should wipe front to back when providing incontinence care to prevent infection. During an interview on 06/05/25 at 12:39 PM, the Administrator stated when a resident is lying lateral staff should wipe up away from the genitalia to prevent infection. A review of a Quarterly Minimum Data Set with the Assessment Reference Date of 05/09/2025, revealed Resident #39 had a Staff Assessment of Mental Status, which indicated the resident had short-term and long-term memory problems. A review of the Care Plan Report revised 06/06/2023, revealed Resident #39 had potential/actual impairment to skin integrity related to incontinence of bowel/bladder and immobility. A review of the policy titled Perineal Care revised February 2018, revealed the purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. A review of an article sourced from the National Library of Medicine, Assisting Patients With Personal Hygiene, indicated, When cleaning the genital area of a patient .make sure to use disposable wipes and wipe from front to back when cleaning the genitals. This process prevents urinary tract infections. On 06/04/25 at 2:38 PM, this surveyor observed Certified Nursing Assistant (CNA) #3 lower the head of the Resident #39 ' s bed until the bed was flat, while the feeding pump was infusing, to provide incontinence care. On 06/04/25 at 2:55 PM, during an interview CNA #4 stated she should have gotten the nurse to turn the feeding pump off prior to lowering the head of the bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/04/25 at 3:08 PM, during an interview Licensed Practical Nurse (LPN) #2 stated when staff need to provide care to a resident on a feeding pump, they should get the nurse to place the pump on hold prior to lowering the head of the bed to prevent aspiration. On 06/05/25 at 10:37 AM, during an interview the Director of Nursing (DON) stated when staff need to provide care to a resident on a feeding pump, they should notify the nurse, so the feeding pump can be paused while care is being provided to prevent aspiration. The DON stated, You do not just lay them down. A review of the quarterly Minimum Data Set with the Assessment Reference Date of 05/09/2025, revealed Resident #39 had a Staff Assessment for Mental Status which indicated there was short-term and long-term memory loss. Resident #39 had diagnoses which included difficulty swallowing directly related to moving food or liquid from the mouth into the esophagus which required use of a feeding tube. A review of the Care Plan Report revised 01/10/2022, revealed Resident #39 required tube feedings related to a swallowing problem. A review of the policy titled Enteral Nutrition revision date of November 2018, revealed risk of aspiration may be affected by: a. diminished level of consciousness b. moderate to severe swallowing difficulties c. improper positioning of the resident during feeding d. failure to confirm placement of the tube prior to initiating the feeding A review of an article sourced from the National Library of Medicine, Enteral Tube Management, indicated, Complications of Enteral Feeding .The most serious complication of enteral feeding is inadvertent respiratory aspiration of gastric contents, causing life-threatening aspiration pneumonia. Other complications include tube clogging, tubing misconnections, and patient intolerance of enteral feeding .Reducing Risk of Aspiration . The American Association of Critical‐ Nurses recommends the following guidelines to reduce the risk for aspiration: Maintain the head of the bed at 30°-45° unless contraindicated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, record reviews, and facility policy review, it was determined that the facility did not ensure proper hand hygiene was used during medication administration for 1 (Resident #238) of 3 residents observed for medication administration, 1 (Resident #39) of 1 resident observed for proper incontinent care technique, and feeding assistance for 1 of 2 meal services observed. The findings include: On 06/02/25 at 12:30 PM, during dining observation, this surveyor observed Certified Nursing Assistant (CNA) #5 assisting residents during meal service. CNA #5 touched both residents, the table, one resident ' s wheelchair, his hair, and picked a spoon up off the floor all without washing or sanitizing his hands before assisting residents with dining. On 06/02/25 at 1:45 PM, during an interview, CNA #5 stated they did not sanitize or wash their hands after adjusting a resident's position in the wheelchair, after touching cups and utensils touched by other residents, or after touching their face or hair before assisting other residents. CNA #5 stated he did not wash or sanitize hands after picking a spoon up off the floor before assisting both residents. On 06/05/25 at 10:50 AM, during an interview, the Director of Nursing (DON) stated that staff should wash or sanitize their hands after touching the residents, tables, chairs, personal clothing, personal face or hair, and objects touched by other residents if they are assisting multiple residents during meal service. On 06/05/25 at 12:47 PM, during an interview, the Administrator stated the staff should wash or sanitize their hands after adjusting a resident's position, touching the residents, touching items that were touched by the residents, touching their face or hair, and picking a spoon up off the floor. Resident #238 A review of an admission Record revealed the facility admitted Resident #238 on 06/02/2025. A review of the Care Plan Report, with initiation date of 06/02/2025, revealed Resident #238 had limited physical mobility. On 06/04/25 at 8:05 AM, during an observation, this surveyor observed Licensed Practical Nurse (LPN) #1 handle over the counter medications, open, close, and lock the medication cart, use the mouse for the computer, remove and return keys to personal pocket, and handle medical equipment with ungloved hands prior to placing medication in Resident #238 ' s mouth using unsanitized and ungloved hands. 06/04/25 at 8:30 AM, during an interview, LPN #1 stated his hands were not clean when he placed the pills in the mouth of Resident #238. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/05/25 at 10:53 AM, during an interview, the DON stated the nurse should have washed or sanitized his hands prior to placing pills in the resident ' s mouth, because the computer, mouse, keys, and stock medications were considered dirty with multiple people touching those items. On 06/05/25 at 12:44 PM, during an interview, the Administrator stated the nurse should have washed his hands after touching the dirty surfaces, prior to placing the pills in the resident's mouth. Resident #39 A review of the quarterly Minimum Data Set with the Assessment Reference Date date of 05/09/2025, revealed Resident #39 had a Staff Assessment of Mental Status score of 3, indicating the resident was severely impaired, and never/rarely made decisions. A review of the Care Plan Report revealed Resident #39 was totally dependent on bed mobility and required two staff for repositioning or turning in bed every two hours and as necessary. On 06/04/25 at 2:38 PM, this surveyor observed CNA #4 and CNA #5 provide incontinence care to Resident #39. This surveyor observed CNA #5 leave the bedside during care to retrieve a clean incontinence brief without removing and/or changing gloves or performing hand hygiene. On 06/04/25 at 2:38 PM, during an interview, CNA #5 stated she did not remove her gloves but should have because it was cross contamination. On 06/05/25 at 10:41 AM, during an interview, the DON stated when staff were providing care and realized that they have forgotten an item they should stop providing care, remove gloves, sanitize hands, retrieve the item they were missing, and then reapply gloves to prevent cross contamination. On 06/05/25 at 12:39 PM, during an interview the Administrator stated when staff were providing care and realized that they had forgotten an item they should remove gloves and wash their hands. A review of the policy titled Handwashing/Hand Hygiene with a revision date of October 2023, indicated the facility considered hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand hygiene is indicated: a. immediately before touching a resident b. after touching a resident c. after touching a resident's environment d. after coming in contact with blood, body fluids, or contaminated surfaces