STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Oak Nursing and Rehabilitation Center LLC	455 31st Street Marion, IA 52302

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 20331 Based on clinical record review, facility policy and staff interview, the facility failed to follow physician orders for 1 of 3 residents reviewed. (Resident #2). The facility reported a census of 70 residents. Findings include: The MDS (Minimum Data Set) dated 4/15/2024 revealed Resident #2 had severe cognitive impairment, dependent on staff for transfers from one surface to another, incontinence of bowel and bladder, and history of falls. The resident diagnoses included falls, encephalopathy, opioid use disorder, depression and COPD (chronic obstructive pulmonary disease). The Care Plan for Resident #2 directed staff to administer psychotropic medications as ordered and observe for side effects. The resident admitted to the facility from the hospital on 4/8/2024 with physician orders that included: a. Buprenorphine HCL - Naloxone HCL (Suboxone) sublingual (under the tongue) 8-2 mg (milligrams). Give one tablet sublingually four times a day for Opioid use disorder. b. Fluoxetine HCL (Prozac) oral capsule, 20 mg tablets, give three tablets (60 mg) by mouth one time a day. Used to treat depression. According to the April MAR (Medication Administration Record), the resident received no Suboxone from 4/8/2024 - 4/24/2024 when she readmitted from the hospital. According to the April MAR the resident also received Fluoxetine 20 mg every day from 4/8 - 4/20/2024 in place of 60 mg daily as the physician ordered. The hospital History and Physical dated 4/24/2024 revealed Resident #2 transferred from the facility to the hospital and admitted with diagnoses including acute metabolic encephalopathy (brain dysfunction caused by problems with metabolism), urinary tract infection, dementia, hypotensive (low blood pressure). Plan: Opioid use disorder, severe, in early remission (HCC), chronic and stable. Home medications include(s): Suboxone 1 tablet 4 times daily. Hold meds for now given patient is NPO (nothing by mouth). Falls frequently. Head CT: No intracranial (within the skull)abnormality. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital Progress Note dated 4/28/2024 revealed the resident had negative blood cultures, and acute and improved UTI (urinary tract infection). In a Progress Note dated 4/19/2024, Staff A, NP (Nurse Practitioner) indicated the facility never arranged for the resident to continue Suboxone treatment which she had been without. The Prozac (Fluoxetine) was accidentally decreased from 60 mg to 20 mg every day. On 4/30/2024 at 12:15 P.M., Staff A, NP reported she met Resident #2 one time at the facility, and the resident did not have clear cognition. On 4/24/2024, the facility reported the resident had altered mental activity, erratic behavior and the resident reported her husband gave her drugs. Staff sent her to the hospital for evaluation. Hospital lab reports revealed a negative drug panel. Staff A indicated since the resident did not receive the Suboxone for some time, it was unlikely that it caused ill effects. Staff A doubted the lower Fluoxetine dose caused anything drastic. On 4/30/2024 at 10:30 A.M., Staff B, DON (Director of Nursing) revealed when the resident admitted from the hospital, they receive the orders and someone must have entered the wrong Fluoxetine order in PCC (Point Click Care), the computerized charting system. The facility made an error when entering the orders into PCC. When they finally got the Suboxone order from the resident's psychiatric provider, the resident had been discharged to the hospital. On 4/30/2024 at 9:10 A.M., Staff D, RN (Registered Nurse) reported on 4/24/2024 Resident #2 had erratic behaviors, which had not been present the day prior. The resident reported her husband gave her drugs the night before. The resident had normal vital signs and the CNA's (Certified Nurse Aides), reported no urinary symptoms. Staff D received an order to transfer the resident to the Emergency Department, and later learned the resident admitted with a UTI. When the resident first admitted with the Suboxone order, Staff D called the pharmacy multiple times to see why they failed to deliver it. The physician revealed the drug needed to be ordered by the resident's psychiatric provider. On 4/29/2024 at 12:40 P.M., Staff C, LPN (Licensed Practical Nurse) reported Resident #2 admitted with the Suboxone order. Eventually they were able to find the provider and get an order. The resident admitted to the hospital before the medication arrived. The facility Medication Administration policy implemented 5/30/2023 included: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20331 Based on clinical record review and staff interviews, the facility failed to provide appropriate assessment and interventions for 1 of 3 residents reviewed. (Resident #1). The facility reported a census of 70 residents. Findings include: The MDS (Minimum Data Set) an assessment tool dated 4/15/2024 revealed Resident #1 had intact cognitive abilities, transferred with the assistance of one staff, a history of falls and pain. The MDS reported the resident received dialysis treatment and had IV (intravenous) access. The MDS documented the resident had diagnoses including diabetes, fracture, anemia, heart failure, renal (kidney) insufficiency, epilepsy and depression. The resident admitted to the facility on [DATE]. On 4/17/2024 the Care Plan added the focus: Resident has a PICC (Peripherally inserted central catheter) line. The care plan directed staff to provide an IV (intravenous) dressing, change dressing and record observation of site per doctor order. Flush PICC line per physician order and monitor for signs of infection. In a Progress Note on 4/8/2023 at 5:03 P.M., Staff E, RN documented Resident #1 arrived from the hospital with her husband. The resident had a port in the left groin and a double lumen right femoral PICC line. The resident's admission orders failed to include orders for the treatment and management of the PICC line on 4/8/2024. In a Progress Note dated 4/16/2024, Staff F, NP (nurse practitioner) documented the resident had an occluded left groin PICC line. The patient stated she had the PICC line for three months. Staff A removed the sutures to remove the PICC line but met resistance and was unable to remove it. Staff A scheduled an appointment with intervention radiology to have the PICC line removed on 4/24/2024 in order to prevent infection source. Staff A ordered staff to change the dressing weekly until the appointment on 4/24/2024. The hospital discharge summary 4/21 - 4/26/2024 indicated Resident #1 had community acquired pneumonia left lower lobe and the removal of the left femoral PICC line. On 4/30/2024 at 11:00 A.M. Staff F, NP revealed she first examined Resident #1 on 4/16/2024 and noticed she had a PICC line. The site had a dressing over it dated 4/1/2024. Staff F called in Staff B, DON to make her aware of the concern. Staff had not been flushing it and it had become completely clogged. Staff F removed the sutures, attempted to remove the line in order to prevent infection at the site, but met resistance. Staff F covered the site with a dressing. The resident told Staff F that nobody flushed it since admission. The resident admitted to the hospital on 4/21/2024 with pneumonia, not related to the PICC line. Staff F observed no sign or symptom of infection at the site on 4/16/2024. The resident had the PICC line removed during her hospital stay. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/2024 at 11:00 A.M., Staff B, DON indicated the admitting nurse on 4/8/2024 should have reached out to the provider for order for PICC line flush and maintenance. Any subsequent nurse who recognized she had the PICC line should have reached out. Staff B planned to educate staff at May 3rd staff meeting. On 4/24/2024 at 1:40 P.M., Staff C, LPN reported she worked on Sunday, 4/21/2024 and got a physician's order to send Resident #1 to the Emergency Department when she had a change in condition. On Saturday, 4/20/204 the resident had an elevated temperature and Staff C notified the physician. The physician ordered Tylenol and blood work, however the lab would not draw blood after 10 A.M. On Sunday the resident had elevated blood sugars. Staff C notified the physician and requested she be sent to the hospital for evaluation. When the resident's blood sugars remained elevated after additional insulin, Staff C asked the physician for an order to send her to the hospital for evaluation. On 4/29/2024, Staff B, DON submitted an education outline she intended to present to staff on 5/3/2024 that included: PICC/IV Access Education: All residents admitting with IV access need to have proper orders in place. If you note a resident has IV access on admission, please ensure we have orders for site maintenance and flushes. If there is no order in place, we need to reach out to the provider to obtain orders. Please let DON know if we are missing orders so we can follow up timely. The facility Intravenous Therapy policy implemented 8/2/2023 included: The facility will adhere to accepted standards of practice regarding infusion practices including administration by trained personnel that is within licensing scope of practice. Intravenous (IV) Therapy is the administration of parenteral fluids or medications through an IV catheter to treat a condition. Compliance Guidelines: #13. IV sites are checked every shift and PRN (as needed) for signs and symptoms of infection or inflammation.