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	08/21/2024

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 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** 19126 Based on clinical record review, staff and resident interviews, policy review, and observations the facility failed to provide adequate assessment and timely interventions for 1 of 4 residents reviewed (Resident #2). The facility reported a census of 73 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE] revealed Resident #2 had diagnoses which included Diabetes Mellitus Type 1, peripheral vascular disease, kidney failure, and heart failure. The MDS indicated the resident had intact cognitive ability and gave accurate information. The resident required total staff assistance for hygiene, toileting, and bathing. Review of the resident Care Plan dated 4/9/24 revealed the resident had a diagnosis of Diabetes Mellitus and directed staff to give diabetic medications as ordered by the physician, to monitor and document for side effects and effectiveness. The Care Plan directed the staff to report any sign and symptoms of hypoglycemia (low blood sugar) sweating, tremors, increased heart rate, pallor, nervousness, slurred speech, lack of coordination and a staggering gait. Review of a Physician's Order dated 8/1/24 revealed the resident had an order for Gyoke HypoPen 2-Pack Subcutaneous Solution Auto injector (Glucagon) Inject 1 milligram subcutaneous as needed for low blood sugar levels. Review of a Nurses Note dated 8/15/24 at 8:10 pm, Staff A-LPN noted the resident went unresponsive and experienced sweating upon checking the resident at 7:15 pm. The nurse performed a blood sugar check and found the resident's blood sugar dropped to 40. Staff A-LPN left the resident and placed a phone call to the resident's primary care provider who directed her to give the resident Glucagon injection and recheck the blood sugar in 15 minutes. The 15 minute blood sugar check revealed the resident now had a glucose level of 46 and remained unresponsive. Staff A placed another call to the primary care physician who ordered the resident be transferred to a local emergency room . The notes indicated the resident returned on 8/16/24 at 3:30 am, the resident returned alert and oriented. During an interview with Staff A-LPN on 8/21/24 at 1:50 pm, Staff A stated at the time Resident #2 experienced a critically low blood sugar and was unresponsive she was confused and didn't know how to treat the resident. She stated she is a new nurse and had not experienced this before. She stated her first instinct was to immediately transfer the resident to the emergency room but was confused and scared, stating she had never seen Resident #2 like this before. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #2's primary care provider on 8/21/24 at 10:30 am, the provider stated Staff A-LPN should have given Resident #2's Glucagon IM for the critically low blood sugar of 40 on 8/15/24 instead of calling the provider to report the low blood sugar. The provider stated she directed Staff A-LPN to hang up the phone immediately and administer the IM Glucagon to the resident, do it immediately before she did anything else at that moment. Review of the Medication Administration Sheet for August 2024 failed to reveal Resident #2 received an injection of Glucagon on 8/15/24. During an interview with Staff B-RN/Director of Nurses on 8/21/24 at 11:27 am, Staff B-Director of Nurses stated she would have expected Staff A-LPN to immediately administer the Glucagon IM upon finding the resident unresponsive and sweaty. Staff B stated she completed re-education with Staff A-LPN regarding emergency procedures for critically low blood sugars and will do an all nurse re-education regarding low blood sugar treatments.