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	02/05/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on clinical record review, facility policy, provider interview, and staff interviews the facility failed to notify resident's representatives and providers in a timely manner of test results related to changes in clinical conditions for 2 of 3 residents reviewed for notification (Residents #2 and #3). The responsible parties were not notified of x-ray results (Resident #2) or a new urinary tract infection (Resident #3). The facility further failed to provide x-ray and urine culture results to providers in a timely manner (Residents #2 and #3). The facility reported a census of 77 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #2 dated 1/19/25 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated severely impaired cognition. Active diagnoses included Alzheimer's disease, malnutrition, and essential hypertension. Resident #2's Care Plan (CP) documented altered cardiovascular status related to hypertension and congestive heart failure. Effective 4/30/24 it directed staff to assess for chest pain, shortness of breath, and cyanosis (bluish-purple discoloration due to low oxygen) and to monitor/document/report as needed any signs or symptoms of coronary artery disease. The Care Plan indicated, as of 1/17/25, the resident had altered respiratory status/difficulty breathing related to shortness of breath and wheezing. Staff were directed to administer medication as ordered, and monitor/document/report signs or symptoms of respiratory distress and abnormal breathing patterns to the provider as needed. On 1/16/25 at 6:30 PM a Progress Note (PN) documented that the resident complained of chest pain while taking a deep breath. Nursing assessed the resident, contacted family, and received the following orders from the on call provider: Guaifenesin 600 mg tablet every 12 hours for 7 days, administer 1-4 L (liters) of oxygen as needed for saturations less than 90%, and Albuterol sulfate inhalation nebulization solution 2/5mg/3mg 3 times a day for 7 days in addition to chest x-rays. At 7:05 PM a Progress Note was added to report that after the nebulizer treatment the resident's oxygen saturation was 96% on 2 L of oxygen. Resident #2's electronic health record did not include documentation of completion of the chest x-ray, follow up with the resident's family regarding the x-ray, or communication with the provider regarding the results of the chest x-ray. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/25 at 10:47 AM the resident's Advanced Registered Nurse Practitioner (ARNP) stated she came to the facility on [DATE] and assessed the resident due to acute (sudden) respiratory concerns, and made sure the order was sent in for the x-ray. She stated she did not receive the results of the chest x-ray until the afternoon of 1/20/25, which was after the resident was sent to the hospital on 1/19/25. When asked if her treatment plan would have been different if the results would have been provided to her when they were received by the facility on 1/17/25, she said she couldn't say. If she would have seen the results of the x-ray she would have asked questions about weight changes, fluid intake, and other questions to determine next steps. The ARNP stated a facility could call after hours, read the report to the on-call staff, and they would determine what to do next if she wasn't available. She also reported the facility did not provide her with the results of another resident's x-rays, taken on the same day, until 1/20/25. The facility was unable to provide documentation that the fax with the chest x-ray results were sent to the provider when received on 1/17/25 or otherwise addressed by facility staff before 1/20/25. During an interview on 2/5/25 at 10:06 AM Staff B, Licensed Practical Nurse (LPN) stated x-ray results usually came in rather quickly. She reported she didn't get Resident #2's results on her shift, but the DON told her to look out for them. Staff B stated she passed the message on to Staff G, Registered Nurse (RN) to watch for them. On 2/4/25 at 2:35 PM the Director of Nursing (DON), when asked about the chest x-ray, stated she took the results off of the fax machine on 1/17/25 and faxed it to the provider some time between 4:00 PM and 5:30 PM. She then told Staff B to follow up or pass it to the next shift and left for the day. She stated there should have been a call made to the provider that evening by Staff B or by Staff G. She had not been able to determine through investigation and interviews why the x-ray results were not addressed by the nursing staff between 1/17/25 and 1/20/25. 2. The Minimum Data Set (MDS) for Resident #3 dated 1/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated moderately impaired cognition. Active diagnoses included renal insufficiency, obstructive uropathy (blocked urine flow leading to the accumulation of urine and potential damage to the kidneys), and non-Alzheimer's dementia. Resident #3's Care Plan (CP) documented bowel and bladder incontinence dated 7/28/23 with an intervention to monitor and document signs and symptoms of UTI including but not limited to pain, burning, blood tinged urine, and urinary frequency. Another focus area dated 7/31/23 indicated the resident had impaired cognitive function and staff were expected to communicate with the resident/family/caregivers regarding the resident's needs. A Progress Note (PN) on 1/11/25 at 10:07 AM titled Health Status Note documented the resident had blood in his urine. The provider was notified and ordered a UA (urinalysis) and C&S (culture and sensitivity). A PN dated 1/12/25 at 11:53 PM documented urine was collected that day and scheduled for pickup tomorrow by the lab. The urine appeared red. On 1/13/25 at 1:34 PM a PN documented the sample went to the lab and the provider was faxed the preliminary results. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 3:40 AM a PN indicated the resident's nurse practitioner reviewed the lab results and was awaiting the culture. Facility staff were directed to fax them to her. The next urine related PN titled Health Status Note, dated 1/18/25 at 5:21 AM documented the resident was noted with very bloody urine, the urinalysis was positive, and the nurse practitioner was awaiting results. The results were faxed 1/15/25. Received telephone order for Cefdinir Oral Capsule 300 mg for burning, pain, frequency of urination. A document from the laboratory indicated a specimen collected 1/13/25 was reported 1/15/25 at 7:53 AM. Notations on the side of the document by Staff C, Licensed Practical Nurse (LPN) revealed the nurse practitioner was notified on 1/18/25 and a new order was given by telephone. None of the Progress Notes or documents listed included documentation that the resident's responsible party was notified. An interview with Staff C, LPN on 2/4/25 at 3:37 PM revealed there was a folder at the nurses station labeled ' waiting for results. ' Standard practice was to notify the provider as soon as possible with a condition change. The family would be notified with any condition change or new order. Staff C stated she spoke with the provider as soon as she saw the culture report and wasn't sure why it wasn't done before that. On 2/4/25 at 2:35 PM the Director of Nursing (DON) stated the responsible party should have been notified of any health changes the resident was having. She expected nursing staff to follow up with providers if they had not heard from them, for staff to communicate between shifts, and acknowledged the time it took to contact the provider was a long wait for this resident to be treated. A policy titled Notification of Changes, reviewed/revised 11/8/23, indicated the purpose of the policy was to ensure the facility promptly informed the resident, consulted the resident's physician, and notified the resident's representative when there was a change requiring notification. These circumstances included: *significant change in physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status and included clinical complications. *circumstances that required a need to alter treatment which included new treatment or a discontinuation of treatment.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48452 Based on review of the electronic health record, hospital reports, facility policy, and interviews the facility failed to provide sufficient resident assessments and interventions to maintain resident's highest practical physical and psychosocial well-being for 2 of 3 residents reviewed (Residents #2 and #3). The review revealed staff assessed a resident with new orders for as needed (PRN) oxygen and new complaints of breathing and chest discomfort 1 time during a 56 hour period, and did not assess a resident with pending urine culture results for 8 days. The facility reported a census of 77 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #2 dated 1/19/25 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated severely impaired cognition. Active diagnoses included Alzheimer's disease, anxiety disorder, and essential hypertension. Resident #2's Care Plan (CP) documented altered cardiovascular status related to hypertension and congestive heart failure. Effective 4/30/24 it directed staff to assess for chest pain, shortness of breath, and cyanosis (bluish-purple discoloration due to low oxygen) and to monitor/document/report as needed any signs or symptoms of coronary artery disease. The Care Plan indicated, as of 1/17/25, the resident had altered respiratory status/difficulty breathing related to shortness of breath and wheezing. Staff were directed to administer medication as ordered, monitor and document changes in orientation, restlessness, anxiety, and air hunger, and to provide oxygen according to provider orders. On 1/16/25 at 6:30 PM a Progress Note (PN) documented that the resident complained of chest pain while taking a deep breath. Nursing assessed the resident, contacted family, and received treatment orders from the on-call provider. Resident #2's Electronic Health Record (EHR) did not include documentation of completion of the chest x-ray or communication with the provider until 1/20/25. The vitals tab of the EHR did not have oxygen saturation assessments between 12/6/25 and 1/23/25. There was no documentation the resident's status was assessed by nursing staff on 1/18/25. During an interview on 2/4/25 at 10:47 AM the resident's Advanced Registered Nurse Practitioner (ARNP) stated she came to the facility the morning of 1/17/25 and assessed the resident due to acute (sudden) respiratory concerns. She stated she did not receive the results of the chest x-ray or updates about the resident's status from the facility until the afternoon of 1/20/25, which was after the resident was sent to the hospital on 1/19/25. On 2/4/25 at 1:11 PM Staff F, Certified Nursing Assistant (CNA) stated she saw some changes in the resident before he went to the hospital. She indicated he was more short of breath. He would start the day doing okay and then by lunch would tell them he was having a hard time breathing. Staff F stated the CNAs told the nurses so they could assess the resident. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at 1:28 PM Staff D, LPN stated it was standard practice to assess vitals, monitor oxygen, and call the on-call with concerns if a resident was having trouble breathing. She reported she didn't know the results of the chest x-ray and didn't remember seeing them. Staff D stated she worked on 1/18/25 and did monitor and assess the resident. When asked why no assessments or vitals were documented if they were done, Staff D stated sometimes they were busy and just didn't have time. On 2/4/25 at 2:35 PM the Director of Nursing (DON) reported she had not been able to determine through investigation and interviews why the x-ray results were not addressed by the nursing staff between 1/17/25 and 1/20/25. When asked about her documentation and assessment expectations, the DON stated she would want to see documentation of appearance, vitals, symptoms, head to toe assessment, did the resident complain or ask for PRN, and how the resident looked. She stated she thought the nurses were busy, the resident was not unnoticed, but the staff were just not doing their best documentation. She acknowledged it was difficult to prove an assessment was done if there was no record of it. 2. The Minimum Data Set (MDS) for Resident #3 dated 1/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated moderately impaired cognition. Active diagnoses included renal insufficiency, obstructive uropathy (blocked urine flow leading to the accumulation of urine and potential damage to the kidneys), and non-Alzheimer's dementia. Resident #3's Care Plan (CP) documented bowel and bladder incontinence dated 7/28/23 with an intervention to monitor and document signs and symptoms of UTI including but not limited to pain, burning, fever, blood tinged urine, and urinary frequency. A Progress Note (PN) on 1/11/25 at 10:07 AM titled Health Status Note documented the resident had blood in his urine. The provider was notified and ordered a UA (urinalysis) and C&S (culture and sensitivity). On 1/14/25 at 3:40 AM a PN indicated the resident's nurse practitioner reviewed the lab results and was awaiting the culture results. The next PN titled Health Status Note, dated 1/18/25 at 5:21 AM, documented the resident was noted with very bloody urine, the urinalysis was positive, and the nurse practitioner was awaiting results. The results were faxed 1/15/25. Received telephone order for Cefdinir Oral Capsule 300 mg for burning, pain, frequency of urination. Between 1/13/25 and 1/21/25 there were no Progress Notes to indicate Resident #3 had been assessed for pain or burning, additional bleeding, or fever while he waited for the results to be read. During an interview 2/5/25 at 10:06 AM Staff B, LPN reported assessments should be done with any antibiotic use, respiratory changes, or other changes in condition. Results could be documented in the EHR as Progress Notes, in the vital signs tab, or added as an assessment if one didn't automatically pop up. Staff B didn't know why assessments were not done every shift while the resident waited for the antibiotic. On 2/4/25 at 2:35 PM the Director of Nursing (DON) stated the resident should have been assessed at a minimum one time per shift and the assessment documented as a Progress Note. She acknowledged that was not done with Resident #3. The DON further stated she knew staff sometimes got busy but it was important to document, and that was nursing 101. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide a policy or protocol regarding conducting resident assessments related to changes in condition.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48452 Based on clinical record review and staff interviews the facility failed to maintain accurate and complete clinical records for 2 of 3 residents reviewed for records (Residents #2 and #3). The medical records for Resident #2 and Resident #3 failed to reflect the resident's current health conditions and the services provided to ensure communication throughout the interdisciplinary team. The facility reported a census of 77 residents. Findings include: 1. Resident #2 received an order for chest x-rays on the morning of 1/17/25. The resident's clinical record did not contain documentation that the resident received the chest x-rays, the same day results of the x-rays, timely follow up with the provider, or documentation of resident assessments, monitoring, and interventions related to an acute change in condition. On 2/4/25 at 2:35 PM the Director of Nursing (DON) reported she had not been able to determine through investigation and interviews why the chest x-ray results were not addressed by the nursing staff between 1/17/25 and 1/20/25. She confirmed the resident was transferred to the hospital on 1/19/25. She was unable to provide a record of the resident's assessments by nursing staff between 1/17/25 and 1/19/25, communication with responsible parties, services provided to support the resident's change in condition, or confirmation that the chest x-ray report was sent to the ARNP before 1/20/25. 2. Resident #3 received an order for a urinalysis (UA) and C&S (culture and sensitivity) on 1/11/25. Between 1/13/25 and 1/21/25 the resident's clinical record did not provide sufficient information for staff to respond to the needs of the resident. There was no indication Resident #3 had been assessed by nursing staff for bladder related pain or burning, additional blood in the urine, or fever while waiting for the results of the urinalysis to be read. On 2/4/25 at 2:35 PM the DON indicated she was not aware there were no assessments during that time period. She was sure they were monitoring for changes, and acknowledged it was hard to confirm that without Progress Notes or other assessments. She indicated assessments should be done for changes in condition at a minimum every shift and more often if needed. She stated some staff needed better education. An interview with the Administrator on 2/5/25 at 3:59 PM determined she expected the resident's medical record to contain any staff member concerns, assessments, and resident changes in condition. She stated she hoped nurses would be checking residents at least every shift, and some residents would be higher on the priority list based on their needs. The Administrator was not aware the nurses were not making regular assessments of residents with changes in condition part of the medical record.