

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2025
NAME OF PROVIDER OR SUPPLIER Silver Oak Nursing and Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility policy review, the facility failed to report an allegation of resident to resident abuse,(Resident #3 and Resident #4). The facility reported a census of 76 residents. Findings include:The MDS (Minimum Data Set) dated 7/26/2025 revealed Resident #4 had severe cognitive impairment, ambulated independently and had a history of physical behaviors. The resident had diagnoses including dementia, depression and mood disorder. The Care Plan indicated the Resident #4 had behaviors including physical aggression towards others. It instructed staff to administer medications as ordered, monitor and document behaviors and intervene as needed. The resident's Progress Notes dated 6/21/2025 at 1:59 p.m. revealed staff heard a resident yell help in the dining room. Resident #4 slapped another resident's face (Resident #3), knocking her glasses off. The other resident also reported Resident #4 pulled her hair. The MDS dated [DATE] revealed Resident #3 had severe cognitive impairment, ambulated independently, and had diagnoses including seizure disorder and dementia. Progress Notes dated 6/21/2025 at 1:59 p.m. revealed staff heard a resident yell help in the dining room, a CNA entered the room, Resident #3 received a slap to her face, knocking her glasses off. On 6/21/2025 at 10:16 p.m. staff documented the resident had a small scratch on her face. On 6/27/2026, Staff B, Nurse Practitioner saw the resident concerning an intact blister on her face and ordered an antibiotic for seven days. On 7/1/2025, staff documented the resident continued on an antibiotic for a left outer eye abscess. Staff B saw the resident on 6/27/2025. In her Progress Note, Staff B documented staff report the recent development of a blister, which has been increasing in size and causing discomfort. The blister is located at the corner of her left eye but does not involve the eye lids or eye lashes. She has attempted to alleviate the discomfort by applying a warm washcloth. An Incident Report dated 6/21/2025 at 1:59 p.m., revealed Resident #4 slapped Resident #3. Staff A, LPN (Licensed Practical Nurse) documented staff heard a resident yell help in the dining room. A CNA (Certified Nurse's Aide) entered the room and Resident #3 reported she received a full slap to her face, knocking her glasses off. The resident also reported Resident #4 pulled her hair. Staff immediately separated the residents. On 9/15/2025 at 8:12 a.m., Staff B, ARNP reported the resident had an infected abscess at the bottom of her left eye, it did not involve the eye lid, it was not a sty, and it cleared up with antibiotics. Staff began notifying her a couple of days prior to her visit on 6/27/2025. Staff B indicated the abscess could have been a result of trauma. Nursing staff failed to inform Staff B of the resident to resident incident at the time of the visit. On 9/15/2025 at 9:10 a.m., Staff D, Administrator and Staff C, Director of Nursing both indicated the incident involving Resident #3 and Resident #4 on 6/21/2025 should have been reported to the state. According to their abuse policy, it should have been reported. On 9/10/2025 at 9:40 a.m., Staff A, LPN reported on 6/21/2025, Resident #4 entered the dining room, came up behind Resident #3 and slapped her. The two residents do not get along and staff try to keep them apart. Staff A verified she documented the incident. The facility Abuse Policy implemented March, 2022 and revised 9/2025 included: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.VII. Reporting/ResponseA. The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p>

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on the Centers for Medicare and Medicaid Services (CMS) Statement of Deficiencies form, the facility Quality Assurance and Performance Improvement (QAPI) Plan, and staff interviews the facility failed to carry out Quality Assurance activities to ensure effective measures had been taken to correct deficiencies and prevent their ongoing prevalence. The facility reported a census of 76 residents. Findings include: The CMS 2567, dated 4/9/2025 reflected deficiencies identified for failure to report an allegation of abuse. The current complaint survey, conducted 9/8/2025 - 9/15/2025 also identified the above concern. During an interview on 9/15/2025 at 11:31 a.m. with Staff D, Administrator and Staff C, DON, Staff D explained the QAPI team met at least quarterly to discuss Performance Improvement Projects (PIP). The next committee meeting is scheduled for October 6 with administration, heads of departments and the medical director. Issues are discussed in the morning meetings, and those issues are carried over to QA (Quality Assurance). Data is collected via PCC (Point Click Care), grievance forms, and any relevant vendor notes such as pharmacy. Staff can leave notes or texts and they can call the compliance line anonymously. The committee decides which issues to work on by ranking them in order with which affect the residents first. Administration held a nurse's meeting regarding the failure to report. Staff were given an opportunity to voice some of the things they reported to prior administration. Things they felt should have been reported but were not. Staff were told they could put notes under the administrator's door if they had a concern. The facility Quality Assurance and Performance Improvement (QAPI) implemented 7/17/2023 included: Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. The QAPI plan will address the following elements: a. Design and scope of the facility's QAPI program and QAA Committee responsibilities and actions. b. Policies and procedures for feedback, data collection systems, and monitoring. c. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: i. Tracking and measuring performance. ii. Establishing goals and thresholds for performance improvements. iii. Identifying and prioritizing quality deficiencies. iv. Systematically analyzing underlying causes of systemic quality deficiencies. v. Developing and implementing corrective action or performance improvement activities. vi. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. d. A prioritization of program activities that focus on resident safety, health outcomes, autonomy, choice, and quality of care, as well as, high-risk, high-volume, or problem-prone areas as identified in the facility assessment that reflects the specific units, programs, departments, and unique population the facility serves. The facility must also consider the incidence, prevalence, and severity of problems or potential problems identified. e. A commitment to quality assessment and performance improvement by the governing body and/or executive leaders. f. Process to ensure care and services delivered meet accepted standards of quality. The facility QAPI Plan received from the administrator on 8/25/2025</p>		