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	10/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, resident interviews, staff interviews, training documentation, personnel files, and policy review the facility failed to ensure 2 of 5 residents received respectful dignified care that protected their right to privacy (Residents #2 and #8). An Activity Assistant walked into Resident #2's room while a Certified Nurses Aide (CNA) was providing personal cares, and into Resident #8's room while she was dressing and using the restroom. The facility reported a census of 70 residents.Findings include:1. The Minimum Data Set (MDS) for Resident #2 dated 7/6/25 documented diagnoses of cancer, multiple sclerosis, and schizophrenia. Her Brief Interview for Mental Status indicated she was cognitively intact with a score of 15/15. Section GG revealed she was dependent on staff for hygiene, dressing, transfers, and bed mobility.A progress note titled Psychosocial Note dated 10/2/25 at 1:00 PM documented the resident was receiving cares when the Activity Assistant came into the room without knocking. The CNA stated the Activity Assistant saw the resident exposed and that caused the resident distress. She was uncomfortable that the staff entered the room, and very upset by the belief that the staff member would be fired. She spoke with the Director of Nursing about the incident.Investigation documentation titled Questions - Alert and Oriented Residents dated 10/3/25 revealed Resident #2 told the facility that Staff D, Activities Assistant had entered her room twice without knocking and that it made her feel uncomfortable.During an interview on 10/22/25 at 10:14 AM Resident #2 confirmed Staff D entered her room without waiting for the CNA taking care of her (Staff A, CNA) to announce that she was providing care. She stated she was naked and the CNA was providing peri care. The resident stated she mostly felt embarrassed at the time and she told Staff A she was upset. She reported Staff D apologized later and she was no longer upset.During an interview on 10/22/25 at 11:46 AM Staff A confirmed the resident's account of the incident and stated the resident was very upset when it happened. She reported the incident to the nurse and Director of Nursing for follow up. Staff A did not think most staff entered rooms without knocking but other residents had commented about the Activity Assistant not knocking and not waiting for a response.2. The most recent submitted MDS for Resident #8 dated 9/21/25 revealed diagnoses of bipolar disorder, osteoarthritis, and polyneuropathy (damage or disease affecting nerves on both sides of the body).A facility Assessment Scoring Report dated 7/20/25 to 10/20/25 documented the resident scored 11/15 on the BIMS assessment which indicated moderate cognitive impairment.The Care Plan (CP) for Resident #8 dated 10/12/23 revealed she had risk for or actual impaired ability to transfer independently related to musculoskeletal impairment, and the intervention dated 8/26/24 revealed the resident could usually transfer independently. A current Care Plan intervention dated 8/26/24 revealed the resident could independently complete both toilet transfers and hygiene. Staff were directed to check in with the resident to be sure she didn't require more help.Investigation documentation titled Questions - Alert and Oriented Residents dated 10/3/25 and 10/6/25 revealed Resident #8 told 2 employees that Staff D, Activities Assistant had entered her room without knocking too many times to count and that it made her uncomfortable.During an interview on 10/22/25 at 10:30 AM Resident #8 reported that Staff D had come into her room without knocking or without waiting for her to answer his knock many times. She provided examples that included asking him to get out while she finished dressing, asking him to come back in 10 minutes when she heard him open the door and call out while she was in the bathroom, and opening the door when she was trying to get in bed. She did not think he was trying to hurt her, but she didn't feel like he thought about her privacy while he was doing his job. She stated residents at resident council had reported the same concerns.During an interview with the facility's Corporate Nurse on 10/22/25 at 12:19 PM she confirmed that the incident with Resident #2 and the concerns brought forward by Resident #8 were not the first time Staff D had entered resident rooms without knocking.At 12:22 PM on 10/22/25 the Administrator stated Staff D had been educated and re-educated regarding the correct way to enter a resident room. This included teach back training where she demonstrated her expectations to him and he then performed the task. At 12:47 PM the Administrator provided disciplinary action reports dated 8/12/25 and 9/9/25 for Staff D regarding similar incidents. Training records provided did not include documentation of all staff training regarding dignity and privacy.On 10/22/25 at 1:22 PM Staff D confirmed he entered Resident #2's room during cares and stated he took full responsibility for that. He reported that he knocked and said who he was, didn't hear them, and then opened the door. He said his voice was soft and they might not have heard him. When asked if he waited for a response to open the door he said no. When asked if there were incidents where he entered a resident's room without waiting for a response he said no.A policy titled Resident Rights