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	04/23/2026

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

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on the Centers for Medicare and Medicaid Services (CMS) Statement of Deficiencies forms, review of the facility Quality Assurance and Performance Improvement (QAPI) documentation, QAPI policy review, and staff interview the facility failed to implement effective quality assurance processes to address deficient practices with F658 Services Provided Meet Professional Standards, F725 Sufficient Nursing Staff, and F880 Infection Prevention and Control, resulting in deficient practices previously identified in 2025 also identified on the facility's current survey. The facility reported a census of 75 residents.Findings include: A review of the CMS CASPER reports revealed the following deficiencies had been cited as follows: a. F658 Services Provided Meet Professional Standards in 2021,2022,2024, and 2025. b. F725 Sufficient Nursing Staff in 2025.c. F880 Infection Prevention and Control in 2025.Deficient practices were identified with F658, F725, and F880 during the facility's most current survey, conducted 4/20/26-4/23/26. A review of the facility QAPI Plan revealed the following: The Governing Body: Reviews QAPI data, findings, and trends, oversees corrective actions and performance improvement activities, ensures adequate staffing, training and resources and supports regulatory compliance and quality outcomes the QAPI/QAA Committee is responsible for the implementation, coordination, and ongoing monitoring of the facility's Quality Assurance and Performance Improvement (QAPI) program and Performance Improvement Projects (PIPs), 4. Feedback, Data Systems, and Monitoring: The following methods will be used to monitor care and services that draw data: Quality indicator reports, CASPER reports, Resident concerns/ grievances, audit tools, monthly facility tracking and trending reports, self-reports, Survey results Department of Inspections and Appeals (DIA) 2567.In an interview on 4/23/26 at 12:45 PM, the Administrator reported concerns were brought to the QA Committee from audits, grievance forms. The QA Committee decided which issues to work on based on what was needed, what was urgent, and what was required. The Administrator was responsible for providing updates to the Council on a monthly basis or as requested.

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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interviews, facility document review and facility policy review the facility failed to answer call lights timely for 4 out of 6 residents reviewed (Resident #1, Resident #26, Resident #50,and Resident #80). The facility reported a census of 75 residents.Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #26 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated moderate cognitive impairment. The MDS also documented diagnoses of complete traumatic amputation above the knee of left lower extremity, anxiety, depression, and the need for assistance with personal care. The MDS revealed Resident #26 required partial/moderate assistance with toileting hygiene. The Care Plan focus area dated 2/14/25 revealed the resident was at risk for or has actual impaired ability to independently toilet. The intervention for Resident #26 dated 5/22/25 instructed when toileting, the resident can complete both the transfer and hygiene tasks independently. Check in with the resident early in the shift to be sure the resident isn't requiring more assistance than usual. On 4/20/26 at 11:28 AM, Resident #26 reported having to wait 45 minutes for staff to answer the bathroom call light to assist with wiping while she was sitting on the toilet. 2. The MDS assessment for Resident #50 dated 3/17/26 documented a BIMS score of 15 out of 15, which indicated intact cognition. The MDS reflected the following diagnoses of spondylosis, chronic pain syndrome, Fibromyalgia, osteoporosis, and muscle weakness. The assessment indicated Resident #50 was dependent on staff for toileting, dressing upper and lower body, and required substantial assistance for chair/bed to chair transfers. On 4/20/2026 at 11:00 AM, Resident #50 verbalized she had waited up to 40 minutes for assistance but said it was getting better, only had to wait 20-25 minutes now. 3. The Minimum Data Set (MDS) assessment for Resident #1 dated 4/05/26 listed diagnoses of end stage renal disease, high blood pressure, diabetes mellitus (DM). The MDS reflected a BIMS score of 15 out of 15, which indicated intact cognition. The MDS reflected Resident #1 required partial/moderate assistance to sit up in the bed, sitting to lying on the bed, from sitting to standing, and with toileting hygiene. The Care Plan intervention for Resident #1 dated 4/6/26 directed keep call light within reach and encourage the resident to use it, if not cognitively impaired, for assistance as needed. On 4/20/26 11:01 AM Resident #1 reported he'd waited 40 minutes for staff to come help him. Resident#1 stated the weekends were worse, felt not enough staff on the weekends. 4. The MDS for Resident #80 dated 4/13/26 listed diagnoses of heart failure, diabetes mellitus (DM), and respiratory failure. The BIMS listed a score of 15 out of 15, which indicated intact cognition. The MDS reflected Resident #80 was dependent on staff for toileting hygiene, lower body dressing, rolling to the left and right, sit to standing and bed to chair transfer. The MDS showed Resident #80 required substantial/maximal assistance for upper body dressing and bath/shower. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan intervention for Resident #80 dated 9/1/2023 revealed, call light within reach and encourage the resident to use it, if not cognitively impaired, for assistance as needed. On 4/23/26 at 7:27 AM, the Call light Monitor on the wall at the North nurses station read Resident #80's room number on 26 minutes. Staff K, Certified Nurse Aide (CNA) sat the nursing station. On 4/23/26 at 7:29 AM, the Staffing Scheduler/CNA went into the Resident #80's room to see what the resident needed. Staff K went into the room. The call light turned off after 28 minutes. Resident #80 reported the staff were checking and changing her. On 4/23/2026 at 10:02 AM, Resident #80 reported her call light on for sometime before the staff came to help her. On 4/23/26 at 1:07 PM the Director of Nursing (DON) reported she expected call lights answered in 15 minutes. The Resident Council notes dated 1/12/26 identified call lights not being answered. The Resident Council notes dated 1/29/26 identified call lights not being answered timely. The Resident Council notes dated 2/9/26 identified call lights not being answered timely. The Resident Council notes dated 4/13/26 revealed resident has to wait an hour for CNA to come help them. The facility provided a policy titled Call Lights: Accessibility and Timely Response dated 12/1/25 reflected the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interviews, employee files, facility document review, and facility policy review the facility failed to check the licensure for 1 of 1 nurse before hire, and failed to obtain clearance from the Department of Criminal Investigation (DCI) before 1 out of 5 staff were hired. The facility reported a census of 75 residents.Findings include:1. The employee timecard for Staff H, Certified Nurse Aide (CNA) showed the employee was rehired on 9/29/2025.The Employee Master Form dated 10/1/25 revealed a requested rehire 9/29/25. The Employee file for Staff H failed to hold a background check dated 9/29/25 or within 30 days before hire. The Division of Criminal Investigation (DCI) advised on 10/2/25 more information needed.The Submission Status/Results Summary dated 1/29/26 showed Criminal History pending further research. 2. The Employee File for Staff I showed the SING completed 6/26/25. The SING failed to show a nurse licensure verification.The facility completed Staff I's licensure verification on 4/2/26. On 4/23/26 at 8:00 AM the Administrator reported the facility verified Staff I's nursing License in 1/2026. The Administrator reported she expected the licensure verification completed before hire. On 4/23/2026 at 10:45 AM the Administrator confirmed the facility failed to have a copy of the clearance for Staff H to work before the hire date of 9/29/25. The Administrator reported these need completed before hire. The Facility provided a blank new hire check list that directed License/Certification Copy AND Verification as part of Pre-Hire, as well as SING Results & May Work Letter (required for anyone with and un-clean SING report) as part of pre-hire.The facility provided a policy titled Abuse, Neglect and Exploitation dated 4/22/25 revealed the following per the Screening section:A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants.2. Screenings may be conducted by the facility itself, third-party agency or academic institution.3. The facility will maintain documentation of proof that the screening occurred.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and clinical record review the facility failed to notify the Long-Term Care Ombudsman of discharge and transfers as required for 1 of 1 resident reviewed for hospitalizations (Resident #13). The facility reported a census of 75 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident # 13 relayed the resident entered the facility from the hospital. The Care Plan initiated 11/14/2024 for Resident #13 relayed resident has altered respiratory status, difficulty breathing, chronic obstructive pulmonary disease, heart failure and chronic hypoxic respiratory failure. Resident #13's Electronic Record listed multiple hospitalizations:-hospitalized on [DATE] and returned on 6/3/25 -hospitalized on [DATE] and returned on 11/13/25-hospitalized on [DATE] and returned on 12/24/25-hospitalized on [DATE] and returned on 1/16/26 On 4/20/26 at 11:17 AM, Resident #13 confirmed recent hospitalizations, contributed to breathing issues.On 4/22/2026 at 11:15 AM, the Administrator reported had believed the Social Services interim staff had notified the Ombudsman appropriately. On 4/22/26 at 11:30 AM, Social Services, Staff B relayed had not been trained correctly regarding reporting to the Ombudsman, could not provide documents that indicated notification of Resident #13's transfers, and agreed processes needed improved for correct Ombudsman report submission. The Administrator relayed on 4/23/26 at 9:30 AM had a report that tracked admission and discharges and thought social services was reporting to the Ombudsman. Per the Administrator, would ensure training and correct the processes. The Transfer and Discharge policy revised 7/14/25 directed the Social Services Director, or designee, would provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for contents of the such notices.

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	165171	A. Building B. Wing	04/23/2026

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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. Based on observation, record review, staff interviews, resident interviews, and policy review the facility failed to follow Physician's Orders when applying topical medication for 1 of 5 residents reviewed (Resident #50). The facility reported a census of 75 residents.The findings include: The Minimum Data Set (MDS) assessment for Resident #50 dated 3/17/26 documented a BIMS (Brief Interview for Mental Status) score of 15/15, which indicated intact cognition. The MDS reflected the following diagnoses of arthritis, chronic pain syndrome, fibromyalgia (disorder causing pain, fatigue, sleep disturbances and cognition issues), osteoporosis, and muscle weakness. The resident's Care Plan focus area dated 8/31/23 revealed the resident had potential for pain related to knee pain, fibromyalgia, chronic pain syndrome, hx (history) skin cancer of face, thoracic spondylosis (spinal osteoarthritis). Interventions dated 8/31/23 included:a. Anticipate resident need for pain relief, to evaluate the effectiveness of pain interventions.b. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.On 4/20/26 at 11:00 AM, Resident #50 stated her Voltaren cream (for pain) and hydrocortisone cream (for rash) were not applied like ordered. A document titled Treatment Administration Record (TAR) for March 2026 lacked documentation that the resident received her scheduled Voltaren gel for 16 out of 93 applications, and Hydrocortisone cream for 2 out of 62 doses.A document titled Treatment Administration Record (TAR) for April 2026 lacked documentation that the resident received her scheduled Voltaren gel for 7 out of 67 doses, and lacked documentation for Hydrocortisone cream for 4 out of 45 doses.On 4/22/26 at 1:00 PM, the Director of Nursing (DON) confirmed her expectation that staff were to sign off on treatments once completed, and if staff did not complete a treatment, they wrote a progress note and notified the physician. A document titled Medication Administration Policy last revised 4/9/25 stated 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. The policy explanation and compliance guidelines included, Sign MAR after administered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on clinical record review, staff interview, and policy review the facility failed to ensure assessments were completed before and after dialysis and ensure ongoing coordination between the facility and dialysis center for 1 of 1 resident reviewed for dialysis (Resident #1). The facility reported a census of 75 residents. Findings include:The Minimum Data Set (MDS) assessment for Resident #1 dated 4/5/26 revealed a diagnosis of renal insufficiency/End Stage Renal Disease (ESRD). Per the MDS assessment, the resident received dialysis. The resident's Brief Interview for Mental Status (BIMS) assessment scored 15 out of 15, which indicated intact cognition. The Care Plan initiated 4/2/26 documented Resident #1 received dialysis three times weekly, and the intervention dated 4/6/26 directed to monitor vital signs pre and post dialysis and as needed. The Electronic Record for Resident #1 Titled Dialysis Communication, included the dialysis communication tool assessment and facility communication tool assessment for April 1, 3, 6, 10, 14, 16, 18, and 21. A Dialysis Communication Tool dated 4/1/26 revealed Section 2 titled Dialysis Center Communication was blank.A Dialysis Communication Tool on 4/3/26 revealed Section 2 titled Dialysis Center Communication was blank.A Dialysis Communication Tool on 4/16/26 revealed Section 2 titled Dialysis Center Communication was blank.A Dialysis Communication Tool dated 4/18/26 revealed Section 2 titled Dialysis Center Communication was blank.A Dialysis Communication Tool dated 4/21/26 revealed Section 1 titled Facility Communication was incomplete on the shunt exam section. During an interview on 4/21/26 at 2:30 PM, Staff C, Licensed Practical Nurse relayed the pre-dialysis assessment was completed by the facility nurse before Resident #1 left the facility, and the post-dialysis assessment was completed at the dialysis center. The information relayed by the dialysis center was supposed to be sent back with the resident and entered into the facility assessment documents. Staff C relayed was not sure why some assessments were missing. During an interview on 4/22/26 at 3:10 PM with the Director of Nursing (DON), the DON explained an assessment should be done before dialysis and after dialysis by the facility. The DON relayed would ensure an improved process to ensure dialysis assessments are completed before and after dialysis procedures. The facility policy titled, Hemodialysis revised 12/2/24 documented the facility will assure ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interviews, and facility policy review the facility failed to implement Enhanced Barrier Precautions (EBP) for 2 of 3 residents reviewed (Resident #6 and Resident #11). The facility reported a census of 75 residents.Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #6 dated 3/20/26 listed diagnoses of Atrial Fibrillation (irregular heart beat), acute respiratory failure, and gastrostomy tube (feeding tube) status. The Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicated intact cognition. The gray box on Resident #6's room door held Personal Protective Equipment (PPE) that included gowns, gloves and face masks. The sign on the box that held the PPE read EBP. Everyone must clean their hand before entering and before leaving the room. Providers and Staff must also: Wear gloves and gown for the following activities. Dressing, bath/shower, transferring, changing linens, providing hygiene changing briefs or assisting with toileting, Device care or use: central lines, urinary catheter, feeding tube. On 4/23/26 at 8:25 AM, Staff F Wound Nurse checked the order for the tube feeding (TF) and water flush. Staff F completed hand hygiene applied gloved. Staff F flushed the tube feeding and set up the feeding per the physician's order. Staff F failed to use gown and mask with the TF. On 4/23/26 at 9:46 AM upon entering Resident #6's room, Staff C Licensed Practical Nurse (LPN) and the Speech therapy (ST) were in the room. ST directed Resident #6 to work on swallowing exercises. Staff C wore a pair of gloves and failed to wear other EBP. The feeding tube was unconnected from Resident #6. Staff C removed her gloves, left the room. Staff C reported she needed to find the Director of Nursing (DON).On 4/23/26 at 9:52 AM, Staff C completed hand hygiene, put a gown, mask and gloves on, and administered Resident #6's medication through the feeding tube. On 4/23/26 at 10:15 AM, Staff F reported she failed to wear the gown and mask (EBP) when she hooked up Resident #6's TF. On 4/23/26 at 10:37 AM, Staff C reported she failed to put the gown, mask on and when she went into Resident #6 room to flush her TF after her feeding completed. Staff C acknowledged she only wore only gloves for that care. 2. The MDS assessment for Resident #11 dated 3/20/26 listed diagnoses of retention of urine, and need for assistance with personal care. The MDS included a BIMS score of 15 out of 15, which indicated intact cognition. The MDS revealed the resident had an indwelling urinary catheter.The Care Plan for Resident #11 dated 4/17/26 identified an indwelling foley catheter related to retention of urine. The Intervention dated 4/20/26 directed EBP.On 4/20/26 at 1:00 PM, 4/21/26 at 9:30 AM, and 4/22/26 at 8:05 AM, Resident #11's room door failed to hold an EBP Sign or box with PPE. The Medication Administration Record (MAR)/Treatment Administration Record (TAR) dated 4/2026 directed indwelling Foley catheter 16 French 15 milliliters (ml) per Urology physician for urine retention. On 4/23/26 at 8:46 AM, Resident #11 and Staff E, Certified Nurse Aide (CNA) walked out of the shower/bath room across the hall from Resident #11's room. Staff E reported she just completed bathing for Resident #11.Staff E said she failed to need EBP for a bath. Staff E said CNAs did the catheter care but they only needed to use gloves for her cares, no gown or other PPE. Resident #11's room door failed to hold an EBP sign or PPE.On 4/23/26 at 10:30 AM, Staff C reported the CNA needed to wear the EBP when they did things with Resident#11's catheter bag. She said if the staff didn't move the bag or wash her, they don't need to use EBP. On 4/23/26 at 10:35 AM Staff E reported she told Resident #11 to wash herself during the shower. Staff E revealed she just wore gloves with Resident #11's shower. On 4/23/26 at 10:35 AM, the Infection Preventionist (IP) said EBP was needed when entering the room for catheter care handling of urine. All need an EBP tray holder on the door and the sign. The IP confirmed staff were expected to use EBP for residents with tube feedings. On 4/23/26 1:08 PM, the Director of Nursing (DON) reported she expected the staff to use the EBP as directed on the signage with high contact activities. The facility provided a policy titled Enhanced Barrier Precautions dated 9/9/25 which revealed, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms Enhanced barrier precautions (EBP) refer to an infection control intervention designed to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.The Implementation of Enhanced Barrier Precautions section revealed, a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room .4. High-contact resident care activities include:a. Dressingb. Bathingc. Transferringd. Providing hygienee. Changing linensf. Changing briefs or assisting with toiletingg. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) lines, midline cathetersh. Wound care: any skin opening requiring a dressing.5. Enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room, and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility.