STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165171	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Iowa, 52302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Correction date: 5/23/26 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #2733744-C, # 2807907-C, #2980543-C, and #2991147-C, conducted April 20, 2026 to April 23, 2026. Complaint #2733744-C resulted in a deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F0865		

✓ KBS

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 reverse for further 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
AR Deering	Administrator	✓ 5.15.26

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F0865 SS = F	Continued from page 1 §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;	F0865		

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F0865 SS = F	Continued from page 2 §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: 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:	F0865		

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F0865 SS = F	Continued from page 3 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.	F0865		
F0725 SS = E	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses	F0725		

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F0725 SS = E	Continued from page 4 of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: 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 3/16/26 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	F0725		

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F0725 SS = E	Continued from page 5 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.	F0725		

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F0725 SS = E	Continued from page 6 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.	F0725		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of	F0607		

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F0607 SS = D	Continued from page 7 resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: 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.	F0607		

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F0607 SS = D	Continued from page 8 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.	F0607		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the	F0628		

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F0628 SS = D	Continued from page 9 facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F0628		

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F0628 SS = D	Continued from page 10 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F0628		

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F0628 SS = D	Continued from page 11 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the	F0628		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0628 SS = D	Continued from page 12 time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: 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 4/3/26 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 6/1/25 and returned on 6/3/25 -hospitalized on 11/8/25 and returned on 11/13/25	F0628		

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F0628 SS = D	Continued from page 13 -hospitalized on 12/23/25 and returned on 12/24/25 -hospitalized on 1/9/26 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.	F0628		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: 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:	F0658		

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F0658 SS = D	Continued from page 14 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.	F0658		

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F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: 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.	F0698		

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F0698 SS = D	Continued from page 16 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.	F0698		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based	F0880		

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F0880 SS = D	Continued from page 17 upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F0880		

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F0880 SS = D	Continued from page 18 This REQUIREMENT is NOT MET as evidenced by: 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.	F0880		

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F0880 SS = D	Continued from page 19 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	F0880		

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F0880 SS = D	Continued from page 20 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 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. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) lines, midline catheters h. 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.	F0880		

Final Corrected Plan of Correction
Facility: Silver Oak Nursing and Rehabilitation Center

✓ Alleged Compliance Date for All Tags: 5/23/26 except F607 5/7/2026

F865 – QAPI

1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

The facility reviewed deficiencies cited under F658, F725, and F880 and implemented corrective action related to treatment documentation, infection control practices, and timely response to resident needs.

2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

Residents with the potential to be affected were reviewed through focused audits related to treatment documentation, infection control practices, and call light response times.

3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

The IDT team will be educated on the components of F658, F725 and F880 by the DCS on 5/20/2026. The facility updated QAPI monitoring processes and incorporated ongoing review of treatment documentation, infection control compliance, staffing responsiveness, and identified facility PIPs to ensure concerns are identified and corrected timely. The facility coordinated installation of a 475 device integrating the wander management system with the call light system to allow monitoring and auditing of call light response times and improve staff accountability.

4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place

The DCS will attend the monthly QAPI to ensure continued progress and compliance in F658, F725 and F880. Any areas identified with trends or noncompliance will have retraining and adjustments to the plan and/or PIP as needed. The Administrator/designee will conduct audits monthly x3 months and findings will be reviewed through QAPI for further recommendations as indicated.

F725 – Sufficient Nursing Staff

1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Residents #26, #50, #1 and #80 are now being answered timely.

2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

Residents with the potential to be affected were reviewed through resident interviews and call light monitoring observations.

3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

Staff were re-educated regarding timely response to resident call lights and resident care needs. The facility reinforced expectations regarding timely resident assistance and implemented ongoing monitoring of call light response times. The facility coordinated installation of a 475 device integrating the wander management system with the call light system to allow monitoring and auditing of call light response times and improve staff accountability. Resident Advocate rounds were re-implemented and include routine resident check-ins regarding satisfaction with call light response times.

4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place

The Director of Nursing/designee will conduct QRC of 10 random call light audits and 5 resident interviews weekly x4 weeks, then monthly x3 months through QAPI. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F607 – Hiring Compliance

1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Staff H's May Work letter was received on 1/23/26 and placed in the employee file. Staff I's nurse license verification was obtained on 10/15/25 and placed in the employee file. Staff I was terminated on 5/5/26.

2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

A facility-wide audit of employee files was completed to verify nurse licensure verifications, SING results, DCI clearance documentation, and May Work letters.

3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

Administrator was re-educated regarding nurse licensure verification requirements, SING review, DCI clearance documentation, and use of May Work letters prior to hire when applicable. A new HR representative was hired on 4/30/26 and will receive education related to these requirements prior to independently performing HR functions.

4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place

The Administrator/designee will audit new hire files monthly x3 months with focus on nurse licensure verification, SING results, DCI clearance documentation, and May Work letters through QAPI.

Alleged Compliance Date: 5/7/2026

F628 – Transfer/Discharge Notifications
1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Social Services will re-send the Ombudsman notifications for the previous 6 months utilizing the correct notification form and will continue utilizing the correct form going forward.

2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

Residents with the potential to be affected were reviewed through audit of recent transfer and discharge documentation.

3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

The Administrator will educate Social Services staff regarding Ombudsman notification requirements for resident transfers and discharges. The facility reinforced discharge tracking processes to ensure required notifications are completed timely.

4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place

The Administrator/designee will audit discharge records monthly x3 months through QAPI. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F658 – Professional Standards of Care

1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident #1 is now receiving treatments as ordered. The nurse identified during survey was terminated on 5/5/26.

2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

Residents receiving treatments with the potential to be affected were reviewed through audit of current treatment records and documentation.

3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

Licensed nursing staff were re-educated regarding treatment completion and documentation requirements. The facility reinforced expectations for timely completion and documentation of treatments in accordance with physician orders and facility policy.

4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place

The Director of Nursing/designee will audit treatment documentation of 5 residents weekly x4 weeks, then 5 residents every other week x4 weeks, then monthly x1 month through QAPI. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F698 – Dialysis Services

1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

> Licensed nursing staff were re-educated regarding dialysis communication and pre/post dialysis documentation requirements. The dialysis TAR order was updated to require completion of both pre- and post-dialysis assessments.

2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

> Residents receiving dialysis services with the potential to be affected were reviewed through audit of current dialysis documentation.

3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

> The Director of Nursing/Designee re-educated licensed nurses on dialysis communication and documentation processes to ensure required assessments and communication are completed consistently.

4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place

> The Director of Nursing/designee will audit pre/post dialysis assessments daily x30 days, then weekly x3 months through QAPI. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F880 – Infection Prevention and Control

1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

> Staff are now utilizing EBP while caring for resident #11 while bathing and #6 while administering enteral feeding.

2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

Residents with the potential to be affected were reviewed through infection control rounds and observation of Enhanced Barrier Precaution practices.

3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

Staff were re-educated regarding Enhanced Barrier Precaution requirements, including appropriate PPE use and availability of required signage and supplies. The facility reinforced infection control practices related to PPE use, Enhanced Barrier Precautions, and availability of required supplies and signage. The facility initiated an Infection Control PIP on 3/27/26 which was revised to include Enhanced Barrier Precaution compliance and monitoring.

4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place

The Infection Preventionist/designee will conduct infection control audits weekly to validate use of EBP for 10 residents requiring EBP x 4 weeks then monthly x 2 months through QAPI.

Alleged Compliance Date: 5/23/26 except F607 was 5/7/26