STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145703	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silvis Center for Nursing Rehab & Care	1455 Hospital Road Silvis, IL 61282

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to ensure daily weights were completed as ordered for a resident with congestive heart failure and failed to identify an increase in weight for a resident with congestive heart failure for 1 of 3 residents (R1) reviewed for weights in the sample of 9. This failure resulted in R1's weight not being monitored appropriately, changes not being communicated with the physician, and R1 being transferred to the acute care hospital for treatment of congestive heart failure exacerbations on 4/3/25 and 4/10/25. The findings include: R1's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include acute diastolic congestive heart failure, chronic obstructive pulmonary disease with acute exacerbation, need for assistance with personal care, acute and chronic respiratory failure with hypoxia, primary pulmonary hypertension, other forms of dyspnea, obstructive sleep apnea, and anxiety disorder. R1's facility assessment dated [DATE] showed she has severe cognitive impairment and requires substantial to maximum assist of staff for most cares. On 5/2/25 at 1:08 PM, R1 said, . The daily weights have not happened the way I want it to. Since I've been here it has not hardly been done at all. The fluid content in my body has to be monitored. I used to weigh myself every day at home . R1's 2/3/25 hospital discharge orders showed, . Discharge Plan . Reason for Admission: CHF (Congestive Heart Failure) exacerbation . Instructions for Patients with Heart Failure: Please weigh daily (with the same scale and at the same time each day if possible) . Report weight gain of 3 lbs in 1 day or 5 lbs in 1 week to cardiologist . R1's weight under the vitals tab in the electronic record showed on 2/3/25 she weighed 210 lbs (pounds). R1's February 2025 eMAR (electronic Medication Administration Record) showed an order start date of 2/4/25 for Daily weight due to CHF one time a day. Report a weight gain of greater than 3 pounds in 1 day . R1's weight was documented on this eMAR on 2/4/25 as 216.5 lbs (a weight gain of 6.5 lbs in one day). R1's medical record showed no evidence of notification to her physician on 2/4/25 of the 6.5 lbs weight gain. R1's 2/5/25 nursing note entered at 2:37 PM showed, Possible admission to hospital. Currently on 2 liters of oxygen and COVID positive . R1's record showed she remained in the acute care hospital until 2/18/25. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's 2/18/25 hospital discharge orders showed, . Discharge Plan . Acute bronchitis with COPD . COVID-19 . Hypoxia . Instructions for Patients with Heart Failure: Please weigh daily (with the same scale and at the same time each day if possible) . Report weight gain of 3 lbs in 1 day or 5 lbs in 1 week to cardiologist . R1's census showed she was present in the facility from 2/18/25 through 2/25/25. R1's eMAR showed an order started 2/19/25 for Daily weights x 3, Weekly weight x 4, monthly weight . No order was entered to reflect daily weights. R1's record showed weights documented 2/19/25 as 186, 2/20/25 as 186, and 2/21/25 as 185.6. No weights were documented for 2/22/25, 2/23/25, 2/24/25 or 2/25/25 due to the incorrect order being entered. R1's record showed she remained in the acute care hospital from 2/25/25 through 3/5/25. R1's 3/5/25 hospital discharge orders showed, Discharge Plan: . Instructions for Patients with Heart Failure: Please weigh daily (with the same scale and at the same time each day if possible) . Report weight gain of 3 lbs in 1 day or 5 lbs in 1 week to cardiologist . R1's census showed she was present in the facility from 3/5/25 through 4/3/25. R1's eMAR showed an order start date of 3/6/25 for Daily weights x 3, Weekly weight x 4, monthly weight . No order was entered to reflect daily weights until 3/27/25. R1's record showed her weight documented 3/6/25 as 185.6 lbs, 3/7/25 as 201.4 lbs, and 3/8/25 as 204.1 lbs. R1's medical record showed no evidence of notification to the physician of her weight change 3/7/25. No weights were documented from 3/9/25 through 3/26/25 due to the incorrect order being entered. No daily weights were entered 4/1/25, 4/2/25, or 4/3/25. R1's 4/3/25 nursing note entered at 9:48 AM showed, Patient resting in bed with eyes closed. Had to sternal rub to wake her up. Did respond to verbal stimuli but would not stay awake. Blood pressure 88/48 pulse ox 90 % on room air, appears short of breath, using accessory muscles. Notified [R1's doctor], okay to send to emergency department for evaluation and treatment . R1's record showed she remained in the acute care hospital from 4/3/25 through 4/7/25. R1's 4/7/25 hospital discharge orders showed, . Hospital Course: . presented to the hospital with worsening shortness of breath and cough. admitted for acute CHF and was requiring 2L of O2 throughout the day, rather than only at night. She was diuresed with intravenous Lasix and transitioned back to oral Lasix, her dyspnea (difficulty breathing) resolved . Discharge Plan: . Instructions for Patients with Heart Failure: Please weigh daily (with the same scale and at the same time each day if possible) . Report weight gain of 3 lbs in 1 day or 5 lbs in 1 week to cardiologist . R1's census showed she was in the facility from 4/7/25 through 4/10/25. One weight was documented between 4/7/25 and 4/10/25. 1 of 3 weights completed as ordered. R1's 4/10/25 nursing note entered at 11:47 AM showed, Call placed to [R1's Physician], reviewed current assessment findings of increased confusion . Respirations 32 utilizing abdominal accessory muscles with spO2 98% on 2L per nasal cannula, lung sounds with expiratory wheezing . Guest will open eyes with verbal and tactile stimulation for short periods. New order received for Albuterol Nebulizer treatment one time, reassess after nebulizer treatment and call report back to [R1's Physician]. R1's 4/10/25 nursing note entered at 12:18 PM showed, Call placed to [R1's Physician], reviewed assessment. New order received to send to [acute care hospital] for respiratory distress. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's 4/17/25 hospital discharge orders showed, . Hospital Course: . presented with dyspnea and was admitted with acute on chronic respiratory failure secondary to CHF exacerbation and metabolic encephalopathy . Discharge Plan: . Instructions for Patients with Heart Failure: Please weigh daily (with the same scale and at the same time each day if possible) . Report weight gain of 3 lbs in 1 day or 5 lbs in 1 week to cardiologist . R1's census showed she has been in the facility from 4/17/25 through current. R1's eMAR shows from 4/18/25 through 4/30/25 there were 5 daily weights not completed as ordered. R1's care plan initiated 4/24/25 showed R1 has Congestive Heart Failure but did not include information regarding daily weights or physician notification of weight changes. On 5/6/25 at 11:25 AM, V4 RN (Registered Nurse) said daily weights are important for monitoring residents with CHF to monitor how their heart is functioning and identify when they are retaining fluid. On 5/6/25 at 3:40 PM, V2 DON (Director of Nursing) said, This is considered an order for daily weights. I expect daily weights to be done daily to monitor for fluid overload. Typically, if there is an order for parameters, usually weight gain over 3 lbs in one day we would contact [R1's Physician] so she can evaluate if there should be a need for a fluid restriction, add or change a diuretic, or possibly the need to be seen. Daily weights are important for monitoring the fluid for people with CHF because if there is too much fluid they can go into cardiac arrest especially with quick fluctuations. On 5/6/25 at 12:49 PM, V7 (R1's Physician) said she has concerns with the facility completing daily weights. V7 said she is frustrated because she sees R1 every week for the most part and tries to communicate with the facility staff. V7 said part of the problem she feels is that the staff are always changing so there is not the follow through with the orders. V7 said she has expected to receive updates on R1's weights including notification of significant changes as the parameters on R1's record shows. V7 said she has received R1's weights one time since she was admitted to the facility. V7 said R1 has CHF which is the reason she is on daily weights. The daily weights monitor for fluid retention and the need to modify her medications and diuretics. V7 said she would expect them to have given me her weights so she could adjust R1's medications and possibly prevent her from having to go to the hospital. The facility's weight policy was obtained but did not include daily weights. On 5/6/25 at 3:40 PM, V2 DON said the facility does not have a policy regarding care of residents with Congestive Heart Failure or have a policy related specifically to daily weights. V2 said the order for daily weights would be expected to be completed as all other physician orders are.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to ensure a resident with an order for a BiPAP (Bilevel Positive Airway Pressure) machine was provided one for 1 of 3 residents (R1) reviewed for respiratory devices in the sample of 9. This failure resulted in R1 being hospitalized for respiratory failure due to not using BiPAP machine. The findings include: R1's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include acute diastolic congestive heart failure, chronic obstructive pulmonary disease with acute exacerbation, need for assistance with personal care, acute and chronic respiratory failure with hypoxia, primary pulmonary hypertension, other forms of dyspnea, obstructive sleep apnea, and anxiety disorder. R1's facility assessment dated [DATE] showed she has severe cognitive impairment and requires substantial to maximum assist of staff for most cares. On 5/6/25 at 10:45 AM, V12 (R1's Power of Attorney) said R1 had a CPAP prescribed at home and they were in the middle of getting her settings readjusted when she went into the hospital. V12 said they took R1's home CPAP machine to the facility for use with the settings she was using at home. V12 said coming out of the hospital on 4/17/25 there was an order for a BiPAP because she was doing well on a BiPAP in the hospital. V12 said he was concerned that the facility did not have the BiPAP available until 4/22/25 (5 days after R1 returned from the hospital) which caused her to have marked difficulty with disorientation, cognitive ability, and sleep patterns . R1's 2/3/25 hospital discharge orders showed, Durable Medical Equipment (DME)(CPAP) See instructions: BiPAP at 14/7, mask and supplies . R1's 2/3/25 Admission/Readmission Screener assessment showed no oxygen used and showed no information regarding R1 wearing a CPAP or BiPAP at night. R1's census showed she went back to the acute care hospital 2/5/25 and was readmitted to the long term care facility 2/18/25. R1's 2/18/25 hospital discharge orders showed, Durable Medical Equipment (DME)(CPAP) See instructions: BiPAP at 14/7, mask and supplies . R1's 2/18/25 Admission/Readmission Screener assessment showed no oxygen was used and no CPAP or BiPAP was used. R1's February 2025 eMAR (electronic Medication Administration Record) and eTAR (electronic Treatment Administration Record) showed no orders for applying either a CPAP or a BiPAP at night. R1's census showed she went back to the acute care hospital 2/25/25 and was readmitted to the long term care facility 3/5/25. R1's 3/5/25 hospital discharge orders showed, Durable Medical Equipment (DME)(CPAP) See instructions: BiPAP at 14/7, mask and supplies . R1's 3/5/25 Admission/Readmission Screener assessment showed no information related to R1's oxygen use, CPAP, or BiPAP use. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	R1's March 2025 eMAR showed an order started 3/5/25 for CPAP worn at night- 14/7, every night related to sleep apnea . Between 3/5/25 and 3/31/25, there was documentation of 6 nights which R1 did not wear her CPAP. R1's census showed she went back to the acute care hospital 4/3/25 and returned to the facility 4/7/25. R1's 4/7/25 hospital discharge orders showed, Durable Medical Equipment (DME)(CPAP) See instructions: BiPAP at 14/7, mask and supplies . R1's 4/7/25 Admission/Readmission Screener assessment showed R1 was wearing oxygen at 2 LPM and had neither a CPAP or a BiPAP. R1's April 2025 eMAR showed no order for CPAP or BiPAP entered upon R1's return to the facility 4/7/25. R1's census showed she went back to the acute care hospital 4/10/25 and returned to the long term care facility 4/17/25. R1's 4/17/25 hospital discharge orders showed, Durable Medical Equipment (DME)(CPAP) See instructions: BiPAP at 14/7, mask and supplies . Hospital Course: was admitted with acute on chronic respiratory failure secondary to CHF exacerbation and metabolic encephalopathy. Respiratory failure due to noncompliance with diet and not using BiPAP. Family initially wanted a different skilled nursing facility but are now agreeable to go back to where she came from. She is requiring 2L of oxygen and is supposed to be on BiPAP at night. Patient has not been compliant with this, and long discussions have been had with her daughter regarding continuing current treatment she encouraged her mom to be compliant with BiPAP . Strongly recommend complying with BiPAP at night or patient is at risk for readmission . R1's 4/17/25 Admission/Readmission Screener assessment showed R1 using oxygen but indicated no for CPAP/BiPAP. R1's care plan initiated 4/24/25 (the first indication in R1's care plan of BiPAP use) showed, The resident utilizes a BiPAP related to Obstructive Sleep Apnea . The resident intermittently refuses to wear BiPAP as prescribed, placing them at risk for respiratory complications such as hypoxia, fatigue, and poor sleep quality . Use BiPAP as scheduled. R1's April 2025 eMAR showed an order started 4/17/25 for BiPAP at night- bilevel 14/7. The facility provided a receipt showing a BiPAP machine was delivered by their Durable Medical Equipment provider on 4/22/25. R1's same eMAR showed R1 has refused wearing the BiPAP 4 times between 4/17/25 and 4/30/25 and being compliant with wearing the BiPAP 10 nights. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On 5/6/25 at 12:49 PM, V7 (R1's Physician) said, [R1] had been on BiPAP in the past in the hospital. She historically had not wanted to wear her CPAP when she was at home. Since she has been at the facility, she has not been wearing it. In part, she has hesitation to wear it, but it's only been the last week that her BiPAP was even there for her to use . Based off of the orders she had coming from the hospital she should have had the BiPAP starting all the way back 2/3/25 when she first admitted . I think the reason it was done now after this admission is there was more detail in the discharge because there was a conversation about hospice. I think it was a more forceful conversation that she has to have the BiPAP or she is not going to make it. For her, the BiPAP is very important . On 5/6/25 12:06 PM, V2 DON (Director of Nursing) said, [R1] had a CPAP at home that she was noncompliant with it . We tried to encourage her to use her CPAP, but it was hit or miss. She brought it from home when she was admitted . She went back to the hospital and when she returned to us, they changed her to a BiPAP on her last hospitalization . The family is aware that she has a lot of reasons she doesn't like wearing it. Not sure the reason, just uncomfortable. The BiPAP was delivered 4/22/25. We are fine tuning DME process. Typically, the equipment is here within a couple of days. I think the ordering of this fell on a holiday weekend and it ended up being several more days. [V7] (R1's physician) was fine with her using her CPAP until the BiPAP arrived. [Reviewing the documents from the hospital] it clearly looks like the order was for BiPAP all along (from 2/3/25) so I don't know why there was confusion . It is here and set to 16/6 which is the correct setting. I would have expected them to clarify what she was supposed to have based on the orders we received. We should have known exactly what the settings were, and it should have been on the eMAR. The facility's policy and procedure with review date of 5/6/2025 showed, Policy for CPAP/BiPAP . BiPAP provides continuous positive pressure to the airways of spontaneously breathing residents . Purpose: to augment breathing . to treat sleep disorders . to correct arterial hypoxemia . to decrease work of breathing . to increase compliance .

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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** 38488 Based on observation, interview, and record review the facility failed to ensure sufficient staffing to provide dependent residents with cares for 5 of 5 residents (R4, R6, R7, R8, R9) reviewed for staffing in the sample of 9. The findings include: 1. R4's face sheet showed she was admitted to the facility 3/11/21 with diagnoses to include hemiplegia and hemiparesis following cerebral infarction, Type 2 Diabetes, hypertensive heart disease, congestive heart failure, major depressive disorder, osteoarthritis, and generalized anxiety disorder. R4's facility assessment dated [DATE] showed she has no cognitive impairment. This same assessment showed R4 is occasionally incontinent of bowel of bladder. On 5/6/25 at 2:23 PM, R4 was in her wheelchair sitting in the hallway. R4 said, Last night they only had 3 CNAs and 1 nurse. The nurses rarely help at night. My call light takes an hour or more most of the time. I have accidents all the time while I'm waiting for them to answer my call light to help me to go to the bathroom and it makes me feel degraded and humiliated. I hate it. I don't think it is fair. They will tell me, 'sorry but you are not the only one in here.' Call lights are not their priority. I'm the resident council president and we discuss call light wait times and staffing in every meeting. I'm really tired of this. 2. R6's face sheet showed she was admitted to the facility 3/26/25 with diagnoses to include nondisplaced fracture of left femur, atrial fibrillation, hypertensive heart and chronic kidney disease with heart failure, congestive heart failure, hyperlipidemia, lack of coordination, and anxiety disorder. R6's facility assessment dated [DATE] showed she has moderate cognitive impairment, is dependent on staff for toileting needs, and is frequently incontinent of urine. On 5/6/25 at 1:44 PM, R6 said it takes staff between 30 minutes to an hour to answer her call light. R6 said she uses her call light because she needs to be changed because she is incontinent. R6 said she had not been changed since staff were in her room this morning to get her up for the day. R6's call light was on. R6 had a visitor in the room with her and they stated the call light had already been on for over 20 minutes at the time the surveyor entered the room. R6's call light was observed being answered at 1:50 PM. 3. R7's face sheet showed she was admitted to the facility 3/17/25 with diagnoses to include end stage renal disease, chronic respiratory failure, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, muscle wasting and atrophy, rheumatoid arthritis, weakness, depression, and dependence on renal dialysis. R7's facility assessment dated [DATE] showed she has no cognitive impairment, requires substantial to maximum assist with toileting, and is frequently incontinent. On 5/6/25 at 1:18 PM, R7 was frail appearing and sitting in her chair with oxygen in place. R7 said it takes staff at least 30 minutes to answer her call light when she needs to get up to go to the bathroom or get up into her chair. R7 said she has urinated in her brief waiting for assistance, and she does not like that, but she knows the staff have other people to take care of too. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R8's face sheet showed he was admitted to the facility 5/1/25 with diagnoses to include aftercare following joint replacement surgery, rheumatoid arthritis, polyneuropathy, hypertension, and disorders of bladder. On 5/6/25 at 1:35 PM, R8 was laying in his bed with his right foot and leg completed wrapped in bandages. R8 had a urinal at bedside. R8 said he is not able to bear weight on his right leg due a surgery. R8 said he is sorry to have to tell the surveyor this, but he uses the urinal and turns on his call light to have it emptied. R8 said he unfortunately gives up in regard to having the light answered and he has to dump the urinal in the trash can near the bed in order to be able to use it again. 5. R9's face sheet showed he was admitted to the facility 5/1/25 with diagnoses to include Type 2 Diabetes, hypertensive heart disease and chronic kidney failure, repeated falls, and depression. On 5/6/25 at 1:45 PM, R9 was in the bathroom with V10 (R9's spouse). V10 exited the bathroom to talk with the surveyor. V10 said R9's stay at the facility is not going well. V10 said R9 arrived last Thursday and requires assistance to get into and out of the bathroom. V10 said R9 waits over 30 minutes to have his call light answered to go to bathroom consistently and often wets himself before they can get to him. On 5/6/25 at 2:40 PM, V6 LPN (Licensed Practical Nurse) was near the nursing station preparing medications for R8. R8's MAR (Medication Administration Record) was open and showed he was due to receive hydrocodone at 12:00 PM and Gabapentin scheduled at 1:00 PM. R8's hydrocodone was administered 1 hour and 40 minutes outside of the scheduled time and his Gabapentin was administered 40 minutes outside of the scheduled time. V6 said the first shift nurse did not finish the lunch medication pass prior to shift change. The facility's resident council meeting minutes for February 2025 showed, Nursing: 2 residents said they had received their medication late, and 2 other residents said they had received double doses of medicine within two hours of each other . Administration: Residents raised concerns about CNA staffing. 11 out of 11 residents at the council said they feel there is not enough staff to help with care. [The facility staff member at the meeting] informed them that they meet the minimum staffing requirements and that he will bring this issue up to the administrator . Therapy: 3 of the residents at the council said they are not getting enough restorative therapy because the aide is being pulled to the floor. The facility's resident council meeting minutes for March 2025 showed, . Nursing: Residents said call lights are being turned off before their needs are met. They would like them to be left on until their needs are met. 6 out of the 12 residents at the council said they hadn't received a shower. [Staff member in the meeting] then asked the group if they hadn't had a shower in more than a week, the residents said yes . The facility's resident council meeting minutes for April 2025 showed, . they noted that call light wait times are longer than an hour and a half. When CNAs enter the rooms, they turn off the call lights and leave before providing help. The residents reported that CNAs often tell them, 'I'll be back in a minute.' and that this issue is especially bad during the 3rd shift . (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/25 at 2:00 PM, V8 CNA (Certified Nursing Assistant) said some days are better than others but often they do not have time to get to everyone. There is often not enough time to get showers done. V8 said they used to have 3 CNAs and 2 nurses on their assignment, but they have switched to 1 nurse and due to call offs, there are often only 2 CNAs. V8 said with only one nurse they can't help out because they are passing medications for most of their shift. V8 said the skilled unit is high acuity and they have many residents who require 2 assist so they are often looking for help. On 5/6/25 at 12:48 PM, V7 (Physician) said, There is a different staff member there every time I go there, I have tried to contact the DON in the past with no luck. The communication with them is not good . the staffing there is not ideal. When I was there one of the last times, the nurse told me she was the only nurse available. When my office calls the facility, they often might not be able to get anyone to answer the phone. I have one patient there and she is not there anymore, I will no longer be following my patients there because they can't tell me what is going with the patient. The last 2 times I have seen my patient there she has been in bed, wearing a hospital gown, and she should be up and dressed because I'm usually there between 1:30 PM and 2:00 PM. On 5/6/25 at 3:40 PM, V2 DON (Director of Nursing) said she is aware they have had complaints regarding call lights not being answered timely. V2 said the call lights came up in their annual survey. V2 said this is something they are working hard at changing. V2 said she feels the delay in answering call lights is a culture change because when the facility changed hands nursing ratios were cut back and management roles were added. The whole change process is difficult. V2 said she expects lunch medications to be passed within the allotted time frames, one hour before and one hour after their scheduled time. V2 said she has spoken with the nurse managers about monitoring the medication administration records around 11:30 AM to ensure the nurses are on track with their medication pass. V2 said they have plenty of nurse managers around that can help out if the floor nurse is struggling to get tasks done. The facility's call light policy with revision date 3/27/19 showed, . All staff responds promptly when the call system is activated. The facility's policy and procedure with review date 5/6/25 showed, Medication Administration . Medications must be prepared and administered within one hour of the designated time or as ordered .