

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145703	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2025
NAME OF PROVIDER OR SUPPLIER  Silvis Center for Nursing Rehab & Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1455 Hospital Road Silvis, IL 61282	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on observation, interview, and record review the facility failed to revise a resident's care plan and include interventions to reduce risk for injury for one of three residents (R1) who frequently becomes physical causing self-harm or harm to others, in a sample of four. Findings Include: The facility's Change in Condition Guidelines policy dated May 2025 documents, All facility staff must remain alert to changes in condition in all residents. Upon recognition of a change, appropriate nursing and medical interventions must be initiated promptly to address the resident's needs. The interdisciplinary team will ensure the change is assessed, documented, and communicated according to federal and state guidelines . 6. Interdisciplinary Review and Follow-Up: Review the residents care plan to determine if updates are necessary. R1's Current Care Plan, not dated, documents R1 has a medical diagnosis of Parkinson's Disease and Anxiety. R1's Current Care Plan, not dated does not document R1's behaviors, or triggers. On 12/1/2025 at 9:38 AM, R1 was in her room, dressed, V6 and V7 (Certified Nurse Assistants) in room trying to get R1 to stay in her room. R1 had an open laceration on her left top forearm. V6 placed an adhesive bandage on open laceration. R1 was not interview able. R1 was walking around her room, anxious, angry, and calling staff members verbal unpleasant names. Once R1 was walking in the hallway with her wheeled walker, V2 (Director of Nursing) attempted to get R1 back to her room by walking with her. V2 eventually assisted R1 into her wheelchair. R1 slapped V2 twice on her head as V2 tried to assist R1's feet into wheelchair pedals. V2 wheeled R1 back to her room. R1 refused to sit in bed, and her chair and continued walking around anxious, and angry. On 12/3/2025 at 11:43 AM, V5 (Nurse Practitioner) stated she started working for the facility as their nurse practitioner in August of 2025. V5 did not see R1's mental state when R1 was admitted in May of 2025. V5 stated R1 is very busy, has anxiety, and V5 has seen R1 be physical a few times towards staff when she is over stimulated, and staff try to redirect her. V5 stated R1 has declined mentally since August of 2025 to now, and does not feel like the facility is a good fit for her and R1 would be better suited for a memory care facility. V5 stated this facility is too busy and loud for R1. On 12/3/2025 at 1:35 PM, V3 (Care Plan and MDS Coordinator/Assistant Director of Nursing) confirmed R1 does not have an updated care plan to show R1 is known to be physical with staff members or injures herself and is easily triggered with multiple staff trying to help.</p>

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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