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 03/04/2026
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)
F 0684 Level of Harm - Minimal harm or potential for 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** Based on Interview and Record Review, the facility failed to ensure a resident with increased confusion and a resident with a diagnosis of lung cancer were taken to scheduled neurology and pulmonology specialist appointments for two of three residents (R1, R2) reviewed for physician appointments in the sample of nine.Findings include:The facility's Facility Assessment Tool, dated 2/12/26, documents The facility may accept residents with, or residents may develop, the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management. Mental and Behavioral Health, Heart/Circulatory System, Neurological System, Vision, Hearing, Musculoskeletal System Neoplasm, Metabolic Disorders, Respiratory System, Genitourinary System, Diseases of Blood, Digestive System, Integumentary System, and Infection Diseases. For persons that have diagnoses or conditions that the facility is less familiar with and has not previously supported, a thorough review of the patient's medical record is completed to determine resources and services needed, whether those resources/services are currently available or could be obtained, what specialized equipment and training will be needed, if adjustments are needed in staffing, physical plant, and whether the IDT (Inter Disciplinary Team) as a whole, including medical director, determine the patient's needs can be safely and effectively met.1. R1's Care Plan, dated 9/4/25, documents R2 has a diagnoses of obstructive sleep apnea, congestive heart failure and right lower lobe lung cancer.The facility's calendar spreadsheet dated 12/2025 and provided by V2 (Director of Nursing), documents R1 had a scheduled specialist appointment with V17 (R1's pulmonologist) for 12/1/25 at 2:10 PM.R1's nursing progress notes, dated 12/1/25 at 1:57 PM and completed by V14 (Licensed Practical Nurse, LPN), documents (R1) had an appointment with (V17). (R1) was ready, no transportation came to pick resident up. (Contracted transportation companies) both stated that they did not have (R1) down for pick up today. (R1) would need to be rescheduled for (V17) appointment and transportation pick up.On 3/2/26 at 12:35 PM, V14 (LPN) confirmed she took care of R1 on 12/1/25 and that R1 missed her appointment with the pulmonologist due to not having transportation. V14 stated I do remember when (R1) missed her doctor appointment. I had made arrangements for a CNA (Certified Nursing Assistant) to travel with her, and (R1) was ready and prepared for transport and then no transport was set up. I made phone calls but there was not a way to get her to her appointment in time. So, she did not go.2. R2's Care Plan, dated 11/6/25, documents R2 was admitted to the facility on [DATE] and has a plan of care documenting (R2) is a high risk for falls related to confusion, deconditioning, gait/balance problems, poor safety awareness, and a history of falls prior to admission.R2's nursing progress note, dated 11/21/25 at 1:35 PM, documents Order received per (V9, Nurse Practitioner) for neurology referral related to confusion.R2's nursing progress note, dated 11/24/25 at 3:54 PM, documents Referral paperwork faxed to (V18, R2's neurologist) office. (V11, R2's family) notified of this new order and is in agreement with this plan of care.R2's nursing progress note, dated 12/1/25 at 11:57 AM, documents (Neurology) appointment is for Monday 12/8/25 at 3:15 PM.The facility's calendar spreadsheet dated 12/2025 and provided by V2 (Director of Nursing), documents R2 had a scheduled neurologist appointment with V18 on 12/8/25 at 3:15 PM.On 2/27/26 at 1:20 PM, V11 (R2's family) stated R2 was supposed to see a neurologist due (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to his condition but missed his appointments. V11 stated R2 had increased confusion, falls after being admitted to the facility and was an alcoholic in the past. V11 stated The facility could not get (R2) to his appointments, and he was charged no show fees because of this. He also ended up going to the emergency room for signs of a stroke. He should have seen a neurologist before that date but instead ended up in the emergency room.R2's nursing progress note, dated 12/9/25 at 8:45 AM, documents (R2) complained of new onset of left hand/arm numbness and weakness. States he went to pick up remote but was unable. Notified facility provider, family and D.O.N (V2, Director of Nursing).On 3/2/26 at 10:19 AM, V8 (Licensed Practical Nurse) confirmed caring for R2 while he was in the facility. V8 stated I remember (V11) wanted (R2) to see a neurologist and she was upset he missed some appointments because of transportation issues. One time I remember specifically he missed because of transportation not being set up. He had an order for a neurologist referral. I had been off for several days and when I came back it was still outstanding.On 3/2/26 at 12:00 PM, V9 (Nurse Practitioner) confirmed she saw R2 frequently while in the facility and stated she ordered a neurology consult for him. V9 stated I remember there being an issue with transportation to his appointment. I did order a neurology consult for him. During (R2's) stay here, he also had some signs and symptoms of stroke and went to the emergency room for it. I know he missed one appointment due to a transportation issue. I remember instructing staff to reschedule, because it was needed.On 3/3/26 at 1:14 PM, V2 (Director of Nursing) confirmed R1 and R2 missed scheduled referral appointments with health specialists on 12/1/25 and 12/8/25. V2 stated There have been some transportation issues. We use outside contracted transport services which isn't always reliable.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on Interview and Record Review, the facility failed to ensure a resident with declining mobility and signs and symptoms of a urinary tract infection was started timely on antibiotic treatment and was care planned for urinary tract infection monitoring and an increase in care needs for one of three residents (R1) reviewed for urinary tract infections in the sample of nine. These failures resulted in R1 suffering suprapubic pain and burning with urination, blood and odor in the urine and waiting seven days to receive treatment for a contagious bacterial urinary tract infection.Findings Include:The facility's Algorithm for the Antimicrobial Management of Urinary Tract Infections in Older Adults document (undated), documents Patient presents with new signs and symptoms of UTI (Urinary Tract Infection): new or marked incontinence, fever and/or leukocytosis, gross hematuria, pain on urination, new or worsening urinary frequency, lower abdominal pain/discomfort (if yes, then); criteria met for treatment with antibiotics (symptomatic bacteriuria): assess for medication allergies, assess for renal impairment, asymptomatic patients with bacteria in the urine do not have a UTI and are not candidates for treatment with antibiotics. This same sheet documents UTI in older persons and males are considered complicated with or without pyelonephritis (kidney infection).The facility's Guidelines for Incontinence Care policy, dated 9/21/23, documents It is the policy of the facility to ensure that residents receive as much assistance as needed for cleansing the perineum and buttocks after an incontinent episode or with routine daily care. Frequency depends on bladder diary results and/or routine minimal every two-hour checks as well as care planning.R1's Care Plan, dated 9/8/25, documents R1 has diagnoses of Chronic Kidney Disease, stage three and Hypertensive Chronic Kidney Disease. The care plan documents (R1) has bladder incontinence related to impaired mobility. Monitor/document for signs and symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. This care plan also documents (R1) has an ADL (Activities of Daily Living) self-care performance deficit related to impaired mobility, weakness. Bed Mobility: The resident is independent with bed mobility. Toilet Use: The resident requires supervision with toileting.On 2/27/26 at 12:05 PM, V10 (R1's family member) stated R1 got a UTI in December and again in January. V10 confirmed R1 was undergoing cancer treatments and her immune system was compromised. V10 stated I know (R1) was not getting cleaned adequately. She sat in soaked incontinence briefs for too long without being cleaned. She required more help towards the end of her stay, and it seemed like staff didn't understand.R1's nursing progress note, dated 12/11/25 at 2:37 PM, documents NP (Nurse Practitioner, V9) assessed (R1) today. (R1) complained of fatigue, cough and suprapubic pain.R1's nursing progress note, dated 12/12/25 at 6:32 AM, documents UA (urine analysis) was collected. Hematuria, complaints of suprapubic pain, no complaints of SOB (Shortness of Breath) and no complaints of cough.R1's nursing progress note, dated 12/13/25 at 3:26 AM, documents 12:30 AM, UA was set up for a c/s (culture and sensitivity), temperature 98.4, incontinent of dark brown odorous urine, complaints of suprapubic pain and dysuria, fluids encouraged, denied the need for anything for pain, resting quietly since.R1's nursing progress note, dated 12/17/25 at 3:17 PM, documents reported ESBL (Extended- Spectrum Beta-Lactamase infection) positive urine collection.R1's urinalysis lab results report, dated 12/17/25, documents initial urine results showed R1's urine color to be dark brown, extra turbid clarity, two plus protein, three plus blood and three plus leukocytes (inflammatory white blood cells) on 12/12/25. This same report documents the final culture was complete on 12/17/25 at 3:17 PM and grew positive for Klebsiella Pneumoniae and Proteus Mirabilis ESBL. This report documents Confirmed ESBL producing organism. ESBLs are enzymes that mediate resistance to (antibiotics). Recommend caution and monitoring of patients during and after therapy.R1's nursing progress note, dated 12/18/25 at 2:44 AM, documents Final UA culture and sensitivity results shows ESBL in the urine, placed on Contact (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Isolation and will notify NP (V9) in AM.R1's nursing progress note, dated 12/18/25 at 2:44 PM, documents V9 (Nurse Practitioner) reviewed urine culture results and ordered Levaquin 500 milligrams (antibiotic medication) every other day for seven days.R1's Medication Administration Record (MAR), dated 12/1/25- 12/31/25, documents R1's first dose of Levaquin was administered at 8:00 PM on 12/18/25 (seven days after R1's urinary infections symptoms were first identified and more than 28 hours after R1's positive ESBL urine culture results were received).On 3/2/26 at 12:00 PM, V9 (Nurse Practitioner) confirmed she ordered a urinalysis for R1 after she complained of having pelvic pressure in December. V9 stated With a UTI, we usually look at the big clinical picture. If someone is just having confusion but no other signs or symptoms, we may wait for cultures to come back to start medication. I remember ordering a UA on (R1) and then waiting for cultures to come back for an antibiotic. I wasn't aware that nurses were documenting more symptoms or that her signs and symptoms seemed to worsen over several days before cultures came back. In that case I would have started an antibiotic sooner, because sometimes those cultures can take forever. If they (staff) had called me to tell me everything that was being charted in the nursing notes, then yes, I would have started her treatment sooner. I believe I saw her when ordering the UA and then not again until January. I have to be notified if there are changes. V9 confirmed R1 was diagnosed with a subsequent UTI in late January 2026, that was also positive for ESBL.R1's Minimum Data Set assessment, dated 12/29/25, documents R1 requires supervision/touching assistance for toileting and hygiene and partial to moderate assistance with toilet transfers.R1's Minimum Data Set assessment, dated 2/3/26, documents R1 is dependent for toileting and requires substantial/maximal assistance for toilet transfers.R1's Care Plan at the time of discharge (2/3/26) does not document any increased care needs for toileting, hygiene or interventions and monitoring for R1's urinary tract infections. On 3/3/26 at 1:15 PM, V2 (Director of Nursing) stated (R1) has had a steady decline that happened fairly quickly after her UTI began in December. (R1's) care level for incontinence/toileting and her toileting care plan interventions were not updated to match her level of care. V2 confirmed R2 was diagnosed with a UTI with ESBL in December and a second one in late January. V2 stated (R1's) change occurred in the last few weeks she was here. The nurses and CNAs (Certified Nursing Assistants) would not have known she was requiring peri-care and more dependent on staff from her care plan, it would just be report and word of mouth between staff. I don't have any paper documentation to show (R1's) change in condition or that incontinence care and monitoring needs had changed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on Observation, Interview and Record Review the facility failed to ensure sufficient staff were available to meet the needs of the residents. This failure has the potential to affect all 73 residents currently residing at the facility.Findings include:The facility's Daily Census Report dated 2/26/26 and provided by V1 (Administrator), documents 73 residents reside in the facility.The facility's Facility Assessment Tool, dated 2/12/26, documents Based on the facility's resident population and their needs for care and support, staffing is provided at adequate levels to ensure that the needs of the residents can be met at any given time. Taken into consideration are the state and federal regulations for appropriate staffing levels, facility layout, and resident acuity as well as census. 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 of the facility's resident population in accordance with the facility assessment.On 2/27/26 at 2:05 PM, R4 was in her room lying in bed. R4 stated she has a history of falling and getting dizzy and passing out and that she waits a long time when she pushes her call light for assistance. R4 stated Call lights take an hour sometimes before they come see what I need.On 3/2/26 at 10:19 AM, V8 (Licensed Practical Nurse) confirmed she works in the facility as needed and the facility has issues with staffing. V8 stated The other day we had two CNA's (Certified Nursing Assistants) for 50 residents. Things like showers do not get done when we don't have enough staff. Nearly every weekend is that way. I believe Thursday or Friday of last week, there were like three to four CNA's that called in. (R5) complained to me that he waited over an hour to go to bed and it took that long for his call light to be answered.On 3/2/26 at 12:35 PM, V14 (Licensed Practical Nurse) stated They (the facility) do not have enough nurses and staff to get things done that need to be. There are times I spend the entire shift on my feet, and I don't get to everything or the charting that needs completed. The ratio of patients to nurses with the residents needs makes it impossible to get everyone adequate help.On 3/3/26 at 11:12 AM, R7's call light was alarming. At this time, R7 was sitting in her room in wheelchair and hanging clothes up with one hand/arm, the opposite arm appeared flaccid. R7 stated I have my call light on because I need changed and can't do it on my own. Call lights always take a long time and I have to wait. I have had accidents while waiting for them to come. Usually takes over thirty minutes to get help.On 3/3/26 at 11:20 AM, R8 was sitting in the hallway outside of the dining room working on a puzzle. R8 stated I have only lived here for about eight months and call lights take a long time to be answered. Typically, it's 30-45 minutes for someone to answer my call light.On 3/3/26 at 12:08 PM, V15 (Certified Nursing Assistant) stated she works 2nd and 3rd shift overlap. V15 stated There are CNA call-ins every day and they are not always replaced. We often start a shift fully staffed and then by the end there's been call offs, people don't come in and the shift ends with not enough help. Second shift is especially short staffed. Last night was rough and we didn't even have any call offs. The residents are busy too and some have dementia and require more help. It becomes really hard to give good patient care and answer call lights when there are not enough staff there. Residents do have to wait longer to get changed and cleaned up. It is an issue. I know (R9) gets frustrated often due to long wait times when she uses her call light.On 3/3/26 at 1:00 PM, R6 was sitting in her room in a wheelchair. R6 stated she is the resident council president and call lights, and staffing are frequently an issue. R6 stated The call lights do take a long time to be answered, and they (the facility) do not have enough staff. I sometimes am having to wait an hour. Even when I press the light, they just don't come. I have had accidents waiting for staff to help me to the bathroom. It's humiliating and I can't do anything about it. One night I waited from 11:00 PM to 12:00 AM for help to go to the bathroom. It's painful to wait that long and try and hold it. This topic is brought up all of the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	time in council meetings and it's not fixed. There are not enough staff here to care for us (residents). I have even thought about moving to a different facility, but I don't think there's anywhere to go that will be any better.On 3/3/26 at 2:45 PM, V2 (Director of Nursing) stated We have been aware of concerns with call lights. I would expect that staff get to residents timely when they are needing assistance and I know that for them five minutes might feel like an hour. V2 confirmed that 30 minutes is too long for someone to be expected to hold their bladder and that staff calling off work seems to increase this time of year (Spring).