STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146070	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Willows Nursing Center	1600 North Broadway Salem, IL 62881

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review the facility failed to provide the consulting services of a Registered Dietician. This failure has the potential to affect all 22 residents that reside at the facility.Findings include:On 04/01/26 at 2:54 PM, V19 (previous Registered Dietician) stated, she is not familiar with any of the residents at the facility. V19 stated, she has not physically been at the facility since October 2023.On 04/01/26 at 3:10 PM, V8 (Dietary Manager) stated they currently do not have a RD (Registered Dietician), they have not had one since the end of 2023. V8 stated she does not do BMIs (Body Mass Index), goal weights, the amount of calories needed, or estimated calories given for the residents. On 04/01/26 at 3:17 PM, V2 (Director of Nursing) stated they do not currently have a RD, they have not had one for a little while. V2 stated, V19 was their last RD, and it could have been around October 2023 since she has been the facility's RD. The facility document titled, Facility Assessment Tool dated 02/10/26 documents: Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies staff type: food and nutrition services (Dietary Manager, support staff, Registered Dietician).The Long-Term Care Facility Application for Medicare and Medicaid form dated 3/30/26 documents there are 22 residents living in the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on interview, observation, and record review the facility failed to maintain a safe, clean, sanitary environment in the common foyer area of the facility. This failure has the potential to affect all 22 residents residing at the facility.Findings include:On 03/30/26 at 8:50 AM the ceiling vent in the entrance foyer had a large accumulation of a black substance covering approximately 90 % of the vent with a concentration around the edges and the center of the vent.On 03/31/26 at 8:45 AM the ceiling vent in the entrance foyer had a large accumulation of a black substance covering approximately 90 % of the vent with a concentration around the edges and the center of the vent.On 04/01/26 at 8:30 AM the ceiling vent in the entrance foyer had a large accumulation of a black substance covering approximately 90 % of the vent with a concentration around the edges and the center of the vent.On 04/02/26 at 3:10 PM V2 (Director of Nursing) stated, the vents in the foyer area should be cleaned, she will get V20 (Maintenance Director) to clean it right away.The undated facility policy titled, Facility Environmental Policy documents: it is the policy of (facility name) to provide housekeeping and maintenance staffing to promote a safe and functional environment.The Long-Term Care Facility Application for Medicare and Medicaid form dated 3/30/26 documents there are 22 residents living in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on interview, observation and record review the facility failed to provide an accessible call light for the shower room on the north hall for 10 (R5, R7, R8, R9, R10, R12, R15, R18, R20, and R22) of 10 residents reviewed for assessable call lights in a sample of 22.Findings include:1.On 03/30/26 at 1:55 PM the shower room on the north hall had a call light but the call light did not have a string to activate it. On 04/02/26 at 9:55 AM the shower room on the north hall had a call light but the call light did not have a string to activate it. On 04/01/26 at 1:19 PM, V12 (Certified Nurse Aide) stated there are shower rooms on the north and the east halls. V12 stated, typically the residents on the north hall would be showered in the shower on the north hall. On 04/02/26 at 3:12 PM, V2 (Director of Nursing) stated the call light in the shower room works the string just broke off. V2 stated, she will have it fixed before she leaves for the day.On 3/30/26 the facility provided a list titled, Wing Group Assignments that documented: R5, R7, R8, R9, R10, R12, R15, R18, R20, and R22 reside on the north hall. The undated facility policy titled, Facility Environmental Policy documents: it is the policy of (facility name) to provide housekeeping and maintenance staffing to promote a safe and functional environment.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to serve food in the appropriate texture for 4 (R7, R8, R15, and R22) of 10 residents reviewed for dining in a sample of 22.Findings include:The facility document titled, Patient Literal Orders by Category documents R7, R8, R15, and R22 receive a mechanical soft diet. On 03/31/26 between 11:30 AM and 12:05 PM R7, R8, R15, and R22 received a half a baked potato with the skin still on for their lunch meal. On 03/31/26 at 11:58 AM, R8 was sitting up in her bed in her room. R8 had half a baked potato and a piece of meatloaf on her food tray sitting in front of her. R8 was attempting break off pieces of the baked potato with her fork with her left hand. R8 was able to get a chunk of her baked broke off that was over 1.5 inches in length and put it into her mouth and attempted to chew. R8 then pulled pieces of the potato skin out of her mouth and placed them on the side of her tray. R8 struggled to chew the size of the piece of potato in her mouth. R8 then was able to break off another smaller piece of potato and chewed that piece with no problems. R8 then attempted to stab the piece of meatloaf that was approximately 2 inches by 3 inches in size, she was unable to acquire any of the meatloaf on her fork and gave up and went back to attempting to break pieces of her potato off and eating what she could break off. When R8's tray was picked up no meatloaf was eaten.On 04/01/26 at 2:23 PM V16 (Family) stated, R8 is nonverbal, but will make some facial expressions. R8 cannot use her right side at all and her food is supposed to be cut into manageable size pieces because eating has been challenging for her to eat with her nondominant hand (her left hand) but with the food in pieces sized that she can easily stab with her fork she does ok. V16 stated the facility has assured her that R8's food will be cut up into manageable size pieces for R8 to be able to handle. V16 stated, R8 loves potatoes. On 04/01/26 between 11:30 AM and 12:01 PM R7, R8, R15 and R22 received carrot slices with some of the slices being between 0.5 inches and 1.5 inches in diameter with their lunch meal.On 04/02/26 at 3:17 PM, V8 (Dietary Manager) stated, she does not know if she can find a menu with the baked potato actually on the menu, they have to hand write in in because it is not on the menu and the residents want baked potato on Tuesdays. V8 stated, she cannot access the recipe for the mechanical soft baked potato because they are locked out of the menu program when they lost their Registered Dietician. V8 stated the baked potato for the mechanical soft should not have the [NAME] on them. V8 stated, they substituted the carrot slices for the mechanical soft diet for the wax beans. V8 stated, the recipe states the carrots should be bite size pieces. V8 stated, some of the carrot slices were over 0.5 inches in diameter. On 04/02/26 at 3:40 PM, V8 (Dietary Manager) stated, R8's meatloaf should have been cut into bite size pieces and her potato should have been cut into pieces she could easily get onto her fork and chew.The facility document dated day 19 supper titled, Soft Chopped Carrots documents: 4. chop carrots into bite-size portions prior to serving.The facility document dated 2012 titled, Dental Soft (Mechanical Soft) Diet documents: 6. vegetables are cooked soft, moist and fork tender with no large chucks or pieces, 10. hard crisp fried potatoes and potato skins are excluded. Food guide: allowed: vegetables: all vegetables should be chopped or diced into bite-size pieces (1/2 inch or smaller), peeled, cooked potatoes; not allowed: potato skins.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain adequate infection control practices including hand hygiene, identification of appropriate isolation, and proper handling of soiled linens for 6 of 6 residents (R2, R5, R7, R9, R18, and R20) reviewed to infection control in the sample of 22.Findings include:1. On 3/30/26 at 10:00 AM there were no signs on R20's door indicating she was on any type of isolation.R20's laboratory results dated [DATE], regarding her urine culture, documents she has a urinary tract infection with the causative bacteria identified as Escherichia coli (E.coli),extended-spectrum beta-lactamase (ESBL), and Proteus mirabilis.R20's Physician Order dated 3/16/2026 documents, Augmentin 875/125 milligram (mg) 1 tab by mouth twice daily for 10 days related to E Coli, ESBL, Proteus miabilis per vagina and urine.On 4/1/2026 at 1:55 PM, V4 (Certified Nursing Assistant/CNA) reported R20 has not been on contact isolation recently. V4 stated she had asked V2, Director of Nursing (DON), why R20 was not on isolation after ESBL was identified on her urine culture. V4 stated she had heard that R20's urine had come back with three different infections and one of them was ESBL. V4 stated she knows ESBL is very contagious. V4 stated V2 informed her that as long as standard precautions were used for R20, contact isolation was not necessary. V4 stated she was concerned because R20's laundry was being mixed with other residents' clothes. 2. On 4/1/2026 at 11:17 AM, V5 (CNA) and V10 (CNA), provided catheter care to R5. During care, V5 and V10 removed their gloves multiple times, when soiled, and donned new gloves without performing hand hygiene.3. On 3/30/2026 at 12:33 PM, V5 was feeding R18, and R2 walked up to R18's table. V5 took a plastic cup from R2 and held R2's straw with her ungloved hand to provide drinks to R2 while R2 was standing. V5 did not perform hand hygiene before drink was provided and she did not perform hand hygiene after giving R2 a drink and before resuming feeding for R18. 4. On 3/30/2026 at 1:11 PM, V4 left R7's room after performing incontinent care, with unbagged soiled linen in gloved hand, and walked down the facility hallway into north hall's shower room and discarded dirty linen in the hamper.5. On 3/30/2026 at 1:21 PM, V4 left R9's room after performing incontinent care, with unbagged soiled linen in gloved hand, and walked down the facility hallway into north hall's shower room and discarded dirty linen in the hamper.On 4/2/26 at 3:30 PM, V2 (Director of Nursing/DON) stated staff should perform hand hygiene any time they are going from one resident to another, when they touch contaminated surfaces and if changing gloves during care. The facility's undated policy, Laundry, documents, Inadequate processing of soiled linen and clothing can lead to infection in residents, and the laundry personnel themselves are at risk of infection if they do not take proper precautions themselves as they work. All soiled linen from all residents should be handled and treated as if it were contaminated with pathogenic microorganisms, including blood borne pathogens. It should be bagged (or placed into leak proof, covered carts) at the location where it was used.The facility's undated policy, Isolation Procedures and Infection Control, documents, Upon being informed of the existence of an infectious case the resident shall be placed in the appropriate type of isolation for the specific type of infection.The facility's undated policy, Feeding and Hydration of Residents, documents, When residents have to be feed by personnel, special attention should be given to preventing cross contamination. The Centers for Disease Control (CDC) in its guidelines for handwashing, states that hands do not have to be washed after handing a patient food. If the hands become contaminated with saliva or there is extensive contact with the resident when feeding him or her, however, the hands should be washed before feeding another resident.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to provide eating assistance with respect and dignity for 2 (R12, R18) of 3 residents reviewed for dignity in a sample of 22. Findings include:1.R18's admission record documents an admission date of 06/10/21 with diagnoses including: dementia, anemia, major depressive disorder, cataract, gastro-esophageal reflux disease, and age related osteoporosis. R18's Minimum Data Set (MDS) dated [DATE] documents no brief interview of mental status (BIMS) should be conducted due to resident is rarely/never understood. Section GG documents R18's eating performance is dependent, indicating helper does all the effort. On 3/30/2026 at 12:13 PM, V5 Certified Nurses Assistant (CNA) answered her personal cellphone during the lunch meal while she continued to provide bites of food to R18 while talking on her phone. At end of her phone conversation V5 was heard stating, I have to get off here, I'm feeding. The conversation lasted 2 minutes. On 3/30/2026 at 12:43 PM, V5 was feeding R18 a mixture of orange colored pureed food (baked beans) and dark brown colored pureed pudding. R18 was observed making disgruntled faces while eating the bites of mixed food R18 was feeding her. On 04/02/26 at 12:19 PM, V5 was assisting R18 with the lunch meal, from 12:18 PM until 12:25 PM R18 had pureed food from under her nose to down past her mid chin before V5 wiped her mouth. 2. On 4/2/2026 from 12:04 PM to 12:26 PM, V14 CNA was assisting R12 with the noon meal of pureed mashed potatoes, peas, chicken and gravy and lemon cake. R12 had a large amount of pureed food substance under lower lip and across her chin and dripping off chin onto her clothing protector. V14 did not wipe excess food off R12' s face and continued to offer bites of food and drinks to resident who sat with eyes closed during meal. On 4/2/26 at 3:00 PM, V2 Director of Nursing stated she does not have a policy specific to dignity of residents. On 4/2/2025 at 3:30 PM V2 stated staff should not be answering phone calls while providing care, including assisting with eating, but it would be allowed if there was an emergency. On 4/3/2026 at 9:41 AM during phone interview, V2 stated that it is expected that staff who are feeding a resident would tap the spoon on the side of the bowl or plate when going from one food item to another to avoid mixing the food, but she can't guarantee that some food might get slightly mixed with others and they can't use fourteen spoons per tray. V2 stated she would expect staff to clean off a resident's face if they have food on their face during feeding. The facility's document, Residents' Rights, revised 2/07, documents, 1. Your rights to safety and good care: Your facility must provide services to keep your physical and mental health, and sense of satisfaction with yourself, at their highest practical levels.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Uniform Practitioner Orders For Life-Sustaining Treatment (POLST) status reflected resident wishes as desired throughout resident health record for 1 of 2 residents (R19) reviewed for advanced directives in a sample of 22.Findings include:R19's admission Record documented R19 was admitted to this facility on [DATE]. R19's Physician's Order Sheet dated [DATE] documented admitting diagnoses of congestive heart failure, and chronic kidney disease stage 4 among others.R19's MDS (minimum data set) dated [DATE] documented a BIMS (brief interview for mental status) score of 15 out of 15 total, which indicates R19 is cognitively intact.R19's Physician Order Sheet dated [DATE]-[DATE] documented R19 as DNR (do not resuscitate). R19's Physician Order Sheet dated [DATE]-[DATE] documented R19 as DNR. R19's Physician Order Sheet dated [DATE]-[DATE] documented R19 as DNR.R19's Social Service assessment dated [DATE] documents under section titled Advanced Directives documented R19 as a DNR. R19's Advanced Directive/ POLST (practitioners order for life sustaining treatment) form dated [DATE] documented R19 wants CPR attempted but does not want to be intubated or receive dialysis for life sustaining treatment in the event of cardiac arrest.On [DATE] at 3:30pm, R19 said she understood what CPR was. R19 said she wants CPR performed if her heart stopped.On [DATE] at 10:00am, V3 (Registered Nurse) said the resident's advance directives/POLST forms are kept in each resident's chart under the Advanced Directives section in the back of the chart. V3 said the facility does not keep this information anywhere else except the residents' chart and the facility does not keep a special binder or location for this information outside of the resident's chart.On [DATE] at 10:50am, V3 identified R19 as a DNR by looking at R19's Physician's order sheet dated [DATE]-[DATE]. V3 stated as far she knew R19 was a DNR and she would not perform CPR on R19 if R19 had cardiac arrest, V3 found R19's Advanced Directive/POLST form (dated [DATE]) in the back of R19's medical chart. V3 said she was wrong, R19 is supposed to have CPR performed in the event of a cardiac arrest. V3 said someone made a mistake and she would correct the issue.Facility's undated policy titled Advance directives documented in part: Purpose: to ensure all residents are given the right to choose in advance, their end-of-life decisions. Upon admission, the Director of Nursing or designee shall receive resident's directive's concerning end of life decisions.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review the facility failed to provide a safe, clean, sanitary environment for one (R2) of ten residents reviewed for a safe, clean, sanitary environment in a sample of 22. Findings include:On 03/30/26 at 10:20 AM the bathroom on the east hall had 10 1 inch by 1 inch tiles missing in the floor near the toilet and 20 1 inch by 1 inch tiles missing in another location on the floor. There was also a build up of dirt and debris around pedestal of the toilet. On 04/02/26 at 3:10 PM, V2 (Director of Nursing) stated, R2 is the only resident that uses the bathroom on the east hall. V2 stated she will get V20 (Maintenance Director) to clean and repair it right away.The undated facility policy titled, Facility Environmental Policy documents: it is the policy of (facility name) to provide housekeeping and maintenance staffing to promote a safe and functional environment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to accurately assess a resident eating abilities for 1 of 1 resident (R2) reviewed for accuracy of assessments in a sample of 22.Findings include:R2's admission record documents an admission date of 02/18/26 with diagnoses including: neurocognitive disorder with Lewy Bodies, anxiety disorder, progressive spinal muscle atrophy, and insomnia. R2's Minimum Data Set (MDS) dated [DATE] documents a brief interview of mental status (BIMS) of 01 indicating severe cognitive impairment. Section GG documents R2's eating performance as independent.R2's care plan for 3/9/26 documents a focus area of: potential for excessive weight gain or loss related to Lewy body dementia, progressive atrophy, confusion and hand tremors. Interventions to include: R2 can feed himself, he often requests seconds of foods he likes, attempt to second helping when he requests, monitor meal intake with every meal.R2's Malnutrition Risk assessment dated [DATE] documents in part that R2 feeds self slowly and only part of the meal and his food intake is poor eating less than 25% of most meals. This assessment is signed by V11 (Registered Nurse).R2's CNA (Certified Nurse Aide) ADL (activities of daily living) daily record dated March 2026 under eating documents R2 is a 6, independent with eating on all meals except lunch for the days of 1, 7, 14, 15, 23, 27, 28, 31; for dinner the days of: 4, 7 8, 13, 25, and 28. The meals are left blank. On 03/31/26 at 11:39 AM, R2 was observed trying to eat his food, R2's hand was shaking so bad his food was falling off of his fork and he was getting very little food into his mouth, less than 10 percent. On 03/31/26 at 11:54 AM, V4 (Certified Nurse Aide) sat down to assist R2 with his lunch, R2 then ate 100% of his lunch. On 04/01/26 at 12:04 PM R2 was served his lunch. At 12:05 PM R2 attempted to pick up his drink with his right hand and was shaking so badly R2 struggled to pick up his drink and the drink glass kept hitting the table and clicking against the table. R2 then received his lunch of chili, cottage cheese, carrots, and fruit cocktail, with R2's lunch sitting in front of him he attempted to pick up his drink glass several times but his right hand had severe tremors making it difficult for him to lift the glass and be able to drink out of the straw. At 12:27 PM R2 picked up his spoon and attempted to eat some cottage cheese but his hand was shaking so bad most the cottage cheese came off the spoon before he was able to get it to his mouth, by 12:51 PM R2 had only been able to eat approximately three bites of food. At 12:51 PM, V4 (Certified Nurse Aide /CNA) told R2 he should try to use his left hand to eat, it is not shaking as bad, at 12:58 PM V4 sat down and assisted R2 with his lunch and was able to eat 85% of his food by 1:12 PM.On 04/02/26 at 12:01 PM, R2 received his lunch of baked chicken and gravy, mashed potatoes, peas, bread with butter, and cake. At 12:07 PM, R2 picked up the buttered bread and ate it. R2 sat and stared at his food until 12:29 PM when he tried to get a piece of the cake onto his fork which shortly after fell off his fork into the gravy of the chicken. R2 tried to get the cake back onto his fork with the gravy on it and get it into his mouth. R2 then tried to get a second bite of cake onto his fork and attempted to keep it on his fork with his left hand and attempted to get it into his mouth. At 12:33 PM, V14 (CNA) asked R2 if he was doing ok but, did not stop to assist R2. At 12:42 PM R2 still had only been able to get the two bites of cake into his mouth and V9 CNA sat by R2 and assisted him with his lunch and by 12:52 PM R2 had eaten 100 % of his lunch.On 04/02/26 at 12:56 PM, V9 stated R2 has been shaking bad for a bit now. V9 stated, if she sees he is shaking bad she will stop and assist him with his lunch. V9 stated, she has never seen R2 with weighted silverware.On 04/01/26 at 1:19 PM, V12 (CNA) stated she has never heard R2 ask for seconds, V12 stated, she rarely hears R2 say anything. V12 stated, R2's right hand does shake a lot, it does cause him problems eating with silverware.On 04/01/26 at 3:10 PM, V2 (Director of Nursing) stated, she expects the staff to feed R2.On 04/02/26 at 1:02 PM, V15 CNA stated R2's right hand shakes, sometimes it will shake worse than other times. V15 stated, she feels it has been about the same since he has been at the facility. V15 stated, he is better with finger foods so he will eat the bread with butter probably first and he is pretty good if you hand him a peanut (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	butter and jelly sandwich. V15 stated, with today's lunch she would think R2 would have been documented for eating assistance as a two, because he was slightly helping, not a six because he only ate the bread by himself. V15 stated, she has not seen R2 ever attempt to eat with weighted silverware.On 04/01/26 at 3:10 PM, V8 (Dietary Manager) stated, she does not assess residents, she does not do BMIs (Body Mass Index), estimated calories, or goal weights for any of the residents. V8 stated, they do not currently have a Registered Dietician and have not since approximately October 2023. V8 stated, she believes R2 should have been assessed for weighted silverware.On 04/01/26 at 3:17 PM, V10 (Medical Records/MDS Coordinator) stated she puts the MDS together, she gets the eating information from the CNA books, meaning how much assistance they have had to give him.On 04/02/26 at 3:42 PM, V17 (Medical Director) stated, he is familiar with R2. V17 stated, he doesn't remember having an in-depth conversation about R2's nutrition or eating assistance. V17 stated, R2's hand does shake. V17 stated, some intervention for R2 would be reasonable and weighted silverware could be beneficial for R2.On 04/02/26 at 3:54 PM, V2 (Director of Nursing) stated, she does not know if she has a policy for assessment.On 04/03/26 at 10:00 AM, V2 stated, she assessed R2 when he came to the facility.

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	146070	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Willows Nursing Center	1600 North Broadway Salem, IL 62881

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to provide assistance with eating assistance in a timely manner and failed to ensure that residents who require assistance with showering received a shower for 2 of 4 residents (R2, R7) reviewed for Activities of Daily Living in a sample of 22.Findings include:1. R2's admission record documents an admission date of 02/18/26 with diagnoses including: neurocognitive disorder with Lewy Bodies, anxiety disorder, progressive spinal muscle atrophy, and insomnia. R2's Minimum Data Set (MDS) dated [DATE] documents a brief interview of mental status (BIMS) of 01 indicating severe cognitive impairment. Section GG documents R2's eating performance as independent. This same MDS documents R2 needs partial/moderate assistance from one staff member for showering R2's care plan for 3/9/26 documents a focus area of: potential for excessive weight gain or loss related to Lewy body dementia, progressive atrophy, confusion and hand tremors. Interventions to include: R2 can feed himself, he often requests seconds of foods he likes, attempt to second helping when he requests, monitor meal intake with every meal. R2's care plan does not address showering/bathing R2's Malnutrition Risk assessment dated [DATE] documents in part that R2 feeds self slowly and only part of the meal and his food intake is poor eating less than 25% of most meals. This assessment is signed by V11 (Registered Nurse). On 03/31/26 at 11:39 AM, R2 was observed trying to eat his food, R2's hand was shaking so bad his food was falling off of his fork and he was getting very little food into his mouth, less than 10 percent. On 03/31/26 at 11:54 AM, V4 (Certified Nurse Aide) sat down to assist R2 with his lunch, R2 then ate 100% of his lunch. On 04/01/26 at 12:04 PM R2 was served his lunch. At 12:05 PM R2 attempted to pick up his drink with his right hand and was shaking so badly R2 struggled to pick up his drink and the drink glass kept hitting the table and clicking against the table. R2 then received his lunch of chili, cottage cheese, carrots, and fruit cocktail, with R2's lunch sitting in front of him he attempted to pick up his drink glass several times but his right hand had severe tremors making it difficult for him to lift the glass and be able to drink out of the straw. At 12:27 PM R2 picked up his spoon and attempted to eat some cottage cheese but his hand was shaking so bad most the cottage cheese came off the spoon before he was able to get it to his mouth, by 12:51 PM R2 had only been able to eat approximately three bites of food. At 12:51 PM, V4 (Certified Nurse Aide /CNA) told R2 he should try to use his left hand to eat, it is not shaking as bad, at 12:58 PM V4 sat down and assisted R2 with his lunch and was able to eat 85% of his food by 1:12 PM. On 04/02/26 at 12:01 PM, R2 received his lunch of baked chicken and gravy, mashed potatoes, peas, bread with butter, and cake. At 12:07 PM, R2 picked up the buttered bread and ate it. R2 sat and stared at his food until 12:29 PM when he tried to get a piece of the cake onto his fork which shortly after fell off his fork into the gravy of the chicken. R2 tried to get the cake back onto his fork with the gravy on it and get it into his mouth. R2 then tried to get a second bite of cake onto his fork and attempted to keep it on his fork with his left hand and attempted to get it into his mouth. At 12:33 PM, V14 (CNA) asked R2 if he was doing ok but, did not stop to assist R2. At 12:42 PM R2 still had only been able to get the two bites of cake into his mouth and V9 CNA sat by R2 and assisted him with his (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lunch and by 12:52 PM R2 had eaten 100 % of his lunch. On 04/02/26 at 12:56 PM, V9 stated R2 has been shaking bad for a bit now. V9 stated, if she sees he is shaking bad she will stop and assist him with his lunch. V9 stated, she has never seen R2 with weighted silverware. On 04/01/26 at 1:19 PM, V12 (CNA) stated she has never heard R2 ask for seconds, V12 stated, she rarely hears R2 say anything. V12 stated, R2's right hand does shake a lot, it does cause him problems eating with silverware. On 04/01/26 at 3:10 PM, V2 (Director of Nursing) stated, she expects the staff to feed R2. On 04/02/26 at 1:06 PM, V2 stated if the staff see a resident has not been able to eat for 30 minutes or maybe less, they should assist the resident with eating. 2. The facility's shower list for the week of February 14-20, 2026, document R2 was scheduled for a shower on Friday 2/20/26 but did not receive a shower any day during that week. The facility's shower list for the week of February 21-27, 2026, document R2 was scheduled for a shower on Friday 2/27/26 but did not receive a shower any day during that week. The facility's shower list for the week of February 28-March 6, 2026, documented R2 was showered on Friday 3/6/36 and had not received a shower since being admitted to this facility on 2/18/26, which was 16 days later. The facility's shower list for the week of March 14-20, 2026, documented R2 received a shower on Friday 3/20/26, but missed his scheduled shower the week of March 21-27, 2026 which was due on Friday 3/27/26 and had not been showered as of today's date of 4/2/26. According to the documentation R2 was not showered between 3/21/26-4/2/26. (12 days total) R2's nurse's notes for February/March 2026 does not address why R2 missed his scheduled showers during that time period. R7's admission Record documented admission date of 10/28/2024. R7's Physician Orders sheet (4/1/26-4/30/25) documents R7's admission diagnoses of alerted mental status, dementia, hypertension, and diabetes mellitus. R7's MDS dated [DATE], documents R7's BIMS of 6 out of 15 total, which indicates R7 has severe cognitive impairment. This same MDS documents R7 needs partial/moderate assistance from one staff member to shower/bathe. The facility's shower list for the week of February 7-13, 2026, documented R7 received a shower on Sunday 2/8/26. The facility's shower list for the week of February 14-20,2026 document R7 did not get her shower, which was scheduled for Sunday 2/15/26. R7's shower sheets documents R7 did not receive a shower until her next scheduled shower day of Sunday 2/22/26. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the shower list R7 was scheduled for a shower on Sunday 3/1/26 but was not showered until her next scheduled shower day of Sunday 3/8/26. According to the shower list R7 was not showered/bathed from 2/9/26-2/21/26 a total of 13 days during this period and was not showered/bathed from 2/23/26-3/7/26 a total of 12 days. R7's nurses notes for February or March 2026 does not address why R7 was not showered during her missed scheduled shower during that time period. On 4/2/2026 at 2:00pm, V2 (Director of Nursing) said she has not received any requests to change or alter R2 or R7's shower schedule. V2 said she expected all residents, including R2 and R7 to be bathed according to the shower schedule. V2 said two weeks without a bath is too long and she would address the issue. V2 said she has not been informed of R1 or R7 refusing any scheduled showers. Facility policy (none dated) titled Shower policy, Purpose: To provide each resident with a method to receive proper hygiene. Each wee a shower schedule will be posted with names, dated, and special instructions. CNAs are to shower/bathe each resident per the posted schedule. If a scheduled shower must be changed for days, times, certain personal, etc., notify the DON (Director of Nursing) to request a posted change to meet the resident's wishes/needs. If a scheduled shower cannot be done as posted, notify the charge nurse, who will make different plans to ensure the resident receives showers/baths as needed/requested.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to supervise residents who are at risk of choking during meals for 1 of 1 resident (R23) reviewed for supervision in the sample of 22. Findings include:R23's admission Records documents R23 was admitted on [DATE] with diagnoses to include: muscle wasting and atrophy, gastro-esophageal reflux disease, muscle weakness, need for assistance with personal care.R23's Minimum Data Set (MDS) dated [DATE] documents R23 is severely cognitively impaired and she requires partial to moderate assist with eating.R23's care plan dated 1/14/2026 documents, Potential for nutritional problem related to: she is unsatisfied with the idea of gaining weight, Lasix therapy, and choking hazard. The interventions for this care plan include, Staff supervision with all meals related to choking hazard. Monitor for any signs or symptoms of aspiration, or dysphagia: choking, fever coughing.On 3/30/26 from 12:54 PM to 1:11 PM R23 was observed feeding herself chicken strips, baked beans, potato salad, and pudding during the lunch meal. There were no staff present in the dining room during that time frame to supervise residents who were still eating their meal.On 4/2/2026 from 12:42 PM to 12:46 PM R23 was being assisted with eating by V15 Certified Nursing Assistant (CNA) during lunch noon meal. R23 began coughing while eating her food and V15 asked R23 if she was okay. V14, another CNA, also asked R23 if she was alright. R23 continued to cough, then nodded her head that she was alright, and V15 gave R23 a drink of fluid. V15 told V14 that R23 started choking on the last bite she had fed her. After giving her a drink, V15 asked R23, Do you feel better? and R23 nodded yes. R23 continued to cough on and off for several more minutes while continuing to eat. On 4/2/26 at 12:58 PM, V15 stated she has worked for the facility for about a year and this was the first time R23 had a coughing episode while she was being fed.On 4/2/26 at 3:30 PM V2, Director of Nursing (DON) stated there should always be a staff member in the dining room any time there are residents in there eating their meal.On 4/2/26 at 3:45 PM V5, CNA stated the reason R23 is assisted with feeding is because R23 will stop eating and they encourage her to eat more. V5 stated she has never witnessed R23 choke or have a coughing fit while eating.On 4/3/26 at 9:41 AM, during a phone interview, V2 stated she is not sure if the facility has a policy regarding staff being present in the dining room while residents are eating. She stated she will check.The facility's policy, Dining policy does not address supervision by qualified staff during mealtimes for resident safety.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to assess, monitor and document meal intakes on resident who is considered underweight for weight gain/loss for 1 of 5 residents (R9) reviewed for weight loss in a sample of 22.Findings include:R9's admission record documents an admission date of 02/12/15 with diagnoses including: Alzheimer's disease, dementia, methicillin resistant staphylococcus aureus infection, essential hypertension, extended spectrum beta lactamase resistance, major depressive disorder, gastro-esophageal reflux disease (GERD), and hypothyroidism.R9's Minimum Data Set, dated [DATE] documents the question; should brief interview for mental status with no marked indicating resident is rarely/never understood. Section GG documents eating status of dependent indicating helper does all of the effort. Section K documents a height of 65 inches and a weight of 102 pounds.R9's care plan last revised 3/3/26 documents a problem area indicating R9 has the potential for excessive weight loss related to short attention span, difficulty staying focused to eat, is fed by staff, sometimes she is so sleepy she can't stay awake to eat, and she has a potential for excessive vomiting related to GERD. Intervention to include: give resident supplements as ordered, alert nurse/dietitian if not consuming on a regular basis and R9 is on a regular pureed diet with fortified foods, she receives super cereal at breakfast, health shakes with all 3 meals, and she receives 8 ounces health shake in the morning and afternoon.R9's Care Plan Conference Summary dated 3/3/26 documents R23 had a March weight of 98 pounds, February 102 pounds and January 103 pounds. This summary documents R23 consumes 50% of meals, is on a regular puree diet, supercereal at breakfast, fortified supplements at meals 10am and 2pm.R9's physician's order sheet documents dietary orders for health shakes at 10:00 AM and 2:00 PM dated 04/23/21, regular diet with a pureed diet dated 09/04/19, super cereal at breakfast related to weight loss dated 09/04/19, health shakes 8 ounces with meals dated 05/02/19 and fortified foods dated 04/14/21. R9's Quarterly Nutritional Re-evaluation documents: diet orders/snacks/supplements: with health supplement at meals, 10:00 AM and 2:45 PM the box dated 08/25/25 documents: regular puree, super cereal at breakfast and fortified, this same line documents the same box dated 11/25/25 and 02/25/26 documents same, the line of height/weight documents: 65 inches and 102 pounds dated 08/25/25, 65 inches 101 pounds dated 11/25/25 and 65 inches and 102 pounds dated 02/25/26. The line titled, Nutrition related Medications with low aspirin, Colace, Bisacodyl, metoprolol, Synthroid, MiraLAX, acidophilus, and Zocor dated 08/25/25 with same written in the columns for 11/25/25 and 02/25/26. The evaluations dated 08/25/25, 11/25/25, and 02/25/26 were all signed by V8 (Dietary Manager). The section that allows for written in comments documents: 08/25/25 - remains on same diet, feeder, weight stable, intakes good, 11/25/25 - remains on same diet, feeder, weight stable, intakes good, and 02/25/26 - remains on same diet, weight stable, intakes good, feeder all signed by V8. The page titled, RD (Registered Dietician) Assessment is blank. The facility document titled, Weight Entry (in Pounds) documents R9's January 2026 weight as 103.0 pounds, February 2026 weight as 102.0 pounds, and on March 16 2026 at 12:48 PM as 98.0 pounds. The Center for Disease Control and prevention's website: https://www.cdc.gov/bmi/adult-calculator documents a weight of 102 pounds at 65 inches tall is a body mass index (BMI) of 17.0 % and a weight of 98.0 pounds is a BMI of 16.3%. This same website documents a BMI under 18.5% is considered underweight. The facility document titled, CNA (Certified Nurse Aide) ADL (activities of daily living) Daily Record dated March 2026 documents: for breakfast: list % taken: there is no documentation for the dates 1, 5, 7, 14, 15, 23, 27, 28, and 29, 100% is documented for the dates 2, 3, 4, 9, and 19, and 125% is documented for the dates 6, 8, 10, 11, 12, 13, 16, 17, 18, 20, 21, 22, 24, 25, 26, 30, 31. The line documenting 10 AM snack: list % taken with no documentation for the dates 1, 5, 7, 9, 14, 15, 19, 23, 27, 28, and 29, 100 % is documented for the dates 2,3,4,6,8,10,11,12,13,16,17,18, 20, 21, 22, 24, 25, 26, 30, 31. The line documenting lunch: list % taken has no documentation for the dates: 1, 5, 7, 14, 15, 23, 27, 28, and 29, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	75% is documented for the date 9, 100 % is documented for the dates: 19, 22, and 25, 125% is documented for the dates: 2, 3, 4, 6, 8, 10, 11, 12, 13, 16, 17, 18, 20, 21, 24, 26, 30, and 31. The line for 3:00 Snack: list & taken has no documentation, the line supper: list % taken documents 75% for the 19th, 50 plus for the 31st, and the rest of the line is blank. The line for bedtime snack: list % taken has no documentation. The facility document titled, CNA ADL Daily Record dated February 2026 documents: for breakfast: list % taken: there is no documentation for the dates 1, 3, 4, 5, 10, 14, 15, 20, 23, and 28, 125% is documented for the dates: 2, 6, 7, 8, 9, 11, 12, 13, 16, 17, 18, 19, 21, 22, 24, 25, 26, and 27. The line for 10 AM snack: list % taken: there is no documentation for the dates: 1, 3, 4, 5, 10, 14, 15, 20, 23, and 28, 100 % is documented for the dates: 2, 6, 7, 8, 9, 11, 12, 13, 16, 17, 18, 19, 21, 22, 24, 25, 26, and 27. There is no documentation for the 3:00 PM snack: list & taken. The line for supper: list % taken has 50% documented for the dates 3 and 9, 75% plus is documented for the 26th, and 75% is documented for the 28th, the rest of the dates are blank. On 04/01/26 at 12:01 PM, V4 (CNA) was assisting R9 with her lunch, V4 stopped feeding R9 and R9 started waving her arms, V4 switched sides that she was sitting on, V4 told R9, I'm still here and gave her another bite of food and R9 calmed down and quit waving her arms. R9 then finished all of her food. On 04/01/26 at 12:21 PM V4, stated R9 usually finishes all of her lunch, R9 is a pretty good eater. On 04/02/26 at 1:03 PM, V15 (CNA) stated they are supposed document the amount the residents eat everyday and their eating ability. V15 stated, 125% amount eaten means they ate all their food and their supplement usually. On 04/01/26 at 3:10 PM, V8 (Dietary Manager) stated they currently do not have a RD (Registered Dietician), they have not had one since the end of 2023. V8 stated, she does not do BMIs (Body Mass Index), goal weights, the amount of calories needed, or estimated calories given for the residents. On 04/02/26 at 3:42 PM, V17 (Medical Director) stated he remembers talking about R9's weight but he does not recall it being an in-depth conversation. V17 stated, he doesn't believe R9 has lost weight but she is thin and probably underweight. V17 stated, he does not think medication to stimulate her appetite would be good because her health is not great. V17 stated they have not discussed double portion or extra protein for R9, but that is not a bad idea. V17 stated, an RD consult would be nice. The undated facility policy titled, Weight: Reporting and Recording documents: purpose: 1. to identify weight variance above or below ideal/usual body weight and assess reason for weight variance. 2. establish a measurable goal for resident to fain or lose weight as appropriate to attain ideal/usual body weight range. 3. develop a plan in consultation with the physician and dietician to alter the desired weight gain or loss. The section titled, procedure documents 2. staff nurse: maintain control of procedure by monitoring for: need for dietician consultation and need for quality assurance review. 4. make notes on weight sheet under comments, example (Dr (doctor) notified, see progress notes 1-1-91 or reweighted on different scale.