STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146101	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows Health Center	4054 Albright Lane Rockford, IL 61103

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 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. 20042 Based on interview and record review the facility failed to ensure a resident was positioned safely in bed to prevent a fall for 1 of 3 residents (R2) reviewed for safety and supervision in the sample of 5. The findings include: The Nurse's Note dated 9/20/24 at 8:30 PM showed, Resident (R2) was found at 7:30 PM by CNA (Certified Nursing Assistant) staff at the time this writer arrived resident vitals were assessed and stable. Client told staff she wanted to get her cranberry juice and slid out of her bed. No signs of distress or discomfort shown by client. Client expressed her bottom was hurting but she did not have any other pain. This writer reached out to clients POA with direct phone call and advised client would have to be sent out for further evaluation per standard protocol due to client being on blood thinner medication. On 9/21/24 at 1:00 AM staff was contacted by the hospital nurse and was notified that the resident was being admitted for a subarachnoid bleed. On 9/21/24 at 7:07 PM, Nurse to nurse report given by hospital nurse to this writer/nurse - the hospital performed a head computerized tomography scan that showed trace bilateral subarachnoid bleed. R2 given vitamin K in the emergency room . Resident returned to unit (at facility) by ambulance transport. The Hospital Record for R2 dated 9/21/24 showed the CT of the head for R2 was redone and, the previously mentioned subarachnoid hemorrhage is likely artifactual. On 9/24/24 at 1:19 PM, R2 was sitting in a wheelchair in the activity room. R2 was leaning forward in her wheelchair and was sleepy. (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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NAME OF PROVIDER OR SUPPLIER Willows Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4054 Albright Lane Rockford, IL 61103	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 1:47 PM, V11 CNA stated, V13 (CNA from the agency) had R2. V11 stated V13 sat R2 up on the side of her bed and had the tray table in front of her so she could eat. V11 stated when R2 was done eating she had pushed the tray table away from her. V11 stated R2 was sitting up on the side of her bed for over an hour. V11 stated R2 did not have good sitting balance because she sits forward. V11 stated when R2 is in her wheelchair she leans forward, and you can tell her to sit back, and she will. V11 stated R2 will fall asleep sitting up. R2 is usually put to bed right after lunch and dinner. V11 stated V13 wasn't doing anything; he told V13 to get up and go to the dining room. V11 stated they don't like to leave residents in their rooms for meals because they can't be monitored, and anything can happen. V11 stated R2 slid off the bed onto the floor. V11 stated the nurse came and had to assess to make sure the resident was okay. R2 said she didn't hit her head. It just looked like she slid out onto her butt onto the floor. R2 has poor balance when sitting and gets tired easily. V13 had her sitting up on the side of the bed too long. V11 stated they used a mechanical lift to get her up off the floor and into bed. On 9/24/24 at 2:25 PM, V12 (Licensed Practical Nurse/LPN) stated, the agency CNA had her that night on the 2:00 PM - 10:00 PM shift and R2's cares were explained. After dinner I heard V13 (CNA) yelling that R2 was on the floor. R2 was sitting on her bottom on the floor. I checked her vital signs, assessed her and then a mechanical lift was used to put R2 to bed. V12 stated she talked to the family, and they did not want R2 sent out but V12 told them she needed to because R2 was on a blood thinner. V12 stated she was doing the medication pass at the end of the hall and V11 got to R2's room before she did. V12 stated R2 was sitting on the side of the bed before she slid out and the pad that was under her was partially out of the bed. V12 stated she did not know why R2 was sitting on the side of the bed. R2 can't do that on her own; she is complete dead weight and leans forward all the time. V12 stated R2 said she was trying to get her cranberry juice and if R2 had been in bed with it (bed) in a lower position with the tray table next to her where she could get it then it would not have happened. V12 stated this fall could have been prevented. V12 stated R2 should not have been sitting on the side of the bed. On 9/24/24 at 2:55 PM, V3 (Director of Nursing) stated, R2 slid out of bed reaching for her juice and was sitting on the floor next to her bed. There was no evidence of her hitting her head, but she was on a blood thinner, so she was sent to the hospital. Initially R2 was admitted to the hospital for a bleed but they called us later and told us it was an old bleed. V3 stated she was told R2 rolled out of bed. V3 stated R2 shouldn't have been sitting on the side of the bed. R2 wouldn't be able to do that. The Face Sheet dated 9/24/24 for R2 showed diagnoses including pain in left knee, localized edema, atrial fibrillation, type 2 diabetes mellitus, anemia, anxiety disorder, gastroesophageal reflux disease, hyperlipidemia, history of falling, age related physical debility, and muscle weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Care Plan with the next goal date of 11/29/24 showed she has a potential for falls related to decreased independence with mobility; 9/20/24 slid from bed to floor trying to reach cranberry juice. Sent to emergency room - no new injury. Staff will provide assistance with activities of daily living, transfers, and locomotion per therapy recommendations. Keep call light and personal belongings within resident's reach (5/20/22). Keep bed in low position while resident is resting/sleeping. Provide extensive 2 person assist for transfers with mechanical lift. Ensure resident has her items within reach i.e. glass when she is wanting something to drink (9/20/24). Decreased independence with mobility. Non-ambulatory - spends some of her day in her wheelchair. She is able to propel her wheelchair herself. Dependent on staff for mobility activities. Assist of 2 with repositioning. Propels self in wheelchair in the hallways. R2's care plan does not state that what her sitting balance is or that she leans forward in her chair. The Facility's Fall Prevention Policy (8/2024) showed, all staff will have training on fall prevention and their responsibility on hire and annually.