

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/28/2025
NAME OF PROVIDER OR SUPPLIER  Willows Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>36186</p> <p>Based on interview and record review the facility failed to complete a thorough investigation into an allegation of misappropriation of narcotic medications. This applies to four of four residents (R4-R7) in certified beds of the facility reviewed for abuse investigation in the sample of 13.</p> <p>The findings include:</p> <p>The facility census provided by the facility dated 1/28/2025 for December 24 to December 25, 2024 shows there were four residents residing in certified beds in the E-wing that also had orders for controlled medications.</p> <p>The facility provided a schedule for 12/24/24 which shows V21 (Agency Licensed Practical Nurse/LPN) was assigned the E-wing unit of the health care center from 2:00 PM to 10:30 PM.</p> <p>On 1/21/25 at 12:30 PM, V3 (Director of Nursing/DON) said, . It was [V21 Agency LPN] that was accused. She worked for us for that one day and only worked on the sheltered care side of the facility. She would not have had access to any other medication carts, medication rooms, or comfort packs on any other unit.</p> <p>On 1/22/25 at 3:30 PM, V3 (DON) said no concerns were reported to her regarding the certified wing. V3 said there was no audits completed of any other units other than the sheltered units.</p> <p>On 1/21/25 at 11:30 AM, V1 (Administrator) said the allegation of a drug diversion was not reported to the state agency or the police because nothing could be proved, and the facility could be sued for slander if they began making accusations without proof.</p> <p>On 1/21/25 at 2:20 PM, V22 (Registered Nurse/RN) said, I had worked night shift on Christmas Eve. I was late and did not get there until 11:00 PM. I did not count the narcotics, I assumed it was done by someone else. The next morning when I went to count with the day shift nurse, the count was off. I went down to sheltered care and told [V21 Agency LPN] she needed to come back upstairs to count and see where the problem was. She didn't come up with me. I don't know if she ever did come up .</p> <p>(continued on next page)</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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/22/25 at 10:20 AM, V6 (RN) said, I was working [the certified wing]. My shift started at 6:00 AM. At first when I started to do the count, I noticed the first 3 cards were off. I wasn't tripping at first because you might get in a groove and forget. After the third one was off, I called down and spoke with [V4 LPN]. When I got here and got the keys I was waiting for [V21 Agency Nurse] to come up and count. I was looking over them myself as I waited for [V21]. I then reached out to [V4], and she said her count was off too. [V21 Agency Nurse] came up to verify the count. She was very rushed. I said, 'hey things are off.' She was rushing through and signing medications off. I finally told her she needed to slow down . [V21] was exhibiting different behaviors . she was trying to get into the medication refrigerator to 'get her lunch' . I wouldn't let her back there. Then she went to [another upstairs unit] and then back downstairs . the DON (Director of Nursing) was called, and she said to walk [V21] out . the maintenance guy got her . We count every shift unless we are working a double on the same unit. The whole point of doing a count is to make sure it's right .</p> <p>On 1/22/25 at 12:19 PM, V7 (Maintenance) said he was called over to the radio on Christmas Day to remove a nurse who was acting erratic. V7 said, I was told her shift was done and she needs to leave the building right away. She was trying to outrun me, but I cut her off since I know the building well and told her she needed to leave. She was acting strange . Her pupils were extremely dilated. She was acting like she took some 'gummies' or something. She didn't smell like anything, but she was acting erratic . I took her to the exit, but I didn't think she was going to leave. She sat in her car for at least 10 minutes, just sitting there. So, I picked up the phone to act like I was calling someone and then she headed out. I followed her for a bit just to make sure she actually left . No one at the facility has asked me anything about this .</p> <p>The facility provided an email dated 12/25/24 at 8:26 AM, which showed it was from V3 (DON) to V1 (Administrator). The email showed, . this morning, [V4 LPN] called me with concerns regarding a nurse on [sheltered care unit] for night shift. The nurse was [V21 Agency LPN]. She stated that a CNA (Certified Nursing Assistant) stopped her prior to clocking in and told her the nurse she was working with on nights was all over the place and was caught sleeping 3 times. I was not notified of any of this throughout the night and neither was the nurse on call. She said the office was in complete disarray and she noticed discrepancies in the narcotic count. She forgot to sign out an Ambien, but I did verify with another nurse that this was given, and the count was corrected. [V4] stated a bottle of Norco was unaccounted for but they did locate it in the other narcotic drawer prior to the nurse leaving. [V4] also stated an oxycodone count was off but the pill was located in the bottom of the drawer and count was correct. [V4] stated when they counted the liquids in the fridge, she noticed the consistency seemed off and stated the liquids smelled of mouthwash and Robitussin. I did let her know that the narcotics sent from hospice in comfort packs did have a sweet smell. [V4] stated the nurse kept looking around the unit like she lost something and I advised her that if she did not leave, to please have maintenance escort her out if need be. She did end up leaving on her own accord. I have removed her from her double shift today and will notify her agency about the above. I will also check our policy for suspected medication diversion and consult with pharmacy as the need arises. Please let me know if there is anything you need from me at this time .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility provided an email thread dated 12/31/24 at 7:43 AM which showed V8 (Pharmacy Nurse Consultant) contacted V3 (DON). This email showed, . Can you please call me this morning . we received a call from a nurse, [V4]. She is concerned that 2 residents morphine/lorazepam liquids from the hospice kit were switched with water and is asking if there is a way to test it . On 12/31/24 at 8:46 AM, V4 (LPN) was added to the email and additionally V5 (LPN Nurse Manager) and V1 (Administrator) were copied. This email showed, [V4], I spoke with [V8 Pharmacy Nurse Consultant] this morning. She confirmed there is no test to check the morphine/lorazepam. She consulted with the pharmacist and best practice would be to document (which we have) and ask hospice or pharmacy to supply a new bottle. I am attaching the policy we follow from [the pharmacy] . All proper documentation has already been filed and her agency has already disabled her account. We likely won't know what comes of this for quite some time but we do have all the information we need to move forward . [V5 LPN Nurse Manager] can we please dispose of the narcotics we believe have been tampered with and ensure hospice is able to send a new bottle? .</p> <p>The facility did not provide interviews with all the staff involved in the incident such as the maintenance man who had to escort V21 from the facility. No records of medication cart and drug audits were provided.</p> <p>The facility's policy and procedure received from the facility's pharmacy dated March 2021 showed, Discrepancies, Loss and or Diversion of Medications; Policy: All discrepancies, suspected loss, and/or diversion, the Administrator, Director of Nursing, and Consultant Pharmacist are notified, and an investigation is conducted. The Director of Nursing leads this investigation .</p> <p>The facility's policy and procedure with revision date of 3/5/24 showed, Abuse and Neglect Prevention Protocol Policy . It is the policy of this facility to not tolerate abuse or neglect of its residents by any individual . Definitions: . 11. Misappropriation of resident property means using a resident's cash, clothing, or other possessions without authorization by the resident or the resident's authorized representative . Investigation will be performed by Abuse Prevention Coordinators including but not limited to and interviews of residents and staff members .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>36186</p> <p>Based on interview and record review the facility failed to ensure a narcotic count was completed upon nursing shift change. This applies to one of one resident (R6) in certified beds of the facility reviewed for narcotic counts in the sample of 13.</p> <p>The findings include:</p> <p>The facility face sheet for R6 shows he was admitted to the facility with diagnoses to include encounter for palliative care, hypertensive heart disease with heart failure, atrial fibrillation, dementia, and congestive heart failure. The medication administration record for R6 shows medication orders for lorazepam (anti-anxiety medication) 2 mg/ml (milligrams/milliliters) give 0.5 ml every four hours as needed and morphine (opioid pain medication) 20 mg/ml give 0.25 ml every four hours as needed. (Lorazepam and morphine are controlled substances.)</p> <p>On 1/21/25 at 2:20 PM, V22 (Registered Nurse/RN) said, I had worked night shift on Christmas Eve. I was late and did not get there until 11:00 PM. I did not count the narcotics, I assumed it was done by someone else. The next morning when I went to count with the day shift nurse, the count was off. I went down to sheltered care and told [V21 Agency Licensed Practical Nurse/LPN] she needed to come back upstairs to count and see where the problem was. She didn't come up with me. I don't know if she ever did come up .</p> <p>On 1/22/25 at 10:20 AM, V6 (RN) said, I was working [the certified wing]. My shift started at 6:00 AM. At first when I started to do the count, I noticed the first 3 cards were off. I wasn't tripping at first because you might get in a groove and forget. After the third one off, I called down and spoke with [V4 LPN]. When I got here and got the keys I was waiting for [V21 Agency LPN] to come up and count. I was looking over them myself as I waited for [V21]. I then reached out to [V4], and she said her count was off too. [V21 Agency LPN] came up to verify the count. She was very rushed. I said, 'hey things are off'. She was rushing through and signing medications off. I finally told her she needed to slow down . [V21] was exhibiting different behaviors . she was trying to get into the medication refrigerator to 'get her lunch' . I wouldn't let her back there. Then she went to [another upstairs unit] and then back downstairs . the DON (Director of Nursing) was called, and she said to walk [V21] out . the maintenance guy got her . We count every shift unless we are working a double on the same unit. The whole point of doing a count is to make sure it's right .</p> <p>On 1/22/25 at 3:30 PM, V3 (DON) said, . They should do a [narcotic] count every shift change. When a nurse is handing her keys off to anyone, they should be counting .</p> <p>On 1/28/2025 at 12:03 PM, V3 said the nurses count all scheduled II-V medications.</p> <p>The facility's Controlled Substance Shift to Shift Count Record for December 2024 showed, no signature on 12/25/24 AM (Morning) Off-going nurse or ON-coming nurse and no signatures showing a count was done for the 12/25/24 Off-Going PM nurse.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy and procedure with revision date of 7/2014 showed, . Medications: Storage of and narcotic counts; Purpose: To establish uniform guidelines concerning the storing of drugs and biologicals All Schedule II-V controlled medications will be counted with 2 nurses at each shift change and any discrepancies/corrected counts will be initialed and dated by both nurses.</p>		