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	11/15/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was free from misappropriation for 1 of 3 residents (R2) reviewed for misappropriation in the sample of 3.The findings include:R1's face sheet showed R1 was admitted to the facility on [DATE] with diagnoses to include atherosclerotic heart disease, insomnia, spinal stenosis, dementia with psychotic disturbance, panic disorder, restlessness and agitation, and mood disorder.R2's face sheet showed R2 was admitted to the facility on [DATE] with diagnoses to include anemia, chronic congestive heart failure, hypertension, gout, restlessness and agitation, dementia with behavioral disturbance, and anxiety disorders. R1's physician order sheet showed no order for liquid Ativan obtained until 9/25/25. R2's September 2025 eMAR (electronic Medication Administration Record) showed an order for Lorazepam Oral Concentrate 2ML/ML, give 0.5 ml by mouth every 1 hour as needed for agitation and anxiety.R1's September 2025 eMAR showed no order for liquid Ativan until 9/25/25. This same eMAR showed an order for Ativan Oral Tablet 0.5 mg to be given by mouth every 4 hours as needed. This eMAR documented on 9/24/25, R1 received his ordered 0.5mg tablet of Ativan at 3:00 PM and another 0.5 mg tablet dose at 7:00 PM.On 11/15/25 at 2:10 PM, V2 (Director of Nursing/DON) said, It was reported to me by V7 (Certified Nursing Assistant/CNA) on 9/25/25 that the night of 9/24/25 the nurse V6 (Licensed Practical Nurse/LPN) administered [R1] a liquid medication. [V6] told [V7] she was giving [R1] an ‘extra dose'. [The nurse didn't document that the medication was given. She documented that she had given [R2] a dose of his Ativan earlier in the day, but we don't know if she really did. we took off the 0.5 ml so that it would be exactly correct. We knew it was [R2's] Ativan because when we watched the video [V6] had a medication in her hand with a white stopper, [R2's] Ativan was the only one with a white stopper. When I spoke with V6 about the allegation she said, If the video says I did it, I guess I did it and she hung up on me. I think when V7 reported to her day nurse (V8) that [V6] had given R1 a liquid medication it stood out to her because [R1] didn't have a liquid medication and that prompted [V8] to tell [V7 CNA] to report it to me. On 11/15/25 at 2:34 PM, V8 (LPN) said, I think [R1] had his own Ativan order, but he received a liquid. He didn't have a liquid Ativan order at that time. V7 (CNA) told me that the agency nurse (V6) said to her, if you don't see this, I can give him something and then gave [R1] a liquid medication out of a dropper. [V7] was concerned about that, and I told her she needed to report it. I know she had written a statement. I also told our Administrator when she came up. I asked her (V7) if she reported it and she said no, I didn't put that in my statement, then she added it. I think they investigated it after that. I don't know whose Ativan [V6] used but if there is not an order for it, we can't give it. The facility's Abuse/Neglect Investigation report dated 9/25/25 showed, . Resident Name: [R1]. Date/Time of Incident: 9/24/25 at approximately 7:00 PM. Type of Allegation: Unauthorized administration of medication (Medication Error), Description of Incident: Resident was observed wandering near the nursing station, appearing anxious and agitated. The nurse on duty contacted the Director of Nursing (DON). During follow-up, CNAs reported the nurse verbalized giving an extra dose of medication to manage behavior. Investigation Findings. Video Review. Confirmed nurse administered liquid medication to resident. Resident's MAR (medication administration record) did not include any oral liquid medications. Conclusion: Nurse administered Ativan without a valid liquid PO (by mouth) order. Final Determination, this incident constitutes, Medication Error, Unauthorized Administration of a Controlled Substance, Violation of Resident Rights and Safety Standards. On 11/15/25 at 11:32 AM, V3 (Registered Nurse) said, We absolutely cannot give a resident a medication that is not ordered by the physician, that is not our scope and practice. We can't give them another resident's medications. Giving a resident someone else's medication can affect the other resident by them then being short on supplies.The facility's policy and procedure with review date of 8/2025 showed, Abuse and Neglect Prevention Protocol Policy, Policy: It is the policy of this facility to not tolerate abuse or neglect of its residents by any individual. 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.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure a resident was free of a medication error for 1 of 3 residents (R1) reviewed for medication administration in the sample of 3.The findings include:R1's face sheet showed R1 was admitted to the facility on [DATE] with diagnoses to include atherosclerotic heart disease, insomnia, spinal stenosis, dementia with psychotic disturbance, panic disorder, restlessness and agitation, and mood disorder.R1's undated care plan showed, The resident uses anti-anxiety medications related to anxiety disorder. Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift.R2's face sheet showed R2 was admitted to the facility on [DATE] with diagnoses to include anemia, chronic congestive heart failure, hypertension, gout, restlessness and agitation, dementia with behavioral disturbance, and anxiety disorders. R1's physician order sheet showed no order for liquid Ativan obtained until 9/25/25. R2's September 2025 eMAR showed an order for Lorazepam Oral Concentrate 2ML/ML, give 0.5 ml by mouth every 1 hour as needed for agitation and anxiety.The facility's Abuse/Neglect Investigation report dated 9/25/25 showed, . Resident Name: [R1]. Date/Time of Incident: 9/24/25 at approximately 7:00 PM. Type of Allegation: Unauthorized administration of medication (Medication Error), Description of Incident: Resident was observed wandering near the nursing station, appearing anxious and agitated. The nurse on duty contacted the Director of Nursing (DON). During follow-up, CNAs (Certified Nursing Assistants) reported the nurse verbalized giving an extra dose of medication to manage behavior. Investigation Findings. Video Review. Confirmed nurse administered liquid medication to resident. Resident's MAR (medication administration record) did not include any oral liquid medications. Conclusion: Nurse administered Ativan without a valid liquid PO (by mouth) order. Final Determination, this incident constitutes, Medication Error, Unauthorized Administration of a Controlled Substance, Violation of Resident Rights and Safety Standards. On 11/15/25 at 2:34 PM, V8 (Licensed Practical Nurse/LPN) said, I think [R1] had his own Ativan order, but he received a liquid. He didn't have a liquid Ativan order at that time. V7 (CNA) told me that the agency nurse (V6) said to her, if you don't see this, I can give him something and then gave [R1] a liquid medication out of a dropper.On 1/15/25 at 11:20AM, V4 (Registered Nurse/RN) said, We contact the nurse practitioner or the physician if we need an electronic prescription for a new prescription. We can't borrow someone else's, that is dangerous. You never borrow any medications, and you can't give medications they don't have an order for. we are not doctors, we can't prescribe medications. On 11/15/25 at 11:32 AM, V3 (RN) said, We absolutely cannot give a resident a medication that is not ordered by the physician, that is not our scope and practice. We can't give them another resident's medications. Giving a resident someone else's medication can affect the other resident by them then being short on supplies.On 11/15/25 at 2:10 PM, V2 (Director of Nursing) said, It was reported to me by V7 (CNA) on 9/25/25 that the night of 9/24/25 the nurse V6 (LPN) administered [R1] a liquid medication. [V6] told [V7] she was giving [R1] an 'extra dose'. [The nurse didn't document that the medication was given. She documented that she had given [R2] a dose of his Ativan earlier in the day, but we don't know if she really did. we took off the 0.5 ml so that it would be exactly correct. We knew it was [R2's] Ativan because when we watched the video [V6] had a medication in her hand with a white stopper, [R2's] Ativan was the only one with a white stopper. When I spoke with V6 about the allegation she said, If the video says I did it, I guess I did it and she hung up on me. I think when V7 reported to her day nurse (V8) that [V6] had given R1 a liquid medication it stood out to her because [R1] didn't have a liquid medication and that prompted [V8] to tell [V7 CNA] to report it to me. The facility's policy and procedure with review date of 08/2025 showed, Medication: Delivery by Nursing Personnel; Purpose: To establish a process to ensure that medication is safely and accurately administered. Policy Statement: Medications are administered utilizing the 5 rights of administering medications: 1. Right Resident, 2. Right Medication, 3. Right Dose, 4. Right Route, 5. Right Time. Practice: . 3. A two-step identification process may consist of asking a resident their name, using their photo in our electronic medical record, birth date, or the resident's name on their door. 5. Medications will be administered from the packaging bearing the individual resident's name, prescribing physician, and directions for administration.