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	12/16/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent a resident from acquiring a new pressure ulcer. This applies to one of three residents (R1) reviewed for pressure ulcers in the sample of six.The findings include:The facility face sheet for R1 shows she was admitted to the facility on [DATE] with diagnoses to include pathological fracture to left femur, congestive heart failure, atrial fibrillation and osteoporosis. The facility assessment dated [DATE] shows R1 to be cognitively intact and requires maximum assistance with transfers and rolling in bed. The admission nursing note dated 11/13/2025 shows R1 was admitted with a surgical wound to her left hip and no other areas of concern were observed or documented. On 12/16/2025 at 12:55 PM, V2 (Licensed Practical Nurse) and Nurse Manager said when R1 was admitted to the facility, she completed her admission skin check and R1 did not have any open areas or redness to her heels. V2 said on 11/20/2025 she was alerted by staff that R1 had a pressure ulcer to her left heel. V2 said she went and assessed the wound and found it to be unstageable with areas of black tissue present. V2 said she notified the Physician for orders for wound care and ordered an air mattress for R1 as well as heel boots.On 12/16/2025 at 1:00 PM, V2 (Director of Nursing) said skin checks are done weekly for the residents. V2 said R1's new pressure ulcer may have shown up after her skin check was done as a pressure wound can develop in a few days. V1 said it may be possible if a full inspection of the feet were done daily when R1's legs were wrapped with an ace wrap, that the staff should have noted a change in R1's heels.The Physician orders for R1 dated November 2025 shows an order for ace wraps to both lower extremities from toes to thigh every day.A skin note dated 11/20/25 shows a new facility acquired pressure ulcer was identified as unstageable to R1's left heel.The facility care plan for R1 dated 11/13/2025 for risk for impaired skin shows an intervention to apply ace wraps to both lower extremities, keep skin clean and well lubricated, monitor bony prominences for redness, utilize pillows to avoid direct contact with bony prominences and utilize pressure relieving devices.The facility policy with a revision date of 8/2025 shows the purpose is to provide a systematic assessment that includes visual, identification of risk factors and early interventions.

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