

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  11/25/2025
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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on interview and record review the facility failed to have a system in place to ensure as needed (PRN) psychotropic medications had a stop date for 1 of 5 residents (R14) reviewed for psychotropic meds in the sample of 16. The findings include: R14's Physician Order sheet with an order date of 11/5/25 show an order of: Ativan 0.25 ml sublingual every 2 hours as needed for anxiety. The order had no stop date. On 11/24/25 at 3PM V12 (Nurse Manager) said he was in charge of psychotropic meds making sure psychotropic meds have diagnosis and stop dates. V12 said he was not aware of R14's antianxiety order with no stop date. V12 said this order was carried out by a Hospice staff. They should have clarified the order and got a stop date. V12 said he does not know why the order was placed in the electronic charting with no stop date. On 11/25/25 at 9AM V12 Nurse Manager presented a document for R14's antianxiety order but was not reflected in R14's medical record. V12 said all R14's ordered medications including psych meds with stop dates should be reflected in R14's medical record. V12 said all as needed psychotropic medications including anti-anxiety should have a stop date. The facility policy on Psychotropic Medication Policy, dated 8/25 documents, Appropriate use evaluation and monitoring of Psychotropic medications to comply with state and federal guidelines while providing medication of a therapeutic level to enable residents to experience an optimum quality of life.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 146101	If continuation sheet Page 1 of 13

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to provide toileting assistance to a resident dependent on staff for cares in a timely manner for 1 of 16 residents (R46) reviewed for activities of daily living (ADLs) in the sample of 16. The findings include: R46's face sheet shows he was admitted to the facility on [DATE] and has diagnoses including Parkinson's disease and dementia. R46's admitting care plan shows he has an ADL self-care deficit due to weakness and requires assistance from staff. On 11/23/25 at 10:15 AM, R46's door was closed. Upon entering his room this surveyor observed R46 to be confused and very restless with his legs half on and half off the bed. R46 kept saying he had to stand up and use the bathroom. The surveyor put R46's call light on immediately to get staff assistance. R46 continued to appear very restless and hanging his legs over the side of the bed, the surveyor stayed by R46 continuously and encouraged him to remain in bed and wait for assistance. At 10:27 AM, V20 (Certified Nursing Assistant/CNA) came into the room and turned R46's call light off. V20 said she did not work on this unit but would go try and find the CNA assigned to R46 and left the room. At 10:31 AM, V15 (Registered Nurse/RN) came to R46's doorway and said the CNAs are coming and will be here soon the surveyor informed V15 that R46 is trying to get up on his own to use the bathroom. V15 left the doorway of R46's room. At 10:35 AM V13 and at 10:37 AM, V14 both CNAs came into R46's room to take him to the bathroom. V14 said R46 requires 2 staff to transfer him from bed. At 11:02 AM after toileting R46, V14 said the goal is to answer call lights in 15 minutes but it depends on the acuity of the unit and what is going on. On 11/24/25 at 11:05 AM, V2 (Director of Nursing) said all 3 of the nursing staff who were working on the unit with R46 on 11/23/25 were in the room with another resident however they should have made sure someone was on the unit and not all in the same resident room. The facility Call Light System policy dated 8/2025 shows that staff should respond and assist a resident to the bathroom in a timely manner and if staff are unable to respond in a timely manner due to workload or an emergency, they should notify a supervisor.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide meaningful activities to dementia residents for 4 of 16 residents (R23, R11, R26, R35,) reviewed for activities in the sample of 16. The findings include: 1. R23's electronic face sheet show R23 has with diagnosis of Alzheimer's dementia. On 11/23/25 at 9 AM, R23 was sitting in his wheelchair in front of the TV. At 9:30 AM, R23 was asleep. At 10:20 AM, during a family interview R23's son (V5) said he had been making a point to visit R23 on the weekends because there were no ongoing activities on either Saturday or Sunday. V5 said R23 was an Engineer in the past. V5 said he wanted R23 to engaged in activities. R23's Activity Care plan dated 6/12/25 documents The resident has impaired cognitive function/dementia or impaired thought processes r/t Dementia but has no activity intervention included in R23's care plan. 2. R11's electronic face sheet show, R11's diagnoses include dementia, anxiety and mood disorders. On 11/23/25, at 9AM R11 was wheeling herself around the activity room to the dining room being repeatedly redirected by V8 (License Practical Nurse). R11 continued to wheel herself around in wheelchair wandering. At 2:16 pm, R11 was sitting in the wheelchair facing the TV. R11 said there was nothing to do. V8 said R11 has some moments of being alert and knows what's going on. R11's activity care plan dated 4/22/25 documents, The resident has impaired cognitive function/dementia or impaired thought processes r/t Neurological symptoms, Dx Dementia but R11 had no activity interventions noted. 3. R26's electronic face sheet show R26 has diagnoses of Dx Alzheimer's dementia. On 11/23/2025 at 9AM AM R26 was also sitting in her wheelchair in front of the TV asleep. At 11:30 AM, R26 was now awake looking around, still with no ongoing activities. R26's care plan dated 4/26/24 documents, The resident (R26) is dependent on staff for leisure or pursuits. Life Enrichment will continue to keep R26 on individual visits and monitor activity participation and adjust when needed. 4. R35's electronic face sheet show R35 has diagnosis of dementia. On 11/23/25 at 9 AM, R35 sat at a recliner at the end of the activity room. After lunch at 12:30 PM, R35 sat in the activity table just looking around but no ongoing activities R35's care plan had no activity care plan. The Memory Care Activity Calendar dated 11/23/25 (Saturday) were as follows, 9AM: Positive Affirmation, 10 AM, 1:1 reminisce, 12 PM Short stories, 1 PM [NAME] Games, 2pm Music and movement 3pm Sensory Exploration. None of the above activities were provided. On 11/23/25 at 1PM, V8 (License Practical Nurse) said she works in the dementia unit every other weekends. There were no activities being offered in the dementia unit on the weekends both Saturdays and Sundays. V8 said in between her passing meds and other nursing job, she tries to talk to residents redirect them or sit them by the TV. On 11/23/25 at 1:45 pm, V6, V7, and V9 (all Certified Nursing Assistants/CNAs) said they have their own duties to do, and in between, they try to find time to sit down with the residents to help with puzzles or read a book in between doing their nursing work (toileting, transferring residents to or from bed, feeding). V6, V7, and V9 all said there's no activity on the weekends. On 11/24/25 at 10AM, V10 (Life Enrichment Director) said residents in the Dementia Unit need activities for engagement, keep them stimulated and to enhance their quality of life. On 11/24/25 at 10:12 AM, V12 (Director of Memory Wellness) said there was no Activity staff on the weekends in the Dementia Unit, these activities are for engagement, connection, socialization and to slow cognitive decline. V12 said there will be an activity staff starting by next month (December 2025) The facility policy on Activities dated 11/1/19 show: Establishments activities available to person cognitive or memory diseases. (Dementia): residents' activities upon residents remaining abilities and interests. These activities are at the core of services designed to promote resident wellbeing. Will use ability-centered care as the basis for a structured dementia program. Meaningful activities that focus on the resident's ability rather than</p> <p>(continued on next page)</p>		

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F 0679  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	their disabilities are continually available to residents. An activity-based program has the goal of maintaining and rebuilding the resident's self-esteem while helping residents maintain his or her optimal functional level.		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to follow speech therapy recommendations for a resident (R46) at risk for aspiration. The facility also failed to ensure a resident (R1) at high risk for falls and exhibiting restless behaviors was supervised. This failure resulted in (R1) falling from her wheelchair and sustaining a right hip fracture. This applies to 2 of 16 residents (R1, R46) reviewed for safety and supervision in the sample of 16. The findings include: 1.) R1's face sheet shows she has diagnoses including Alzheimer's Disease, dementia, anxiety disorder, weakness, and a fracture of the neck of the right femur. R1's active care plan initiated 1/8/25 shows she has a cognitive impairment, requires extensive assistance with her Activities of Daily Living/ADL's, requires a mechanical lift for transfers, and is at high risk for falls. Interventions listed on the care plan include prompt response to all requests for assistance, a bed and chair alarm and to encourage resident to engage in activities. An incident note completed by V16 (Registered Nurse/RN) on 8/10/25 shows at approximately 12:00 PM, R1 was found on the floor in the hallway. R1 was complaining of pain to her right extremity and had bleeding from the back of her head. R1 said she was unable to move so 911 was called and she was transported to a local emergency room (ER) for assessment and treatment. An incident note completed by V18 on 8/10/25 shows that R1 was noted to be restless throughout the morning (prior to her fall) and was making comments about needing to go to school. The note also shows that R1 had tried to stand up many times and that her chair alarm was not very loud. An incident note completed on 8/11/25 shows the facility called the hospital for an update and were notified that R1 has a right hip fracture and will be having surgery that day. R1's history and physical from a local community hospital completed on 8/10/25 shows R1 was complaining of pain a 10/10 to her right hip and knee and stated, this side is killing me. Hospital X-ray results completed on 8/10/25 shows that R1 has an acute moderately displaced right femoral fracture. A hospital physician consultation note shows that R1 will need surgical intervention to repair her right femoral head fracture. On 11/24/25 12:11 PM, V16 (RN) said I was called by a CNA (Certified Nursing Assistant) to come to the unit because a resident was on the floor. When I got to the unit, I found her (R1) on the floor bleeding from her head and not able to move her right leg. I assessed her and called 911. The nurse on that unit was on her lunch break at the time and I am not sure where the other staff on the unit were. She did have a chair motion alarm in place that day. On 11/24/25 12:23 PM, V2 (Director of Nursing) said she was aware of R1's fall and she did investigate it with V1 (Administrator). V2 said R1 was anxious that day and trying to stand up from her chair. On 11/24/2025 12:40 PM, V18 (RN) said she was working on the unit the day R1 fell. V18 said they were keeping R1 in their site and had her at the nurses' station that day due to her increased anxiety and trying to stand up from her wheelchair all day. V18 said she went on break and was not on the floor when R1 fell but another staff person came to tell her she had fallen. On 11/24/25 1:00 PM, V19 (CNA) said R1 was extremely restless the day she fell and continuously standing up from her wheelchair. The staff were keeping R1 at the nurses' station or taking her with them room by room if they left her line of site. V19 said I was trying to keep her by me at all times, but I had to take another resident to the bathroom, so I left R1 by another CNA (V17) who I asked to watch her. I had just put the other resident on the toilet when I heard someone yelling for help. I went out and found a resident leaning over consoling R1 who was on the floor. V19 said V17 no longer works at the facility, and I don't know where V17 had gone but she came up from behind me, so she had left the nurses station and R1 was not by her. V17 said R1 did have a chair alarm on her wheelchair but it is very quiet so when she was in the bathroom</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>with the other resident, she could not hear it. V19 said someone should have remained with R1 and not have left her alone by the nurses' station unsupervised. Two attempts were made to contact V17 by phone on 11/25/25 with no success. 2.) R46's face sheet shows he was admitted to the facility on [DATE] from a local hospital and has diagnoses including Parkinson's Disease and dementia.R46's hospital transition report that was sent with the patient on transfer to the facility and a hospital speech pathology and dysphagia treatment plan recommendations completed on 11/17/25 both show that R46 requires 1:1 feeding assistance due to aspiration risk and should not use straws. The speech pathology treatment plan recommendation also states, At discharge, recommend continued SLP services for dysphagia/continued monitoring of swallowing function in the setting of Parkinson's disease. On 11/23/25 at 10:16 AM, R46 was in bed, on the bedside table next to him were 2 Styrofoam cups with liquid inside and straws in both. On 11/23/25 at 1:14 PM, R46 was served his meal tray which also had Styrofoam cups with liquid inside both and straws on the tray. Again on 11/24/25 at 10:31 AM, and 11/25/25 at 9:18 AM, R46 was in his room with cups containing liquid and straws inside all of them. On 11/24/25 at 11:05 AM, V2 (Director of Nursing) said nurses should be following the recommendations from hospital transfer papers that come with a resident on admit.On 11/24/25 at 1:23 AM, V22 (Director of Therapy) said R46 has not yet been assessed by the speech therapist and until he is the facility should be continuing to follow the precautions that were indicated from the hospital. V22 said based on the report from the speech therapy from the hospital no straws should be used due to R46 being at risk of aspiration due to having Parkinson's disease.On 11/25/25 at 11:23 AM, V23 (Speech Therapist) said he finished his evaluation of R46, and his recommendations are that R46 should not have straws due to a potential risk for aspiration. V23 also said staff should follow the speech therapy recommendations for residents who are admitted to the facility and not using straws for R46's liquids is not a hard request to follow. R46's Speech Therapy Evaluation and Plan of Treatment completed by V23 shows for R46's safety it is recommended no straws are used.The facility's Aspiration Risk Policy dated 8/2025 shows the facility staff including nurses, CNA's, dining service and therapy staff should identify and implement interventions for residents at risk for aspiration.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to inform the dietitian of a resident's continued weight loss. The facility failed to obtain weights on a newly admitted resident as per facility policy. These failures apply to 1 of 4 residents (R47) reviewed for weight loss in the sample of 16. The findings include: R47's hospital progress note dated 10/24/25 showed R47 was hospitalized on [DATE] after being diagnosed with a subdural hematoma (brain bleed) where R47 subsequently underwent a craniotomy (brain surgery) on 10/22/25 to repair/drain the bleed. R47's facility admission record showed R47 was admitted to the facility on [DATE]. R47's admission care plan (dated 10/28/25) showed R47 was at risk for weight loss with a goal of Resident will maintain current weight. On 11/23/25 at 9:17 AM, R47 was seated in a recliner in his room. R47 was alert and cognitively intact. R47 stated he recently had brain surgery because they found bleeding in my brain. R47 stated he was transferred to the facility for rehab after his recent hospitalization. R47 stated he had lost a lot of weight since his surgery. R47 stated, After my surgery, food just turned me off. I wasn't hungry. My appetite has started to get better. R47 stated he had been weighed a couple of times in the facility. R47 denied ever refusing to be weighed in the facility. R47's November 2025 Medication Administration Record (MAR) showed a physician order, dated 10/28/25, for R47 to be weighed once a week (every Tuesday). The MAR showed no documented weight for R47 on 11/11/25. R47's Weights and Vitals record showed R47 weighed 179 lbs (pounds) on 10/28/25, 170.4 lbs on 11/4/25, and 167.4 lbs on 11/18/25. The record showed no documented weight was completed on 11/11/25. The record showed R47 sustained a weight loss of 6.5% from 10/28/25-11/18/25. The record showed R47 lost 4 pounds from 11/4-11/18/25. Facility nutrition assessments dated 10/30/25 and 11/4/25 showed R47 was seen and assessed by V4 (Dietician). R47's 11/4/25 assessment showed V4 assessed R47 after his significant weight loss from 10/28/25-11/4/25. The note showed R47's weight loss was likely secondary to fluid shifts related to edema and swelling caused by intravenous fluids R47 received while hospitalized. The note showed facility staff were to continue to monitor R47's weights and notify V4 with any continued weight loss. On 11/24/25 at 9:10 AM, R47's weight record, November 2025 MAR, and progress notes dated 11/11/25-11/18/25 were reviewed with V4 (Dietician). The progress notes showed no documentation of R47 refusing to be weighed. V4 stated, Yes, I see he wasn't weighed on 11/11/25. He should have been weighed weekly. V4 stated when she initially saw R47 on 10/30/25, R47 did not report a decrease in appetite to her. V4 stated, He told me his weight is usually around 170 lb. I expected some weight loss due to fluid shifts after his surgery. He also had some swelling to his legs upon his admission here that has resolved. When V4 was asked if the facility notified her that R47 continued to lose weight from 11/4/25-11/18/25, V4 stated, No. I should have been notified. I would have seen and assessed (R47) again to discuss his diet, intake, and if needed supplements. The facility's Resident Weight Measurements policy dated March 2025 showed, Weigh residents weekly for the first 4 weeks after admission.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure residents medications were available for administration for 2 of 16 residents (R46,R56) reviewed for pharmacy services in the sample of 16. The findings include: 1.R56's admission Record showed R56 was admitted to the facility on [DATE].</p> <p>Physician orders dated 11/21/25 showed R56 was to receive D-Mannose Oral Capsules (supplement to prevent urinary tract infections) 500 mg; give 4 capsules by mouth three times a day and Simvastatin 40 mg; give one tablet once a day.</p> <p>On 11/24/25 at 8:20 AM, V8 (Registered Nurse/RN) prepared and administered R56's morning medications to R56. V8 stated, I can't give (R56's) D-Mannose medication. We don't have it. It looks like we haven't gotten it from our pharmacy. We don't have that medication in our (stock medication cart). We also don't have her Simvastatin, but I can pull that medication from our (stock medication cart). V8 walked over to the facility's (stock medication cart). V8 removed a dose of Simvastatin, to administer to R56. At 8:25 AM, V8 administered all R56's morning medications to her except her D-Mannose medication.</p> <p>R56's November 2025 Medication Administration Record (MAR) showed R56 received no doses of her D-Mannose medication from 11/21/25-11/24/25. The MAR showed R56 received no doses of her Simvastatin on 11/22/25 or 11/23/25. R56's progress notes dated 11/21/25-11/24/25 showed R56 had not received her doses of D-Mannose or Simvastatin on those dates because the medication is not available or awaiting delivery of the medication from pharmacy.</p> <p>On 11/24/25 at 11:10 AM, V2 (Director of Nursing/DON) stated upon a resident admission, medication orders are verified and faxed as soon as possible to the facility's pharmacy. V2 stated, If nurse sees that we don't have a resident's medication, they should pull the medication from our (stock medication cart) if we have it. If we don't have the med in the (stock medication cart), the nurse should call the pharmacy and order the med STAT.</p> <p>The facility's Medication: Delivery by Nursing Personnel policy dated August 2025 showed. If a medication is unavailable for dispensing the nurse will first attempt to utilize the pharmacy (stock medication cart) machine located on the Medicare unit. If not available in the (stock medication cart), the nurse may check availability of the facility's floor stock. The pharmacy will be notified of any unavailable medication and arrangements for delivery will be made. A STAT delivery from the pharmacy will be requested for medication not available in the (stock medication cart) or floor stock.)</p> <p>2. R46's face sheet shows he was admitted on [DATE]. R46's Care Transition Document sent with him to the facility on admission shows that he should receive the following medications on discharge from the hospital: carbidopa-levodopa 25-100 mgs. (milligrams) (medication to treat symptoms of Parkinson's disease) 2 tablets 5 times a day at 7:00 AM, 10:00 AM, 1:00 PM, 4:00 PM, and 7:00 PM and 1 1/2 tablets at night 10:00 PM. And Pravastatin (medication for cholesterol control) 80 mg at 4:00 PM.</p> <p>R46's Medication Administration Record shows R46 did not receive his carbidopa-levodopa on the evening of 11/21/25 and he did not receive the Pravastatin on 11/21 or 11/22/25.</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>R46's Physician Order Summary (POS) shows active orders for the carbidopa-levodopa with a start date of 11/21/25. The POS shows R46's Pravastatin order was changed to Atorvastatin on 11/23/25.</p> <p>On 11/24/25 at 2:07 PM, V24 (R46's family member) said when R46 was admitted the facility they did not have the Parkinson's medication to give to him as it was supposed to be given.</p> <p>On 11/24/2025 at 12:31 PM, V2 (Director of Nursing) said she contacted the nurse who worked on 11/21 and 11/22/25 and the nurse verified that R46's wife brought in and gave R46 his carbidopa at 7:00 PM on 11/21/25 but the nurse did not give his bedtime dose. V2 also confirmed this medication is available in the facility (stock medication cart) and should have been obtained and given. V2 said R46's Pravastatin should be obtained from the pharmacy and given but was not. V2 also said R46's Pravastatin was changed on 11/23/25 to another brand of the medication.</p> <p>On 11/25/25 at 9:07 AM, V8 (Registered Nurse) said when residents are admitted from the hospital, they use the hospital discharge summary and transfer orders and confirm medications with the residents and the physician. V8 said if there is a medication not in the stat safe or (stock medication cart) they should call the Nurse Practitioner and get a stat order for the medication and then obtain it from a local pharmacy or ask family to bring it in. V8 called the pharmacy while the surveyor was present and verified that carbidopa is available in the (stock medication cart) but Pravastatin is not. V8 said if R46's family did not have these medications to provide they should notify the supervisor who can pick them up from a local pharmacy.</p>		

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  11/25/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review that facility failed to store food in a sanitary manner and failed to ensure the cooking areas were clean and sanitary. This applies to all 35 residents residing at the facility. The findings include: The CMS 671 Long-term Care Facility Application for Medicare and Medicaid Form dated 11/24/25 shows that there are 35 residents residing in the facility. On 11/23/25 at 9:56 AM, V26 (Corporate Executive Chef) took the box of French baguettes out of the freezer and disposed of the top baguettes and said that that they should not be stored the way they were stored. On 11/24/2025 at 2:37 PM, V27 (Dietary Liaison) said that food in the freezer should be stored securely by placing the food in a sealed bag or a container with a lid and the food should not be left exposed. V27 said that the exhaust hood is cleaned by an outside company and maintenance schedules their visits. The facility's Production, Purchasing, Storage Policy revised 1/25 shows, Cover, label and date unused portion and open packages .Store bulk materials in NSF approved containers that have tight fitting lids Use food grade plastic bags for food storage . The Facility's Sanitation and Infection Prevention/Control Policy revised on 1/25 shows, Written procedures are available, detailing daily and weekly (as needed) cleaning for all areas and equipment in the department The facility's Maintenance Department is scheduled to clean equipment that requires special training and equipment, such as the ice maker, refrigeration coils and exhaust hood .</p>		

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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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure the required personnel protective equipment was worn in a covid isolation room and failed to implement enhanced barrier precautions for a resident with a peripherally inserted central catheter line (PICC) for 2 of 16 residents (R46, R48) reviewed for infection control in the sample of 16. The findings include: 1.) R46's face sheet shows he was admitted on [DATE] and has Covid-19 infection. R46's Physician order summary shows he is on contact and droplet precautions for Covid-19.</p> <p>On 11/23/25 at 10:16 AM, there were 2 signs outside R46's doorway indicating that he is on contact and droplet precautions and gowns, gloves, face shields or goggles, and masks should be worn inside the room. There was a plastic bin outside the room containing all the required PPE to enter his room. At 10:27 AM, V20 (Certified Nursing Assistant/CNA) entered R46's room with no PPE on at all and turned off R46's call light.</p> <p>On 11/23/25 at 11:44 AM, V21 (Occupational Therapist) entered R46's room and did not apply a face shield.</p> <p>On 11/24/25 at 1:39 PM, V3 (Infection Control Nurse) said no staff should enter R46's room without all the required PPE on, and eyeglasses alone are not acceptable a face shield is still required over the eyeglasses.</p> <p>The facility provided Infection Control Covid-19 policy shows that PPE that should be worn inside a Covid-19 isolation room include a N95 or higher-level respirator, a gown, gloves and eye protection.</p> <p>2.) R48's admission Record dated 11/14/25 showed he was admitted , from a local hospital, with diagnoses including sepsis and bacteremia. R48 was admitted to the facility with a PICC line (peripherally inserted intravenous central catheter) his left arm to facilitate the administration of intravenous antibiotics in the facility.</p> <p>R48's November 2025 Medication Administration Records showed R48 completed his intravenous antibiotic therapy on 11/21/25 however the PICC line remained in place to R48's left arm. The records showed no physician order for R48 to be on Enhanced Barrier Precautions related to his PICC line.</p> <p>A facility Isolation List dated 11/23/25 showed no documentation R48 was on Enhanced Barrier Precautions or any isolation precautions.</p> <p>On 11/23/25 at 9:37 AM, R48 was in bed with a PICC line noted to his left arm. No Enhanced Barrier Precautions signage was noted on or around the door to R48's room. No isolation cart containing PPE (personal protective equipment) was noted outside of or around the doorway to R48's room.</p> <p>On 11/24/25 at 7:42 AM, R48 was in bed with a PICC line noted to his left arm. No Enhanced Barrier Precautions (EBP) signage was noted on or around the door to R48's room. No isolation cart containing PPE was noted outside of or around the doorway to R48's room.</p> <p>On 11/24/25 at 1:50 PM, V3 (Infection Preventionist) stated R48 was not on any isolation precautions or EBP. V3 stated residents with a PICC line or any type of intravenous access should be on</p> <p>(continued on next page)</p>		

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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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Enhanced Barrier Precautions.</p> <p>On 11/24/25 at 2:07 PM, R48 was in bed with a PICC line noted to his left arm. No Enhanced Barrier Precautions (EBP) signage was noted on or around the door to R48's room. No isolation cart containing PPE was noted outside of or around the doorway to R48's room.</p> <p>The facility's Enhanced Barrier Precautions in Skilled Nursing Facilities policy dated August 2025 showed, To prevent the spread of MDROs (multidrug-resistant organisms) by the use of gloves and gowns during high contact resident activities for residents with chronic wounds and/or indwelling medical devices regardless of MDRO colonization, as well as, for residents with MDRO infection or colonization. Post clear signage on the door or wall outside of the resident room, indicating the type of precautions and required PPE. For Enhanced Barrier Precautions, signage should clearly indicate the high-contact resident care activities that require the use of gown and gloves. Make PPE available outside of, or near the resident's room, including gown and gloves.</p>		

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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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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure residents who were eligible for a pneumococcal vaccine according to the Centers for Disease Control and Prevention (CDC) were offered the vaccine for 2 of 5 residents (R23 and R36) reviewed for immunizations in the sample of 16. The findings include:1.R23's Face Sheet shows that he admitted to the facility on [DATE] and is [AGE] years old. R23's Immunizations Report shows that he has not received a pneumococcal vaccine. R23's Progress Note dated 3/11/22 shows, [R23] shares that he received the Pneumococcal 23 vaccination after age [AGE].No other documentation of a pneumococcal vaccine was provided for R23. 2. R36's Face Sheet shows that she was admitted to the facility on [DATE] and is [AGE] years old. R36's Immunizations Report shows that she received the Pneumococcal 23 vaccine on 12/8/21 and no other pneumococcal vaccines were documented as administered. No other documentation of a pneumococcal vaccine was provided for R36. On 11/25/25 at 11:16 AM, V1 (Administrator in training) said that the unit clerk keeps track of the resident's immunization status and if they are due for a specific immunization. V1 said that the facility follows the CDC's recommendations for the pneumococcal vaccine and all immunizations. The CDC Adult Immunization Schedule Notes dated 10/7/25 shows, Pneumococcal Vaccine: age [AGE] years or older who have: Previously received only PPSV23 should receive: 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PPSV23 dose.The facility's Immunization Policy and Procedure: Influenza, Pneumococcal and COVID 19 Policy revised 9/2025 shows, The facility shall: Offer and administer recommended vaccines to all eligible residents and staff. Document all immunizations, refusals, and contraindications .Comply with IDPH, CDC, and CMS immunization requirements .Pneumococcal Vaccine .Type: PCV 20 or sequential PCV 15 + PPSV23 per CDC guidelines Timing: Upon admission and as needed based on immunization history .</p>