STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020792	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS HEALTH CENTER	**4054 ALBRIGHT LANE , ROCKFORD, Illinois, 61103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		12/12/2025
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: 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	S9999		12/12/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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	S9999		

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S9999	Continued from page 2 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 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 11/21/25 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."	S9999		

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S9999	Continued from page 3 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. "A"	S9999		