STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555652	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Creek Healthcare Center	650 W. Alluvial Clovis, CA 93611

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 49538 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was assessed for the risk of entrapment (resident caught, trapped, or entangled in the space in or about the bed and side rail) from bed (side) rails (adjustable metal or rigid plastic bars in various sizes that attach to the bed, and can be placed in a guard (raised) or lowered position) prior to installation when Resident 1 had no entrapment risk assessment, physician order, and care plans prior to the use of side rails. These failures had the potential to place Resident 1 at risk for decreased freedom of movement, entrapment and/or injury. Findings: 1. During an observation on 5/14/24 at 9:28 a.m., with Resident 1, in Resident 1's room, Resident 1 was lying in bed with two bed rails up. During a concurrent observation and interview on 5/14/24 at 10:05 a.m., with Certified Nursing Assistant (CNA) 1, in Resident 1's room, Resident 1 was lying in bed with two bed rails up. CNA 1 stated Resident 1 had two bed rails up. CNA 1 stated Resident 1 cannot ambulate by himself due to his hip surgery. During a concurrent interview and record review on 5/14/24 at 10:13 a.m., with Registered Nurse (RN) 1, Resident 1's clinical record was reviewed. RN 1 stated Resident 1 had two bed rails. RN 1 stated there was no care plan for bed rail use and no physician order. RN 1 stated Resident 1 did not have an entrapment risk assessment in place for bed rails. RN 1 stated Resident 1 ' s Fall Risk Assessment completed at admission on 5/2/24 indicated Resident 1 was at high risk for fall. RN 1 stated it was the licensed nurses' responsibility to develop a care plan once an intervention was started such as the bed rail. During a concurrent observation and interview on 5/14/24 at 10:45 a.m., with Family (FM) 1, in Resident 1 ' s room, Resident 1 was lying in bed with two bed rails up. FM 1 stated the bed rails had been up since Resident 1 returned from the hospital on 5/7/24. (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/14/24 at 11:28 a.m. with the Director of Nursing (DON), the facility policy and procedure (P&P) titled Bed Safety and Bed Rails dated 0/2022 was reviewed. The policy indicated, . Resident beds meet the safety specifications and established by the hospital bed safety work group. The use of bed rails is prohibited unless the criteria for use of bed rails have been met . Bed frames, mattresses and bed rails are checked for compatibility and size prior to use .The use of bedrails or side rails .is prohibited unless the criteria for use of bed rails have been met .interdisciplinary evaluation, resident assessment, and informed consent .the resident assessment to determine risk of entrapment . The DON stated Resident 1 should have had a physician order for the side rails prior to use. The DON stated Resident 1 had no care plan for bed rails and there should be one. The DON stated the purpose of a care plan was a guide to inform the staff of interventions for the residents. The DON stated it was the licensed nurses ' responsibility to create a care plan for bed rails. The DON stated entrapment risk assessment should have been completed prior to use of the side rails. During an interview on 5/14/24 at 11:38 a.m. with the Administrator (ADM), the ADM stated the facility policy did not indicate a physician order and care plan was required for bed rail use but that it was professional standard of practice to have a physician order and care plan for side rail use. During a review of professional reference from the FDA Food and Drug Administration, titled, A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts retrieved from https://www.fda.gov/medical-devices/hospital-beds/guide-bed-safety-bed-rails-hospitals-nursing-homes-and-home-health-care-facts bed safety bed rails hospitals nursing homes and home health care facts dated 12/11/17, indicated, . Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe . Potential risks of bed rails may include: Strangling, suffocating, bodily injury, or death when patients or part of their body are caught between rails or between the bed rails and mattress. More serious injuries from falls when patients climb over rails. Skin bruising, cuts, and scrapes. Inducing agitated behavior when bed rails are used as a restraint. Feeling isolated or unnecessarily restricted. Preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet . Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was assessed for the risk of entrapment (resident caught, trapped, or entangled in the space in or about the bed and side rail) from bed (side) rails (adjustable metal or rigid plastic bars in various sizes that attach to the bed, and can be placed in a guard (raised) or lowered position) prior to installation when Resident 1 had no entrapment risk assessment, physician order, and care plans prior to the use of side rails. These failures had the potential to place Resident 1 at risk for decreased freedom of movement, entrapment and/or injury. Findings: 1. During an observation on 5/14/24 at 9:28 a.m., with Resident 1, in Resident 1's room, Resident 1 was lying in bed with two bed rails up. (continued on next page)

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