

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2024
NAME OF PROVIDER OR SUPPLIER Willow Creek Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>51345</p> <p>Based on observation, interview and record review, the facility failed to ensure the call light was accessible for two of three sampled residents (Resident 1 and Resident 3) when Resident 1 and Resident 3's call light was not within reach on 12/26/2024.</p> <p>These failures had the potential to result in Resident 1 and Resident 3 not being able to access their call light when they needed help and assistance with their activities of the daily living.</p> <p>Findings:</p> <p>During concurrent observation and interview on 12/26/2024 at 2:23 p.m. with Resident 1, in Resident 1's room, Resident 1's call light was wrapped around to the assist bar on the left side of the bed. Resident 1 was looking for his call light and was unable to find his call light. Resident 1 stated he needed his call light, and he used his call light when he needed help but was unable to reach it to call for help.</p> <p>During concurrent observation and interview on 12/27/2024 at 2:32 p.m. in Resident 1's room, with the Director of Staff and Development (DSD), the DSD validated that Resident 1's call light was wrapped around the assist bar on the left side of the bed. The DSD handed the call light to Resident 1 and placed it front of him (on top of his chest) within his reach. Resident 1 was able to demonstrate that he could push his call light.</p> <p>During an observation on 12/26/2024 at 3:32 p.m. in Resident 3's room, Resident 3 was lying in bed, asleep. Resident 3's bed was at the lowest position with floor mat to the right side of bed. Resident t 3's call light was on the floor by the head of the bed on the right side of the bed.</p> <p>During concurrent observation and interview on 12/26/2024 at 3:35 p.m. with the DSD in Resident 3's room, the DSD validated Resident 3's call light was on the floor. The DSD picked up the call light and placed it near Resident 3's reach. The DSD stated Resident 3 used the call light for assistance and had confusion. The DSD stated the expectation was for the staff to check the call light to make sure call lights were within reach. The DSD stated, .Call light should be always within reach . The DSD stated it was important for the Residents to have the call light within reach when they need assistance. The DSD validated Resident 1 and Resident 3had a waterfall sign by their names which indicated they were high risk for falls.</p> <p>(continued on next page)</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
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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 12/26/2024 at 4:01 p.m. with Licensed Vocational Nurse (LVN) 1, [AC1] [ML2] LVN 1 stated Resident 1 used the call light for assistance and sometimes would put the volume of the television high to get attention. LVN 1 stated Resident 1 usually had the call light, bed remote and urinal in front of him on his lap. LVN 1 stated that it was important for Resident 1 to access his call light to call for assistance. LVN 1 stated Resident 1 needed help with transfers and bed positioning. LVN 1 reviewed Resident 1's care plan for falls and indicated one of the interventions was to keep the call light within reach.</p> <p>During a telephone interview on 12/20/2024 at 2:00 p.m. with the Director of Nursing (DON), the DON stated her expectation was to keep call light within reach for the residents so they could call for help and assist the residents with their needs.</p> <p>During a review of Resident 1's Fall Care Plan, revised 12/23/2024, Resident 1's Fall Care Plan indicated, . Keep call light within reach .</p> <p>During a review of Resident 3's Fall Care Plan, revised 12/24/2024, Resident 3's Fall Care Plan indicated, . Keep call light within reach .</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Answering Call light, the P&P indicated, . When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .</p>		