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	05/07/2025

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47254 Based on observation , interview and record review, the facility failed to recognize and appropriately act on a change in condition for one of three sampled residents, Resident 1, when staff were provided a list of medications on Resident 1's admission on 1/30/25 that included insulin (a hormone that lowers the level of glucose (a type of sugar) in the blood) and did not inform the physician. Nursing staff were aware of the diagnosis of diabetes (a disease that occurs when sugar in the blood is too high) and did not closely monitor symptoms of hyperglycemia (high blood sugar), nausea and malaise (general feeling of discomfort) and did not inform the physician of high blood glucose (sugar) measurements. These failures resulted in Resident 1 not being managed appropriately for diabetes, to not receive needed insulin medication to control high blood glucose, experienced several days of feeling unwell, nauseous and malaise and required emergently being transferred to an acute care hospital on 2/10/25. During admission, Resident 1 was diagnosed with uncontrolled hyperglycemia, Diabetic Ketoacidosis (DKA- a complication of diabetes in which acids build up in the blood to levels that can be life-threatening) and sepsis (body's extreme response to an infection a life-threatening medical emergency) he was hospitalized for nine days and was discharged back to the facility on [DATE]. Findings: During a review of Resident 1's Admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/19/25, the admission record indicated, Resident 1 was admitted from the hospital to the facility on [DATE]. The Admission Record indicated Resident 1 has a history that includes but not limited to muscle wasting and atrophy (is the wasting or thinning of your muscle mass leading to muscle weakness), Crohn's Disease (an inflammatory bowel disease that causes chronic inflammation of the GI tract), Chronic Kidney Disease III (your kidneys have mild to moderate damage and are less able to filter waste and fluid out of your blood), Muscle Weakness (a lack of muscle strength), and diabetes type II (high levels of sugar in the blood) chronic pain syndrome (persistent pain). (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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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], Resident 1's MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 14 out of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 1 had no cognitive impairment. During a concurrent observation and interview on 4/22/25 at 2:22 p.m., with Resident 1 in his room, Resident 1 was resting in bed comfortably, dressed appropriate for the season and doing better since his last hospitalization . Resident 1 stated on his first admission to the facility from 1/30/25 to 2/10/25 he did not receive his insulin medication. Resident 1 stated the facility did not provide him with his insulin and he had to go to the hospital due to his diabetes being too high . Residents 1 stated his daughter-in-law gave the facility admission nurse his home medication list when he was admitted on [DATE] and Resident 1 did not understand why the facility would not follow what his doctor had previously prescribed. Resident 1 stated he felt ill days prior to being sent out to the hospital on 2/10/25 and it wasn't until he was sent to the hospital that he was told at the hospital his sugar was high . During a record review of Resident 1's Diabetes Care Plan, dated 2/1/25, the Diabetes Care Plan indicated, . Resident has a diagnosis of diabetes and is at risk for complications on hypo(low)/hyperglycemia (low blood sugar) . administer medications as ordered . diet as ordered . educate on the signs and symptoms of hypo/hyperglycemia and to report promptly . interventions to manage hypo/hyperglycemia episodes as indicated . monitor for signs of hypo/hyperglycemia . During a concurrent interview and record review on 4/22/25 at 2:43 p.m., with License Vocational Nurse (LVN) 1, Resident 1's electronic medical records, Admission/Readmission Evaluation/Assessment and Home Medications, dated 1/30/25 were reviewed. LVN 1 stated, he was aware the family provided the admission nurse with a list of home medications for Resident 1, and the expected normal process was to document order verification for all medications. The admission nurse did not do that for Resident 1. LVN 1 stated telephone communication to the primary care providers should have included the medications that were continued as well as discontinued to clarify the appropriate medications, dosages and frequency to continue while Resident 1 was in the facility. LVN 1 stated that since appropriate communication did not occur, Resident 1 did not receive medication needed to manage his diabetes which placed Resident 1's health and well-being in danger and possibly caused his hospitalization . During a concurrent interview and record review on 5/7/2025 at 9:14 a.m., with the Director of Nurses (DON), Resident 1's electronic medical records, Admission/Readmission Evaluation/Assessment and Home Medications, dated 1/30/25 were reviewed. The DON stated the home medication list provided by family indicated Resident 1 was on insulin (medication used to turn food into energy and mange blood sugar levels) prior to admission and the admission nursing staff did not clearly identify or clarify what medications listed on the home medication list were to be continued or discontinued in her summary note documentation. The DON stated that her expectations are for nursing staff to contact the primary care physician or nurse practitioner and verify all medications listed on provided medication list in order to identify each individual medication and document. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/7/2025 at 9:22 a.m., with the DON, Resident 1's electronic medical record, Blood Sugar Summary and Order Summary Report, dated 1/30/25 to 2/9/25 were reviewed. The DON confirmed that Resident 1's blood sugar ranged from 79 milligrams per deciliter (mg/dl-unit of measurement) to 389 mg/dl. The DON stated normal blood sugar ranges from 70mg/dl to 110 mg/dl for diabetic residents. The DON stated Resident 1's doctors' orders dated 1/30/25 to 2/9/25 indicated to Notify MD if blood sugar is less than 70 and/or greater than 400. The DON stated the physicians should have been notified regardless, because of the range. The DON stated there was no indication that nursing staff notified the primary care provider of blood sugar ranges prior to Resident 1 being sent to the hospital. During a concurrent interview and record review on 5/7/2025 at 9:30 a.m., with the DON, Resident 1's electronic medical records, Home Medications dated 1/30/25 and Order Summary Report, dated January 2025 and February 2025 were reviewed. The DON stated home medications provided by the family should have been clarified and listed individually with date and time of acknowledgment to verify which medications were to be continued in the facility. The DON stated the Home Medication list has markings with unknown origin and no signatures, dates or times documented on sheet. The DON stated it is not clear what medications were verified for Resident 1. The DON stated that because of the missed insulin order for Resident 1, it was a potential factor that could have caused Resident 1 to be admitted for DKA and his hospital admission. During a concurrent interview and record review on 5/7/25 at 10:25 a.m., with Registered Nurse (RN) 1, Resident 1's electronic medical records, Admission/Readmission Evaluation/Assessment and Home Medications, dated 1/30/25 were reviewed. RN 1 stated insulin was indicated on home medications list and should have been continued or clarified by primary care provider. RN 1 stated she is unsure if clarification was obtained by the primary care provider with the admission nurse. RN 1 stated nursing staff should have documented in detail what medications were discussed with the primary care provider during admission evaluation/assessment to verify if any home medications would be continued. RN 1 stated Resident 1 was not on any insulin during his time at the facility from 1/30/25 to 2/10/25 but was receiving blood sugar checks three times a day. During a concurrent interview and record review on 5/7/25 at 10:30 a.m., with RN 1, Blood Sugar Summary, dated 1/30/25 to 2/9/25 were reviewed. RN 1 stated a baseline blood sugar ranges from 70-100 mg/dl and if they are diabetic anything less than 200 is best. RN 1 stated Resident 1's ranges from 79-389 mg/dl which are not within normal ranges and should have been communicated with the primary care provider. RN 1 stated the blood sugar ranges that were documented for Resident 1 should have prompted staff to place Resident 1 under change of condition protocol, due to abnormal blood sugar ranges, this did not occur. RN 1 stated due to the lack of insulin and failure to follow up on communication with primary care providers concerning Resident 1's abnormal blood sugars, these items could have potentially caused Resident 1's admission to the general acute care hospital (GACH) for DKA. During a concurrent interview and record review on 5/12/25 at 1:30 p.m., with the Registered Dietitian (RD), Resident 1's electronic medical records, Admission/Readmission/Evaluation/Assessment, dated 1/30/25 were reviewed. The Admission/Readmission/Evaluation/Assessment, indicated Resident 1 was placed on a regular diet without restrictions. The RD stated he is to evaluate all residents within seven days of admission to determine adequate nutritional needs are met with diet. The RD stated Resident 1 was admitted on [DATE] to 2/10/25 and he did not complete an assessment for Resident 1. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/12/25 at 2:22 p.m., with the Assistant Director of Nurses (ADON), Resident 1's electronic medical records, Blood Sugar Summary, dated 1/30/25 to 2/9/25 were reviewed. The ADON stated baseline blood sugar ranges from 70-100 mg/dl and 70-120 mg/dl for diabetics. Resident 1 had blood sugar ranges from 79-389 mg/dl which should have been documented as out of range and should have been communicated to primary care providers. The ADON stated there is no documentation indicating any nursing staff communicated blood sugar ranges for Resident 1 to primary care provider. The ADON stated that by not communicating blood sugars, the patient can have uncontrolled blood sugars that can cause further harm to the resident if not treated on time. The ADON stated the abnormal blood sugar ranges should have triggered nursing staff to place resident under a change of condition charting. The ADON stated nursing staff did not indicate a change of condition for Resident 1. The ADON stated the facility was monitoring Resident 1's blood sugars but not communicating them to the primary provider. The ADON stated facility staff did not provide Resident 1 with his insulin and Resident home insulin orders were not clarified upon admission. The ADON stated the facility potentially caused the DKA by not providing the insulin to Resident 1. The ADON stated failure to document precise information caused confusion in medication orders which caused residents to not have his insulin. During a record review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR) Communication Form, dated 2/10/25, the SBAR Communication Form indicated, . The change in condition, symptoms or signs observed and evaluated is/are: Abnormal vital signs .Nausea/Vomiting . started on 2/10/25 .Vital signs (reflect essential body functions) .Blood Pressure (the pressure of the blood in the circulatory system) 60/37 (normal ranges for 60 + age group is 133-139/68-69) . pulse (the regular movement of blood through your body that is caused by the beating of your heart) 118 (normal ranges 60-100 beats per minute- units of measurement) .Respirations (the process of breathing) 19 (normal ranges 12-18 breaths per minute- units of measurement) .Temperature (the degree of hotness or coldness of an object) 97.8 (normal ranges 97-99 Degree Fahrenheit- units of measurement) .Summarize .observation and evaluation .writer went in to the resident room to give routine meds. Writer notified by the CNA (certified nursing assistant) that residents BP (Blood Pressure) had been low. Upon initial assessment, the resident complained of nausea and feeling weak. Writer took blood pressure manually and got a reading on 62/34. During this time the resident had green emesis (vomiting) .daughter in law was notified and wanted to send resident to acute care. Doctor agreed and emergency medical services was called at [9:42 a.m.] . Resident taken by gurney (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/19/25 at 3:30 p.m., with the DON, the DON stated, change of condition assessments should be conducted when there are abnormal changes in the resident's condition. The DON stated facility staff failed to accurately identify, verify or document in Resident 1's chart any communication made to primary care providers regarding his insulin, the home medication list or blood sugar readings while being cared for in the facility. The DON's expectations are for detailed events to be documented for each resident to indicate what was discussed, what medications should be continued as well as discontinued as well as indicating any communications made for blood sugars being monitored since staff were taking blood sugars, but no one communicated them. The DON stated there is no record of medication reconciliation between two nurses for Resident 1 as indicated in the facility's policy and procedures titled, Reconciliation of Medications on admitted d July 2017. The DON stated for Resident 1 who was diabetic, not on insulin and getting finger blood sugar checks three times a day, she would have expected the staff to address the change of condition with the MD. The DON stated that a diabetic resident with no insulin administration, abnormal blood sugar ranges required MD notification to make sure the MD is aware of the resident's condition and to give the MD an opportunity to adjust the residents' plan of care. The DON stated potentially that the lack of insulin could have contributed to his admission to the acute care hospital. During a record review of Resident 1's Emergency Department (ED) Provider Notes, dated 2/10/25, the ED Provider Notes indicated, Resident 1 .presented to the emergency department for vomiting and diarrhea. He was severely hypotensive (low blood pressure) but improved with IV (intravenous - a medical technique that administers fluids, medications and nutrients directly into a person's vein) fluids. He is severely acidotic (when acid builds up in your body) and has hyperkalemia (high levels of potassium in the body) . During a record review of Resident 1's General Acute Care Hospital Assessment and Plan for admitted d on 2/11/25, the Assessment and Plan indicated, . [Resident 1] was being admitted for sepsis and Diabetic Ketoacidosis (DKA- a complication of diabetes in which acids build up in the blood to levels that can be life-threatening) . The patient presented with nausea, vomiting, and diarrhea that has been ongoing for couple days. The skilled nursing facility staff reported subjective fever, productive cough and dysuria (painful or uncomfortable sensation experienced during urination) . He was found to be hypotensive at the skilled nursing facility, so he was transferred .in the emergency department (ER) . white blood count (WBC- a test that measures the number of white blood cells in your body) 27.4 (normal ranges 4.5-11.0) . potassium(It helps your nerves to function and muscles to contract) 6.9 (normal ranges-3.6-5.2) .bicarb (a byproduct of your body's metabolism) 12 (normal ranges 22-29), Glucose (sugar level in blood) was 496 During a review of the facility policy and procedure (P&P) titled, Diabetes- Clinical Protocol dated March 2025, the P&P indicated, .For resident with confirmed diabetes, the nurse will assess and document/report the following during the initial assessment . history of medication management . all other current medications . resident blood sugar history over 48 hours . where insulin is indicated, simplified treatment regiments are preferred .the staff will identify and report issues that may affect, or be affected by, a patients diabetes and diabetes management .hyperglycemia . staff will notify the practitioner as soon as possible . (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility policy and procedure (P&P) titled, Change in Resident Condition or Status dated February 2021, the policy and procedure indicated, .The nurse will notify the resident attending physician or physician on call when . significant change in the resident physical/emotional/mental condition . need to alter the resident medical treatment significantly . need to transfer the resident to a hospital .a significant change of condition is a major decline or improvement in the resident status that will not normally resolve itself without interventions by staff or by implement standard disease related clinical interventions . requires interdisciplinary review and /or revision to the care plan and ultimately is based on the judgment of the clinical staff .regardless of the resident current mental and physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatment . the nurse will record in the resident's medical record information relative to the changes . During a review of the facility policy and procedure (P&P) titled, Reconciliation of Medications on admitted d July 2017, the policy and procedure indicated, .The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility . Gather the information needed to reconcile the medications list . all prescription and supplement information obtained from the resident/family during the medication . Medication reconciliation is the process of comparing pre-discharge medications to the post discharge medications by creating an accurate list of both prescription and over the counter mediations that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care . if a medication history has not been obtained from the resident or family, complete this first. Information for the medication history should include prescription medications, including those taken only as needed . dose, route, frequency, and last dose taken for all items .document the medications discrepancies on the medication reconciliation form If the discrepancy was resolved, document how the discrepancy was resolved . During a review of professional reference from the American Diabetes Association (ADA) titled, Standards of Medical Care in Diabetes, dated January 2024, the professional reference indicated .Insulin therapy remains essential for individuals with type 1 diabetes and is often necessary for individuals with type 2 diabetes when glycemic goals are not met with oral agents. Insulin is the most effective agent in lowering blood glucose and reducing the risk of diabetes-related complications when used appropriately .continuous glucose monitoring are essential components of effective diabetes management, allowing for timely adjustments in therapy and prevention of hypoglycemia and hyperglycemia . During a review of professional reference from the Academy of Nutrition and Dietetics titled, Nutrition intervention and monitoring in long-term care settings for individuals with diabetes, dated September 2018, the professional reference indicated .In long-term care and skilled nursing facilities, individualized nutrition therapy is critical for optimizing glycemic control, maintaining nutrition status, and improving quality of life in resident with diabetes. Liberalized diets and consistent carbohydrate meal planning are recommended to enhance adherence and satisfaction while preventing complications .