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	06/02/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors when on 4/23/25 to 5/12/25 ertapenem sodium (antibiotic medication used to treat bacterial infections) medication was not administered via intravenous (IV- Into or within a vein) as prescribed for one of six residents (Resident 1) and no side effects were monitored during the administration of the IV antibiotic medication while in the facility. These failures resulted in Resident 1 not receiving antibiotics as prescribed by the provider and had the potential to contribute to his transfer to a general acute care hospital (GACH) on 5/11/25 and 5/13/25. 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 5/28/25, the admission record indicated, Resident 1 was admitted from the hospital to the facility on 4/22/25. The admission Record indicated Resident 1 has a history that includes but not limited to sepsis (life-threatening response to infection) Chronic Kidney Disease II (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), type II diabetes mellitus (A disease in which glucose levels in the blood are higher than normal because the body does not make enough insulin or use it the way it should), gout (a disease in which defective metabolism of uric acid), history of urinary tract infections (an infection in any part of the urinary system) and morbid obesity (a severe form of obesity characterized by a body mass index [BMI] of 40 or higher, or a BMI of 35 or higher with obesity-related health complications) During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment 4/26/25, 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 12 out of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 1 had moderate cognitive impairment. (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

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	06/02/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/4/25 at 4:20 p.m., with the Registered Nurse (RN) 1, Resident 1 ' s Progress notes, dated 4/22/25 to 5/13/25 was reviewed. RN 1 stated Resident 1 was admitted to the facility on [DATE] from the general acute care hospital (GACH) for sepsis (life-threatening response to infection) and required intravenous (IV- Into or within a vein) antibiotic medication. RN 1 stated Resident 1 was alert and oriented to person, place, time and location upon admission. RN 1 stated because Resident 1 had sepsis and was receiving IV medication, Resident 1 should have been continuously monitored for changes in his vital signs, level of cognition and mental status by nursing staff and it should have been documented daily. During a concurrent interview and record review on 6/4/25 at 4:25 p.m., with RN 1, Resident 1 ' s Electronic Medication Administration Record (EMAR), dated 4/22/25 to 5/13/25 was reviewed. RN 1 stated the EMAR indicated Resident 1 missed two doses of ertapenem sodium (antibiotic medication used to treat bacterial infections) on 4/26/25 and 5/3/25 at the prescribed time of 6 p.m. RN 1 stated ten of the administered antibiotic doses given on 4/23/24 at 7:40 p.m., 4/24/25 at 9:57 p.m., 5/2/25 at 7:10 p.m., 5/4/25 at 8:47 p.m., 5/5/25 at 8:48 p.m., 5/6/25 at 10:08 p.m., 5/7/25 at 9:42 p.m., 5/8/25 at 8:00 p.m.,5/11/25 at 7:25 p.m., and 5/12/25 at 7:55 p.m. were given to Resident 1 over an hour past the prescribed time. RN 1 stated the missed doses and late administration over an hour are considered medication errors and should have been reported to the Director of Nurses, primary care physician and responsible party at the time it occurred. RN 1 stated she did not see any documentation indicating this occurred. RN 1 stated when a dose of any scheduled medication is missed or given late, it is considered a change of condition according to the facility policy and procedures and the resident should be placed under observation for side effects or further changes of condition. RN 1 stated the missed or late doses should have been documented in Resident 1 ' s chart along with Resident 1 ' s vital signs and current condition. RN 1 stated it is important for medication to be given according to physician orders; this will ensure the medication will be effective. RN 1 stated this was especially true for Resident 1 due to the bacteria present that was causing his sepsis. RN 1 stated an audit should have been conducted by the DON every 24 hours to identify missed medication or late doses, but no documentation indicating a change of condition was reported and no further communication was provided to primary care physician or responsible party. RN 1 stated we monitor side effect indicated on the EMAR, but Resident 1 did not have documentation for side effects. During a concurrent interview and record review on 6/4/25 at 4:45 p.m., with RN 1 , the facility policy and procedure (P&P) titled, Administering Medication dated, April 2019 was reviewed. The P&P indicated all medication should be provided as ordered and any medication errors should be documented and reported. RN 1 stated facility nursing staff who have missed doses or gave Resident 1 late doses of IV antibiotic medication did not follow guidelines indicated in the policy. RN 1 stated no audit was conducted indicating education was provided to nursing staff concerning missed and late doses. (continued on next page)

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	06/02/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/4/25 at 4:54 p.m., with Registered Nurse (RN) 2, Resident 1 ' s Electronic Medication Administration Record (EMAR), dated 4/22/25 to 5/13/25 was reviewed. RN 2 stated Resident 1 antibiotic medication should have been given at the scheduled time of 6 p.m. RN 2 stated per documentation on in the EMAR, Resident 1 missed two doses of antibiotics on 4/26/25 and 5/3/25. RN 2 stated there were ten antibiotics doses on 4/23/24, 4/24/25, 5/2/25, 5/4/25, 5/5/25, 5/6/25, 5/7/25, 5/8/25,5/11/25, and 5/12/25 that were given over an hour past the prescribed time. RN 2 stated Resident 1 was taking the antibiotic due to sepsis. RN 2 stated she did not know what sepsis was. RN 2 stated Resident 1 ' s missed doses and late doses of antibiotic would be considered medication errors. RN 2 stated she was not able to locate documentation or communication made concerning the missed and late doses of Resident 1's antibiotic to the primary care provider, responsible party and director of nurses. RN 2 stated each missed dose and late dose provided to Resident 1 would have been considered a change of condition for Resident 1. RN 2 stated Resident 1 should have been administered antibiotics from 4/23/25 to 5/16/25. RN 2 stated notification on facility ' s electronic medical record system would have notified nurses of medication being missed or late. RN 2 stated it is expected that all medications would be provided on time as ordered by the physician. During a concurrent interview and record review on 6/4/25 at 5:15 p.m., with RN 2, Resident 1 ' s Progress notes, dated 4/22/25 to 5/13/25 was reviewed. RN 2 stated there was no documentation in Resident 1 ' s chart for missed and late antibiotic IV doses. RN 2 stated audits are conducted for missed documentation by the DON or RN supervisor daily. RN 2 stated she cannot locate any notes that were written for any missed antibiotic doses. RN 2 stated providing antibiotic IV medication was important for Resident 1 to manage the infection in the body and maintain therapeutic medication levels in the blood. RN 2 stated due to missing the doses and doses being late, this could have contributed to his hospitalization of Resident 1, since Resident 1 was already septic and had an infection. RN 2 stated all nurses failed to follow the change of condition protocols and the facility P&P for medication administration. (continued on next page)

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	06/02/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/4/25 at 5:35 p.m., with the Director of Nurses (DON), Resident 1 ' s Progress notes and electronic medication administration record, dated 4/22/25 to 5/13/25 were reviewed. The DON stated Resident 1 was admitted on [DATE] for sepsis with orders of antibiotic IV therapy [brand name for ertapenem sodium] 1 gram (gm-units of measurements) to be provided every 24 hours until 5/16/25. The DON stated the facility Registered Nurses were responsible for providing IV antibiotic medication and would assist the Licensed Vocational Nurses who were overseeing the care of Resident 1. The DON stated it was the responsibility of all staff to ensure doses were being provided per primary care provider orders and that they were given on time. The DON stated Resident 1 stayed in facility from 4/22/25 to 5/13/25 and on 5/13/25 he had delusions, hallucinations, seizure like activity and involuntary shaking. The DON stated Resident 1 ' s primary care provider was in the facility and assessed Resident 1. The DON stated the responsible party was notified and Resident 1 was sent to the general acute care hospital (GACH) for further evaluation. The DON stated during Resident 1 ' s length of stay, he missed two doses of antibiotics on 4/26/25 and 5/3/25. The DON stated ten of the received doses on 4/23/24,4/24/25, 5/2/25, 5/4/25, 5/5/25, 5/6/25, 5/7/25,5/8/25,5/11/25, and 5/12/25 were more than an hour past due the prescribed time in Resident 1 ' s orders. The DON stated changes of condition assessments should have been conducted because medication errors would be considered a change of condition. The DON stated, I do not see any communication being made by nursing staff regarding missed or late doses. DON stated it would have been important to communicate the medication errors to the primary care physician to determine if adjustments were required in dosages for the resident to maintain therapeutic medication level. The DON stated the medication errors were a lack of continuity of care and it had potential outcomes that include the worsening of an infection as well as being detrimental to overall health for Resident 1. During a concurrent interview and record review on 6/4/25 at 5:35 p.m., with the DON, the facility ' s [pharmacy name] Proof of Delivery dated 4/23/25 to 5/12/25 and Medication Disposition Record, dated 5/16/25 was reviewed. The DON stated [pharmacy name] Proof of Delivery indicated facility received 23 doses of ertapenem sodium antibiotic for Resident 1 from 4/23/25 to 5/12/25. The DON stated the Medication Disposition Record indicated three doses were disposed of once Resident 1 was discharged to GACH. The DON stated this would confirm that resident missed two doses of antibiotic medication during his stay at the facility and one since admitted to the GACH. During a concurrent interview and record review on 6/5/25 at 1:02 p.m., with the DON, the facilities Electronic medical record/Electronic treatment Record/IV Medication Administration Record Audit (medication audit) dated 4/23/25 to 5/13/25 was reviewed. The DON stated the Electronic medical record/Electronic treatment Record/IV Medication Administration Record Audit indicated, name of resident affected by missing information, what nurse missed the documentation, and type of missing information. The DON stated the medication audit did not include specifics as far as missing medication doses, late medication, etc. The DON stated audits go to her office and she or the assistant director of nurses (ADON) will follow up. The DON stated there is no documentation she could present that follow up of missed medication dose for Resident 1 had occurred. During an interview on 6/5/25 at 1:20 p.m., with the DON, the DON stated there were no side effects indicated in the electronic medical record for the IV medication that was administered to the resident. The DON stated antibiotic stewardship is to ensure antibiotics are used properly for the appropriate diagnosis with the appropriate monitoring that includes side effects. The DON stated it is important to monitor the side effects for primary care physicians to address concerns and adjust dosage or change medication as needed based on side effects. (continued on next page)

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	06/02/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure (P&P) titled, Administering Medications dated April 2019, the policy and procedure indicated, .Medications are administered in a safe and timely manner, and as prescribed . medications are administered in accordance with prescriber orders, including any required time frame .medication errors are documented, reported and reviewed by the QAPI committee to inform process changes and or the need for additional staff training . medications are administered within (1) hour of their prescribed time . if a dosage is believe to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber to discuss concerns .the individual administering the medication records in the residents medical record: the date and time the medication was administered . the signature and title of the person administering the drug . 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 professional reference from the National Library of Medicine titled, Nursing Rights of Medication Administration, dated September 2023, the professional reference indicated .Nurses have a unique role and responsibility in medication administration . It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the ' five rights ' or ' five R ' s ' of medication administration . sequence include: . ' Right patient ' – ascertaining that a patient being treated is, in fact, the correct recipient for whom medication was prescribed . ' Right drug ' – ensuring that the medication to be administered is identical to the drug name that was prescribed . ' Right Route ' – Medications can be given to patients in many different ways, all of which vary in the time it takes to absorb the chemical, time it takes for the drug to act, and potential side-effects based on the mode of administration . ' Right time ' – administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level . ' Right dose ' – Incorrect dosage, conversion of units, and incorrect substance concentration are prevalent modalities of medication administration error .