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	01/05/2026

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

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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 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** Based on interview and record review, the facility failed to ensure nursing staff immediately notified the physician for physical and mental health change of condition for one of three residents, Resident 1, when on 4/8/25 Registered Nurse (RN) 1 did not recognize the physical and mental health decline of Resident 1 brought to her attention by Resident 1's daughter who was at the bedside. RN 1 did not provide the necessary medical notification for the altered mental status of Resident 1, symptoms included inability to swallow medications which prompted RN 1 to perform an oral sweep with her fingers, Resident 1's inability to verbally respond, refused breakfast, lunch and dinner which were all changes to Resident 1's baseline condition. RN 1 did not provide a full accurate description and assessment to the physician when the physician was notified of Resident 1's change of condition.These failures resulted in further decline of Resident 1's clinical status until the evening of 4/8/25 when RN 2 notified the physician of the decline, an emergency transport was ordered to transfer Resident 1 to the nearest general acute care hospital (GACH A) emergency department where Resident 1 was diagnosed with intracranial hemorrhage (brain bleed a type of stroke), coma, and required immediate intubation (someone who has a breathing tube placed through their mouth or nose into their windpipe to keep the airway open, support breathing) for life support. Resident 1 was then transferred to GACH B for a higher level of care to support the care of the evolving brain bleed and then passed away on 4/16/25 at 4:29 a.m.During a review of Resident 1's admission Record (document containing resident demographic information and medical diagnoses) dated 12/17/25, the admission record indicated Resident 1 was admitted to the facility on [DATE] for physical and occupation rehabilitation due to recent motor vehicle accident. Resident 1's diagnosis included but not limited to idiopathic peripheral autonomic neuropathy (nerve damage affecting automatic body functions such as heart rate and digestion), diabetes mellitus II (a chronic metabolic disease where the body either does not produce enough insulin or does not use insulin effectively) constipation (a condition in which there is difficulty in emptying the bowels and possibly causing hard stools), hypertension (high blood pressure), and muscle weakness (a general lack of strength), multiple fractures of ribs, left side, fracture of right lower leg, neuromuscular dysfunction of bladder (nerve damage disrupts normal bladder control, causing issues with storing or emptying urine), hypothyroidism (does not produce enough essential hormones, causing your body's functions to slow down), atrial fibrillation (an irregular and often very rapid heart rhythm) and muscle spasms (a sudden, involuntary, and often painful contraction of one or more muscles).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/31/2025, the MDS, indicated, Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately (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
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F 0580 Level of Harm - Actual harm Residents Affected - Few	impaired, 13-15 suggests cognitively intact) indicating Resident 1 was cognitively intact.During a review of Resident 1's Admission/re-admission Summary Note dated 3/28/25 at 4:40 p.m., the Admission/re-admission Summary Note indicated, .Resident was admitted from [GACH A] due to frontal car collision. resident is alert and oriented [person, place, time], able to make her needs known.During a review of Resident 1's Nurses Notes dated 3/28/25 at 3:52 p.m., the Nurses Notes indicated, .writer received report from RN at [GACH A], per report resident full code (when a patient wants all possible life-saving measures taken), Glasgow Coma Scale 15 (GCS - score of 15 means a person has a fully normal level of consciousness: they are awake, alert, oriented, and responsive, with no neurological deficits, representing the highest possible score on the scale).Physical examination: General: Awake and alert, cooperative, no distress.Pain.currently well controlled Oxycodone (pain reliever used to treat moderate to severe pain) HCL oral tablet 5 (milligrams-mg units of measurement).dosage must be closely managed to prevent neurologic/cognitive problems.During a review of Resident 1's Weekly Summary Notes (WSN), dated 4/3/25 at 6:18 p.m., the WSN indicated, .Basic Activities of Daily Living (ADL)/mobility:. Bed mobility: limited supervision.transfer: limited assistance.Dressing: limited assistance. [Resident 1] ate 75% on average for meals. Alert: yes.oriented: person place time situation.During a review of Resident 1's Physicians Progress Note, dated 4/7/25 at 1:35 p.m., the Physicians Progress Note indicated, .Chief complaint: Mobility and [Activities of Daily Living] dysfunction secondary to right ankle fracture.now with improving endurance and safety.no falls, vital signs stable, no new issues reported. Participating well in therapy.During a review of Resident 1's Physical Therapy Treatment Encounter Notes (PTTEN), dated 4/7/25 and 4/8/25, the Physical Therapy Treatment Encounter Notes, indicated date of service 4/7/25. Resident 1 required moderate cueing for body mechanics and education on importance otherwise engaged. Resident 1 fatigues easily and requires prolonged rest between sets and interventions as session progresses. PTTEN indicated Resident 1was agreeable to therapy. PTTEN indicated Resident 1 instructed to stand and to transfer from bed to wheelchair minimum assistance required minimum cueing for hand/foot sequencing. PTTEN indicated Resident 1 instructed in and completed multiple stand pivot transfer with minimum assistance using parallel bars in order to facilitate safe transfers. PTTEN indicated date of service 4/8/25, Resident 1 encountered semi-Fowlers, daughter at bedside. PTTEN indicated [Resident 1] and daughter stating that they don't feel (Resident 1) can do therapy today as she's having a lot of bowel movements as she was given a suppository.During an interview on 12/17/25 at 8:45 a.m., with Resident 1's daughter (RD), RD stated she came to visit her mother on the morning of 4/8/25 approximately a little after 10 a.m. and her mother was not her normal self. RD stated her mother was usually excited to see her and have a conversation with her as well as being eager for her therapy sessions. RD stated her mother was working to get back home as soon as possible, but on this particular day, her mother did not want to talk at all and told her she had an excruciating headache. RD stated her mother refused therapy that morning and refused to eat due to her headache. RD stated her mother fell asleep around lunch time and the daughter stayed with her at bedside until Registered Nurse (RN) 1 came into her mother's room on that day before 2 p.m. to give her mother her scheduled sodium medication. RD expressed her concerns about her mother, but RN 1 did not seem at all concerned and continued to attempt at waking up my mother. RD stated her mother was barely awake when RN 1 gave her medication. RN 1 tried to get her mother to drink soda from a straw, but her mother was not able to drink. RD stated she again expressed her concerns to RN 1, but RN 1 stated that because Resident 1 had responded to her commands she was fine. RD stated once RN 1 realized her mother was not swallowing the pill, RN 1 stuck her hand in her mother's mouth to find the pill, but she could not find it. RD stated RN 1 left the room unconcerned (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	about the changes in her mother's condition. RD stated her mother went back to sleep. RD stated she called the administrator to voice her concerns about her mother's current change in condition and interaction with RN 1. During an interview on 12/17/25 at 10:50 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he does not recall working with Resident 1. LVN 1 stated it was communicated to him by other nursing staff that Resident 1 was sent out for further evaluation to the local hospital and did not return back to the facility. LVN 1 stated that when there is a change of conditions for a resident, the nursing staff is expected to document in the Situation, Background, Assessment and Recommendation (SBAR), change in condition (CIC) and progress nursing (PN) notes, the assessment conducted, communication provided to the responsible party, the primary physician and recommendations made. LVN 1 stated a change of condition can include any of following: change in baseline that could include mental status, physical status, behavioral status; meal consumption and medication administration. LVN 1 stated licensed nurses are trained to document the change of condition accurately and notify the appropriate personnel as indicated in our nursing job descriptions. LVN 1 stated by notifying and providing a complete clinical description of the resident the physician will provide a plan of care specific for that resident. LVN 1 stated an inaccurate resident clinical assessment that is communicated to a physician would be unsafe and potentially harm the resident.During an interview on 12/18/25 at 8:15 a.m., with the certified nursing assistant (CNA) 1, CNA 1 stated she had previously cared for Resident 1 and the resident required extensive to moderate assistance with her activities of daily living (ADL) and set up assistance with eating. CNA 1 stated if a resident change of condition could include going from a high energy to a low energy, refusing meals, refusing care or having behaviors and it should all be reported to the charge nurse immediately. CNA 1 stated Resident 1 was usually wide awake, up in her wheelchair and able to communicate to staff about any issues, concerns, wants, needs and pain. I do not recall this resident being sleepy or groggy while caring for her, she was very alert and able to use the call light for assistance.During a concurrent interview and record review on 12/18/25 at 9 a.m., with the Assistant Director of Nurses (ADON) 1, the facility's document titled PN for Resident 1, dated 4/8/25 at 12:16 p.m. was reviewed. The PN indicated, .[ADON] was notified by charge nurse to accompany to residents' room to take a look at resident. Resident [1] had eyes closed and was responsive. Resident [1] was asked by [RN 1] to squeeze [RN 1's] hands 4 times. Resident responded with 4 squeezes. Resident nodded her head with yes and no questions answered appropriately. ADON 1 stated RN 1 asked her to help check on Resident 1 with her since Resident 1's daughter was concerned because her mother was so sleepy. ADON 1 stated I only made visual observations as [RN 1] assessed [Resident 1] .I never checked on [Resident 1] physically myself. ADON 1 stated the daughter was concerned about her mother's well-being since it was a change from her norm. ADON 1 stated she is a licensed vocational nurse and her scope of practice only allows her to collect data and not assess, so she observed RN 1 assessment of Resident 1. During a concurrent interview and record review on 12/18/25 at 9:10 a.m., with the ADON 1, the facility's document titled PN for Resident 1, dated 4/8/25 at 3:50 p.m. was reviewed. The PN indicated, .Writer tried waking up [Resident 1] and she was able to nod her head yes and no and open her mouth. She took her medicine and sucked on it. Writer wore a glove felt in her mouth until resident swallowed her medication. ADON 1 stated that is not normal practice to place a gloved hand in a resident's mouth unless you are doing a mouth sweep for someone who is unconscious or choking. ADON 1 stated we have never taught that in this facility so I do not understand where [RN 1] would have learned that from.During a concurrent interview and record review on 12/18/25 at 9:15 a.m., with the ADON 1, the facility's document titled Situation, Background, Assessment and Recommendation (SBAR) for Resident 1, dated 4/8/25 at 3:31 (continued on next page)

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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	01/05/2026

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	interprofessional team that includes a neurologist, internist, psychiatrist, a radiologist, and an emergency department physician. Because there are numerous causes of mental status changes, a thorough history is necessary. While the patient is being worked up, the patient with acute mental status changes needs to be monitored by a nurse. The nursing staff should update the team about changes in the condition of the patient. Close communication should be made with the other healthcare professionals so that no serious cause of mental status changes is missed.During a review of a professional reference titled, Nurse-physician communication in the long-term care setting: perceived barriers and impact on patient safety, dated September 2009, retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC2757754, the professional reference indicated . Clear and complete communication between health care providers is a prerequisite for safe patient management.Communication between healthcare workers accounts for the major part of the information flow in healthcare and growing evidence indicates that errors in communication impact on patient safety.nurse competency and preparedness are key components of nurse-physician communication about patient issues.There is evidence that clear communication is associated with improved quality of care and patient outcomes.During a review of a professional reference titled, Golden hour management in the patient with intraparenchymal cerebral hemorrhage: an Italian intersociety document, dated May 9,2025, retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC12065239/ the professional reference indicated . Spontaneous intracerebral hemorrhage (ICH- bleeding inside the skull without trauma) accounts for 9-27% of all strokes (medical emergency where blood flow to part of the brain is cut off)worldwide and is associated with high mortality (death, especially on a large scale) and disability. The main causes include vascular malformations (abnormality of blood vessels), small- and large-vessel angiopathies (disease affecting the blood vessels), and coagulation disorders (conditions that affect the blood's clotting activities). Mortality rates reach approximately 40% in 1 month and 54% in 1 year, largely influenced by early management decisions. Rapid intervention, particularly within the first hour, is crucial. Early intervention within