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	05/14/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to safeguard and protect residents' personal belongings from admission to discharge at the facility for one of three sampled residents (Resident 1) when Resident 1's personal belongings were not returned on 4/23/26 at discharge. This failure resulted in Resident 1's personal items missing at the time of discharge and for Resident 1's go without her personal belongings necessary to perform her activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, personal hygiene, mobility, and toileting a person performs daily to care for themselves).Findings:During an interview on 5/13/26 at 2:23 p.m. with the Director of Nursing (DON), the DON stated social services were responsible for grievances (a complaint, either oral or written, expressing dissatisfaction with service delivery or the quality of care furnished) related to residents' missing personal belongings when searching the facility was not successful.During an interview on 5/13/26 at 2:59 p.m. with Social Services Director (SSD) 1, SSD 1 stated she remembered giving Resident 1's gray storage bin (containing Resident 1's personal belongings) to a female individual. SSD 1 stated she, handed it to her and said thank you. SSD 1 stated she cannot recall the name of the person she handed in the gray storage bin and did not know the date. SSD 1 stated she did not document and check Resident 1's inventory list prior to giving the gray storage bin. SSD 1 stated she received a call from a family member or a caregiver stating items were missing. SSD 1 stated she informed the family member or caregiver that the facility would look for Resident 1's missing personal belongings. SSD 1 stated there was no grievance filed for Resident 1's missing personal belongings. SSD 1 stated it was the facility's protocol to check the inventory list prior to giving personal belongings to the residents and families to ensure all residents' belongings were documented and accounted for. SSD 1 stated the facility's protocol for residents' missing items when not found after searching was to report a list of missing items to the Administrator (ADM) for review and approval for replacement or reimbursement. SSD 1 stated she should have followed up and updated the family of Resident 1. SSD 1 stated a residents' personal belongings were important to them and missing items should be addressed immediately.During an interview on 5/13/26 at 3:30 p.m. with SSD 3, SSD 3 stated he was responsible for the facility residents' property theft and loss. SSD 3 stated the facility has a process for residents' missing personal belongings and it should be followed by all staff. SSD 3 stated it was the facility's protocol to search for a residents' missing personal belongings on the day they were reported missing by resident, family and staff. SSD 3 stated if a residents' missing items were not successful found, he would then review the residents' inventory record, complete a missing item form and submit to the ADM for review and approval for replacement or reimbursement. SSD 3 stated the ADM's approval takes two to three days. SSD 3 stated he did not receive a report about Resident 1's missing personal belongings. SSD 3 stated Resident 1's family should not have to wait for almost a month to resolve the issue of missing personal belongings. SSD 3 stated a residents' personal belonging should be protected from loss or theft because it is a resident right to have their belongings.During an interview on 5/14/26 at 9:32 a.m. with the ADM, the ADM stated he was not aware that there were missing items from Resident 1's personal belongings. The (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADM stated the facility has a process for residents missing personal belongings. The ADM stated the staff will search first for the missing items, if unable to find, the facility will replace or reimburse the missing items immediately. During an interview on 5/14/26 at 9:35 a.m. with the DON, the DON stated it was her expectation for all staff to follow and comply with the facility's process for a resident missing personal belongings, even when the items are reported missing on weekends. The DON stated the nursing staff should identify and complete an inventory list of residents' personal belongings on admission. The DON stated if family reported a missing item from a resident's personal belongings inventory list, nursing staff should look and search right away, if unable to find nursing staff should report to SSD. The SSD will notify the ADM of the need for replacement or reimbursement. The DON stated the process for resident's missing items should take five days to replace or reimburse. The DON stated SSD should call the family to give an update and the plan for resolution regarding missing items. The DON stated a resident's personal belongings should be protected from loss or theft. The DON stated it is a resident right to have their belongings, it's their property. During an interview on 5/14/26 at 11:37 a.m. with the Intermediate Care Facility (ICF-a specialized residential group home) Administrator (ADM), the ICFADM stated Resident 1 was their resident. The ICFADM stated she brought and picked up Resident 1's personal belongings from the facility. The ICFADM stated she completed an inventory list of all Resident 1's personal belongings from admission to the facility with the facility staff. The ICFADM stated she received a call from Assistant Director of Nursing (ADON) 3 that they found two bags of Resident 1's personal belongings yesterday (5/13/26). The ICFADM stated she picked up Resident1's personal belongings on 4/23/26 and yesterday (5/13/26). The ICFADM stated there were remaining items that were still missing. During a concurrent interview and record review on 5/14/26 at 3:05 p.m. with ADON 3, Resident 1's handwritten inventory list dated 5/13/26 was reviewed. The inventory list includes Resident 1's cardigans, slippers, pajama sets, soiled pant, undergarments, socks, capris, blouses and shirts. ADON 3 stated she made an inventory list based on Resident 1's personal belongings found yesterday (5/13/26) and does not include her wheelchair. ADON 3 stated she called the ICFADM yesterday (5/13/26) to pick up two bags containing Resident 1's personal belongings. ADON 3 stated she did not compare what was listed on previously written inventory list dated 4/23/26. ADON 3 stated she was not sure if all Resident 1's personal belongings were accounted for. ADON 3 stated Resident 1's family and caregivers should not wait for about three weeks for the facility to look for Resident 1's personal belongings. ADON 3 stated Resident 1's missing items should be looked for right away and reported to SSD immediately. ADON 3 stated SSD was responsible for escalating Resident 1's missing belongings to the ADM and following up. ADON 3 stated residents had the right to get back all their personal belongings because it's their property. During a review of handwritten inventory list for Resident 1, dated and signed by Registered Nurse (RN) on 4/23/26 at discharge, indicated wheelchair with footrest had no check mark, which indicated not received by ICFADM.During a review of Resident 1's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 5/14/26, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis of Cerebral Palsy (a brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination).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 4/18/26, the MDS section C 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 7 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), indicating Resident 1 with severe cognitive impairment.During a review of facility's In-Service Sign-In Sheet titled, Process of Belonging Handling after Sent to emergency room and admitted , dated 5/8/26, indicated, 1. Nurse gives the inventory list of the send out residents. 2. The CNA will reconcile the belongings with the Inventory List Any (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missing items. Label them with Name and room number and attach the copy of the Inventory List. 4. The bags will be given to SSD Monday to Friday . 5. On the Weekends - Keep the bags in the Utility Room. 6. SSD will follow up on Monday. During a review of facility's policy and procedures (P&P) titled, Resident Rights dated 8/2009, the P&P indicated, .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to; a. Be informed about what rights and responsibilities he or she has; e. Voice grievances and have the facility respond to those grievances. 2. Residents are entitled to exercise their rights and privileges to the fullest extent possible. 7. Inquiries concerning resident' rights should be referred to the Social Servers Director.During a review of a professional reference titled, Know Your Rights . As a Long-Term Care Resident, undated, retrieved from https://ombudsman.ablelaw.org/resources/know-your-rights-as-a-long-term-care-resident/, the professional reference indicated, If you live in a nursing home or residential care facility, you have the same rights as you would if you still lived in your own home. As a consumer of long-term care, you are entitled to a safe and healthy home, and the safekeeping of your belongings. You also have the right to be treated with dignity and consideration at all times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program to provide a safe and sanitary environment for seven of 16 sampled residents (Residents 2, 3, 4, 5, 6, 7, and 8) when:1. Certified Nursing Assistant (CNA) 1 did not discard soiled linens from Resident 2 who was on contact isolation (the practice of separating infected patients from others to prevent the spread of infections transmitted through direct or indirect contact) due to shingles (a painful rash illness caused by the varicella-zoster virus) to a designated isolation barrel (storage unit designed to contain infectious materials and waste) in the soiled utility room on 5/13/26 instead CNA 1 tossed Resident 2's soiled linens into a non-isolation red bin in the soiled utility room on 5/13/26. 2. Laundry Staff (LS) 1 left the blue barrel containing overflowing clean linens inside the dirty area of the laundry room on 5/13/26. These failures had the potential to cause cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) to other residents which could lead to a spread of infection (the invasion and growth of germs in the body), potentially causing health complications, and a facility outbreak (a sudden increase or clustering of disease cases beyond what's normally expected in a specific time, place, or population, often involving common exposure).3. The facility did not report suspected cases of scabies to Fresno County Department of Health (FCDH) and California Department of Health (CDPH) for Residents 3, 4, 5, 6, and 7 when the dermatologist (a medical doctor who specializes in diagnosing, treating, and preventing conditions and diseases that affect the skin, hair, and nails) clinically diagnosed Residents 3, 4, 5, 6, and 7 with suspected scabies on 5/6/26 and 5/7/26, and Resident 8 was assessed by wound doctor on 4/13/26 with suspicious scabies.This failure had resulted in not reporting suspected cases of scabies to local health department and CDPH and had the potential for transmitting and spreading the infection.4. Contact isolation was not initiated for Residents 3, 4, 5, 6, and 7 when symptoms of rash developed. This failure resulted in delay implementation of precautionary measures in mitigating (refers to actions taken to lessen the severity of an outbreak or reduce the probability of disease transmission) the scabies outbreak at the facility and had the potential to cause cross contamination to other residents which could lead to a spread of infection and increasing cases of facility infectious disease outbreak. Findings:1. During an observation on 5/13/26 at 10:49 a.m. in Resident 2's room, a contact isolation sign was posted on the door, one black container with no label was by the door inside the room. CNA 1 and another staff were observed wearing yellow gown and gloves. During an interview on 5/13/26 at 10:55 a.m. with CNA 1, CNA 1 stated he went to soiled utility room and threw a plastic bag containing Resident 2's dirty linen into a bin located in Station 3's soiled utility room. CNA 1 stated he was the CNA assigned for Resident 2. CNA 1 stated Resident 2's bed sheet was changed due to presence of large amount of crusted skin, CNA 2 stated it looked like skin was from his wound. CNA 1 stated Resident 2 also had fluid filled like blisters (a bubble of fluid under the skin) on the side of his head. CNA 1 stated Resident 2 was on contact isolation due to scabies. CNA 1 stated the black container inside Resident 2's room was for trash and used Personal Protective Equipment (PPE -refers to specialized clothing and gear worn by healthcare workers, patients, and visitors to create a barrier that prevents the spread of germs, infectious materials, and dangerous bodily fluids).During a concurrent observation and interview on 5/13/26 at 10:57 a.m. with CNA 1, inside Station 3's soiled utility room, CNA 1 pointed to a red bin and three gray barrels. CNA 1 validated he tossed Resident 2's dirty linens in the red bin. CNA 1 stated the two gray barrels were for resident trash and used PPE. CNA 1 stated there was only one bin for soiled linens in the soiled utility room and there was no designated bin for items from a contact isolation room. During a concurrent observation and interview on 5/13/26 at 11:00 a.m. with CNA 2, inside the soiled utility room, CNA 2 was holding a clear plastic bag containing used PPE and disposed of it into a gray barrel. CNA 2 stated there was no available isolation barrel for dirty (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	soiled linens and laundry for residents on contact isolation in the soiled utility room. CNA 2 stated Station 3 had a scabies outbreak. CNA 2 stated there were residents with scabies in her group assignment. During a concurrent observation and interview on 5/13/26 at 11:10 a.m. with Laundry Staff (LS) 1, inside the soiled utility room, LS 1 was pushing the red bin containing bags of dirty soiled linens. LS 1 stated the red bin was for non-isolation residents only and she did not see a bin for isolation residents inside Station 3's soiled utility room. LS 1 stated there should be two bins, one for isolation and the other one was for non-isolation resident laundry. LS 1 stated laundry staff were responsible in picking up the bins for dirty soiled linens. LS 1stated she washes separately the dirty soiled linens, towels, and personal clothing of isolation residents from non-isolation residents. LS 1 stated the only way to identify dirty soiled linens and laundry for isolation residents, was if they were placed in a designated barrel with an isolation label on top of the lid. During a concurrent observation and interview on 5/13/26 at 11:23 a.m. with the Housekeeping and Laundry Supervisor (HLS), inside the soiled utility room, HLS validated there was no designated barrel for dirty soiled linens and laundry for residents on contact isolation. HLS 1 stated there should be a separate barrel for isolation and should be available to prevent cross-contamination and spread of infection.During an interview on 5/13/26 at 11:31 a.m. with CNA 3, CNA 3 stated CNA 2 was orienting her on the floor, and they were assigned in Station 3. CNA 3 stated she was informed that there is scabies outbreak at Station 3. CNA 3 stated they were assigned to rooms on contact isolation due to scabies. CNA 3 stated there were no isolation barrels for dirty soiled linens and laundry in each isolation room and she only saw a black trash container in isolation rooms. CNA 3 stated she did not see an isolation barrel inside the soiled utility room. CNA 3 stated dirty soiled linens and laundry from isolation rooms should be separated from non-isolation rooms in preventing the spread of infection. During an interview on 5/13/26 at 1:30 p.m. with CNA 1, CNA 1 stated it was his first time to provide care for residents on contact isolation. CNA 1 stated the instruction he received from nurses and CNAs was to dispose resident's soiled and dirty linens and laundry to a red bin located inside the soiled utility room and only use double bag for wet soiled linens and laundry. CNA 1 stated he had not seen a separate bin for isolation inside the soiled utility room. CNA 1 stated he was not aware that Resident 2 had shingles and no scabies. CNA 1 stated dirty soiled linens of residents on contact isolation should be separated the soiled linen should not be mixed, to prevent cross-contamination and to stop the spread of infection. CNA 1 stated the facility has a scabies outbreak in Station 3. During an interview on 5/13/26 at 1:58 p.m. with RN 1, RN 1 stated she's been helping the Infection Preventionist (IP) in providing in-services and training for infection control. RN 1 stated dirty soiled linens should be bagged and airtight while inside residents' room for all residents on contact isolation rooms. RN 1 stated CNAs should use a single bag and use double bag for heavy soiled and wet linens. RN 1 stated the facility does not use a designated container for dirty and soiled linens and laundry for each isolation room. RN 1stated there should be a separate labeled container for dirty and soiled linens and laundry for contact isolation rooms inside the soiled utility room. RN 1 stated the facility process was for laundry staff to pick up the labeled isolation bin containing dirty soiled linen and laundry inside the soiled utility room to prevent the spread of infection. RN 1 stated she started providing in-services today (5/13/26) to nursing staff about infection control: safe handling of soiled linen from isolation rooms.During a review of Resident 2's Order Summary Report (OSR),' ordered date 5/10/26. The OSR indicated, .Strict single room isolation: Contact precautions related to presence of shingles .During an interview on 5/13/26 at 2:50 p.m. with CNA 2, CNA 2 stated the red bin inside Station 3's soiled utility room was for non-isolation rooms' dirty and soiled linens only and should not be used for isolation rooms. CNA 2 stated if there was no isolation bin available, CNAs should notify the licensed nurses and wait until isolation bin was provided. CNA 2 stated isolation rooms' dirty soiled linens should be separated from non-isolation rooms and should be available to prevent cross contamination and spread of infection like scabies. During an interview on 5/13/26 at 3:31 p.m. with the IP, the IP stated the facility's scabies outbreak was contained in Station 3 and had two cases of shingles. The IP stated it was her expectation for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing staff to follow the facility protocol for contact isolation. The IP stated the CNAs should verify with the licensed nurses the type of isolation precautions needed and wear appropriate PPE. The IP stated staff should remove PPE prior to leaving the isolation room. The IP stated the dirty soiled linen and laundry should be bagged up, airtight and disposed to the proper labeled barrel, which should indicate isolation in the soiled utility room. The IP stated isolation rooms' dirty soiled linens and laundry should be separated and handled separately from non-isolation rooms to prevent cross contamination and spread of infection. During an interview on 5/14/26 at 1:40 p.m. with the IP, the IP stated she started placing a label on isolation barrel on Monday (5/11/26) when one confirmed positive scabies was received. The IP stated isolation barrels should be labeled and stated, I didn't see a label on it before. The IP stated a label should be placed on the isolation barrel when suspected scabies were identified. The IP stated it was important that isolation barrels have a label for staff to identify where to properly dispose of the dirty and soiled linens and laundry. The IP stated laundry staff could not identify where to place contact isolation rooms dirty soiled linen if it was not properly labeled. The IP stated this could increase the risk of laundry staff exposure and transmit the infection to other staff and residents.During an interview on 5/14/26 at 1:45 p.m. with the IP, the IP stated there were two new residents identified and diagnosed by the physician with suspected scabies today (5/14/26). The IP stated the total number of scabies cases including confirmed, suspected, and exposure with symptoms was 18. During an interview on 5/14/26 at 2:37 p.m. with the HLS, the HLS stated contact isolation barrels were put in on Monday (5/11/26) by the IP. The HLS stated a designated labeled barrel for contact isolation should be stored and available in the soiled utility room for nursing staff to identify the correct barrel to place the dirty items. The HLS stated isolation's dirty soiled lines and laundry should be double bagged and labeled and should only be discarded to a labeled isolation barrel to prevent cross contamination and spread of infection. The HLS stated if mixed with non-isolation soiled linens, there was no way for the laundry staff to identify, and it would be laundry together with the non-isolation. The HLS stated the laundry staff will be exposed to infection. The HLS stated they were using a different process of laundry for isolation and non-isolation: one time wash for non-isolation and two washes for isolation.During an interview on 5/14/26 at 3:05 p.m. with Assistant Director of Nursing (ADON) 3, ADON 3 stated the facility's protocol and training for soiled linens and laundry from isolation rooms should be disposed to a designated labeled barrel, separate from non-isolation rooms, and should not be mixed to prevent the risk of cross contamination and spread infection.During an interview on 5/14/26 at 3:35 p.m. with the Director of Nursing (DON), the DON stated it was her expectation for nursing staff to follow the facility's protocol for contact isolation. The DON stated soiled linens and laundry from isolation rooms should be bagged and disposed in labeled isolation barrel strictly for isolation located in the soiled utility room. The DON stated there was a risk of cross contamination and spread of highly transmissible infection.During a review of facility's policy and procedures (P&P) titled, Isolation-Categories of Transmission-Based Precaution, dated 9/2022, the P&P indicated, Transmission-based precautions are initiated when resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of infection; or has a laboratory confirmed infection; and is at risk of transmitting infection to other residents.Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected.1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.During a review of a professional reference titled, Appendix D - Linen and Laundry Management, dated 3/19/24, retrieved from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-d.html, the professional reference indicated, .Place soiled linen into a clearly labeled, leak-proof container (e.g., bag, bucket) in the patient care area. Do not transport soiled linen by hand outside the specific patient care area from where it was removed. 2. During a concurrent observation and interview on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/13/26 at 11:16 a.m. with LS 1, inside the laundry room, LS 1 placed the red bin containing dirty soiled linens and laundry beside the blue barrel containing overflowing linens. LS 1 stated she was at the dirty side of the laundry room and was pointing at a blue barrel containing overflowing linen. LS 1 then stated they were washed, it's clean and pointed to the other side of the laundry room. LS 1 stated the blue barrel containing clean linens should not be left at the dirty side of the laundry room. During an interview on 5/14/26 at 2:37 p.m. with the HLS, the HLS stated the dirty area of the laundry room is where the washer and dryer located, the clean side was on the other side of the laundry area. The HLS stated the laundry room has a clean and dirty area. The HLS validated that the blue barrel containing overflowing linens were clean and should not be overflowing. The HLS stated the clean barrel should be covered and not left beside the dirty soiled linens (red bin) and isolation barrels at the dirty side of the laundry room. The HLS stated there should be no clean linens in the dirty area. The HLS stated it was her expectation for the laundry staff to follow the facility's P&P for proper and safe handling and processing of laundry. The HLS stated LS 1 should unload the clean linens from the dryer, placed in a clean covered barrel, and transport immediately to the clean area. The HLS stated clean linens should be stored in the clean side and dirty soiled linens on the dirty side to prevent cross contamination.During an interview on 5/14/26 at 1:45 p.m. with the IP, the IP stated the laundry room has a separate area for clean linens and dirty linens. The IP stated clean linens should not be left or stored in the dirty area to prevent the risk of cross contamination.During an interview on 5/14/26 at 3:35 p.m. with the DON, the DON stated clean lines should be placed to the clean side of the laundry room. The DON stated LS 1 should not leave the barrel containing linens beside the dirty bins and isolation barrel in the dirty side of the laundry room. The DON stated clean barrels should not be overflowing and should be covered. The DON stated laundry staff should unload clean linens from the dryer and transport immediately to the clean area to prevent cross contamination from the dirty linens. During a review of facility's P&P titled, Laundry Handling & Processing Policy, dated 2/1/25, the P&P indicated, Healthcare Services Group, Inc. (HCSG) is committed to providing a safe, clean, and hygienic environment for residents, staff, and visitors in accordance with regulatory guidance and industry best practices. Laundry in a health care facility may include bed sheets, blankets, towels, personal clothing, patient apparel, gowns, and other linens. Standard precautions are effective in reducing the risk of disease transmission to the residents, patients, and staff. The control measures described in this section of the guideline are based on principles of hygiene, common sense, and Centers for Disease Control (CDC) guidance as they pertain to laundry services utilized by healthcare facilities. Employees should collect soiled linens from resident/patient rooms throughout the day. Soiled linens and laundry should be handled with minimum agitation in a manner that reduces the possibility of contamination of air, surfaces, and persons. The workflow of laundry processes should be designed in a way that prevents cross-contamination. Receiving areas for soiled linens should be clearly separated from the clean linen area. Clean linens should be sorted, packaged, transported, and stored in a manner that prevents the risk of contamination by dust, debris, or other soiled items. Clean linen should not be stacked higher than the rim.During a review of a professional reference titled, Appendix D - Linen and Laundry Management, dated 3/19/24, retrieved from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-d.html, the professional reference indicated, . Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. Have a separation between the soiled linen and clean linen storage areas. 3. During a concurrent interview and record review on 5/14/26 at 11:08 a.m. with ADON 2, Resident 3's SBAR (Situation Background Appearance Review and Notify) Communication Form dated 4/21/26 and 5/7/26, and Admission/readmission Evaluation assessment dated [DATE], were reviewed. The SBAR dated 4/21/26 indicated, .generalized rash with scattered lesions (any abnormal change in the structure of an organ or tissue due to injury, disease, or infection), complaint of itching to trunk, [bilateral upper extremities] / [bilateral lower extremities]. [Doctor] arrives at the facility to complete skin assessment. New (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	05/14/2026

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order: referral to dermatology. The SBAR dated 5/7/26 indicated, .suspected scabies.noted with rash to upper back and chest.dermatologist determine suspected scabies.start [brand name topical cream]- ivermectin (a broad-spectrum anti-parasitic medication used primarily to treat infections caused by parasitic worms and specific skin conditions) . strict isolation. The Admission/readmission Evaluation assessment dated [DATE] indicated, .noted rash to upper mid back, redness and raise bumps. resident returning back to facility from hospital sent out on 4/5/26 .received new order from NP (Nurse Practitioner) for hydrocortisone cream (used to treat redness, swelling, itching, and discomfort of various skin conditions) for 14 days then [as needed] for rash to mid back. ADON 2 stated Resident 3 was seen and evaluated by the physician on 4/21/26 due to generalized rashes and ordered referral to dermatologist for consult. ADON 2 stated Resident 3's physician did not indicate suspected scabies. ADON 2 stated Resident 3 was seen and evaluated by dermatologist on 5/6/26 and was diagnosed on [DATE] with suspected scabies. ADON 2 stated Resident 3's skin scraping was done at the dermatologist office and revealed positive for scabies. ADON 2 stated Resident 3 was readmitted from acute care hospital on 4/12/26 with rash to mid back and was treated with hydrocortisone cream for 14 days.During a concurrent interview and record review on 5/14/26 at 11:50 a.m. with the Treatment Nurse (TN), Resident 8's wound doctor's assessment, dated 4/13/26, was reviewed. The wound doctor's assessment indicated, suspicious scabies. The TN stated she assisted wound doctor weekly on Mondays for his wound rounds. During a concurrent interview and record review on 5/14/26 at 2:00 p.m. with the IP, scabies outbreak line listing was reviewed. The line listing indicated, .onset date, location, description of symptoms. The IP stated the onset date of symptoms were the dates when Residents 3, 4, 5, 6, and 7 went to dermatologist to evaluate their rashes, and not when the actual symptoms of rash started. The IP stated Residents 3, 4, and 5 were evaluated and clinically diagnosed by the dermatologist with suspected scabies on 5/6/26. Residents 6, and 7 were evaluated and clinically diagnosed by the dermatologist with suspected scabies on 5/5/26. The IP stated Resident 3 returned to the dermatologist on 5/7/26 for skin scraping to rule out scabies. The IP stated Resident 3's skin scraping for scabies was positive result was received on 5/11/26. The IP stated she reported one confirmed case of scabies and clinically diagnosed suspected scabies to FCDH and CDPH on 5/12/26. The IP sated she did not report the suspected scabies when clinically diagnosed on [DATE] and 5/6/26 by the dermatologist and she waited for a confirmed case for reporting. The IP stated she did not know if suspected scabies should be reported to the health department. The IP stated she needed to check and update the line listing to reflect the actual onset date of symptoms.During a concurrent interview and record review on 5/14/26 at 2:30 p.m. with the IP, Residents 3, 4, 5, 6, and 7's SBAR Communication Form were reviewed. Resident 3's SBAR dated 5/7/26, indicated, .suspected scabies. strict isolation. Resident 4's SBAR dated 5/6/26, indicated, .possible scabies.resident went out to dermatologist appointment came back after skin scraping with diagnosis of possible scabies . Resident 5's SBAR dated 5/7/26, indicated, .noted with possible scabies abdominal area and chest.dermatologist determined suspected scabies. start .strict isolation. Resident 6's SBAR dated 5/8/26, indicated, .dermatologist assistant called to change diagnosis from atopic dermatitis to suspected scabies . Resident 7's SBAR dated 5/8/26, indicated, gave diagnosis of suspected and need to start treatment.noted with rash to entire body, was diagnosed first with atopic dermatitis, changed diagnosis to suspected scabies . During an interview on 5/14/26 at 3:35 p.m. with the DON, the DON stated the facility must report confirmed and suspected cases of scabies to FCDH and CDPH. The DON stated the facility started reporting the scabies outbreak when one confirmed case via skin scraping was received on 5/11/26. The DON stated suspected scabies which were clinically diagnosed by the dermatologist on 5/5/26 and 5/6/26 should be reported to FCDH and CDPH.During a review of facility's scabies outbreak line listing, undated, the line listing indicated Resident 3's onset symptom of rash was on 4/12/26, Resident 4' onset symptoms of rash and itching was on 4/17/26, Residents 5, 6, and 7's onset symptoms of rashes were on 4/21/26.During a review of a professional reference titled, Detecting and Controlling (continued on next page)

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	555652	A. Building B. Wing	05/14/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Outbreaks, undated, retrieved from https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/SNF_DetectAndControlOutbreaks.aspx, the professional reference indicated, .SNF (Skilled Nursing Facility) infection preventionists should have policies and procedures in place for what to do as soon as an outbreak is suspected. SNF must report suspected or confirmed outbreaks and unusual infectious disease occurrences to their LHD (Local Health Department) and CDPH. 4. During a concurrent interview and record review on 5/14/26 at 2:00 p.m. with the IP, scabies outbreak line listing was reviewed. The line listing indicated, .onset date, location, description of symptoms. The IP stated the onset date of symptoms were the dates when Residents 3, 4, 5, 6, and 7 went to dermatologist to evaluate their rashes, and not when the actual symptoms of rash started. The IP stated Residents 3, 4, and 5 were evaluated and clinically diagnosed by the dermatologist with suspected scabies on 5/6/26. Residents 6, and 7 were evaluated and clinically diagnosed by the dermatologist with suspected scabies on 5/5/26. The IP stated Resident 3 returned to the dermatologist on 5/7/26 for skin scraping to rule out scabies. The IP stated Resident 3's skin scraping for scabies positive result was received on 5/11/26. The IP stated Residents 3, 4, 5, 6, and 7's symptom of rash developed prior to visits to the dermatologist on 5/5/26 and 5/6/26. The IP stated she needed to check and update the line listing to reflect the actual onset date of symptoms. The IP stated Residents 3, 4, 5, 6, and 7 reside in Station 3. The IP stated contact isolation started when Residents 3, 4, 5, 6, and 7 were clinically diagnosed by the dermatologist with suspected scabies and not on actual onset of their symptoms. The IP stated Residents 3, 4, 5, 6, and 7 should be placed on contact isolation when symptoms of rash developed to prevent the spread of infection.During an interview on 5/14/26 at 3:35 p.m. with the DON, the DON stated contact isolation should be implemented when suspected or confirmed of being infected with microorganisms (tiny living organisms that are too small to be seen with the naked eye) to prevent transmission of infection. The DON stated onset of symptoms means when the residents developed their symptoms and not when seen by the dermatologist. The DON stated contact isolation is important to be initiated when suspecting of a highly transmissible infection (a disease or germ that is extremely capable of being passed on or spread from one person, animal, or environment to another).During a review of facility's updated scabies outbreak line listing, undated, the line listing indicated Resident 3's onset symptom of rash was on 4/12/26, Resident 4' onset symptoms of rash and itching was on 4/17/26, Residents 5, 6, and 7's onset symptoms of rashes were on 4/21/26.During a review of Resident 3, 4, 5, 6, and 7's isolation precautions care plan report dated 5/7/26 and 5/8/26. Residents 3, 4, and 5's care plan indicated, Isolation Precautions: Resident requires strict isolation with contact precaution related to suspected scabies.Date Initiated 5/7/26. Residents 6 and 7's care plan indicated, Isolation Precautions: Resident requires strict isolation with contact precaution related to suspected scabies.Date Initiated 5/8/26.During a review of facility's policy and procedures (P&P) titled, Isolation-Categories of Transmission-Based Precaution, dated 9/2022, the P&P indicated, Transmission-based precautions are initiated when resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of infection; or has a laboratory confirmed infection; and is at risk of transmitting infection to other residents.Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected.1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.