

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Willow Creek Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 650 W. Alluvial Clovis, CA 93611	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and respect for six of 19 sampled residents (Residents' 36, 74, 115, 138, 361 and 554) when:</p> <ol style="list-style-type: none"> 1. Resident 74 urinary catheter (flexible tube inserted into bladder to drain urine) bag was not covered and was visible to residents and visitors to see. 2. Registered Nurse (RN)1 and Licensed Vocational Nurse (LVN) 9 checked Resident 115 and Resident 361's blood pressure (B/P- measures the pressure of circulating blood against the walls of blood vessels [channels that carry blood throughout the body]) and did not provide privacy. 3. Licensed Vocation Nurse (LVN) 7 checked Resident 554's blood sugar (amount of sugar in the blood) and did not provide privacy. 4. Licensed Vocation Nurse (LVN) 7 administered insulin to Resident 36 and Resident 138 and did not provide privacy. <p>These failures had the potential to violate Residents' 36, 74, 115, 138, 361 and 554 respect and dignity during direct resident care which could potentially impact residents' well-being leading to vulnerability, decreased dignity, anxiety, stress, and depression.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 74's Admission Record [AR-a document with personal identifiable and medical information], dated 4/3/25, the AR indicated Resident 74 was admitted to the facility on [DATE] with diagnoses which included Pressure ulcer (localized skin and soft tissue injury caused by prolonged pressure) of sacral bone (tail bone), and muscle weakness. <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 4/2/25 at 4:55 p.m. in station 1 cart 1 with Licensed Vocational Nurse (LVN) 8 in Resident 74's room, Resident 74 was lying in bed with a urinary catheter bag hanging on the bed frame uncovered, facing the door. The urinary bag was visible and easily seen when entering the room and the bag was filled with yellow urine. Resident 74's family was at bedside visiting. Resident 74 stated she needed the urinary catheter because she was not able to void (urinate). LVN 8 stated she is from staffing agency, and it was her first time in station 1. LVN 8 stated it was Resident 74's right and dignity issue to not have urinary catheter bag exposed and for everyone walking by to see. LVN 8 stated urinary catheter bags should be placed in a privacy bag all the time.</p> <p>During an interview on 4/2/25 at 5:22 p.m. with Certified Nurse Assistant (CNA) 9, CNA 9 stated urinary catheter should be in a privacy bag and not exposed for everyone to see. CNA 9 stated it is a dignity issue and resident rights to not have their urinary catheter bag exposed. CNA 9 stated urinary catheter bag should be placed in a privacy bag and not touching the floor.</p> <p>During an interview on 4/3/25 at 11:15 a.m. with the Infection Preventionist (IP), the IP stated, Urinary catheter bag should be clipped on the bed rails and covered with privacy bag for dignity issue. The IP stated nursing staff are responsible in making sure urinary catheter bag are kept in privacy bag.</p> <p>During an interview on 4/4/25 at 2:15 p.m. with Assistant Director of Nursing (ADON) 1, ADON 1 stated nursing staff are responsible in making sure urinary catheter bags of residents are kept in a privacy bag and not touching the floor. ADON 1 stated, We do not want other residents or visitors being able to see bag full of urine.</p> <p>During an interview on 4/4/25 at 3:40 p.m. with the Director of Nursing (DON), the DON stated urinary catheter bags should always be in a privacy bag. The DON stated residents and visitors are walking by and did not want urinary catheter bags to be exposed for everyone walking by to see. The DON stated it was a dignity issue and resident right to their privacy.</p> <p>During a review of facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated 8/22, the P&P indicated, . Ensure the catheter remains secured wit a securement device to reduce friction and movement at insertion site . Check the resident frequently to be sure he or she is not lying on the catheter . Position the drainage bag lower than the bladder at all times .</p> <p>During a review of facility's policy and procedure titled, Dignity, dated 2/21, the policy and procedure indicated, . 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs . 6. Residents' private space and property are respected at all times . Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures . helping the resident to keep urinary catheter bags covered .</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/4/5 at 2:15 p.m. with Assistant Director of Nursing (ADON) 1, she stated it was the practice in the facility to ensure residents are provided with privacy during medication administration like checking blood sugar, checking B/P and administering insulin to residents. ADON 1 stated it was a dignity issue, there are visitors and residents can walk by and see.</p> <p>During an interview on 4/4/25 at 3:45 p.m. with the Director of Nursing (DON), DON stated her expectation, and the facility protocol was for licensed nursing to provide privacy to residents when checking blood pressure, blood sugar and administering insulin. The DON stated it was resident rights to have their privacy respected and dignity issue. The DON stated there are staff, visitors and residents walking by and could see what direct care was being done to residents. The DON stated, licensed nurses just had their skills check on medication administration recently, I was expecting more from them.</p> <p>During a review of facility's policy and procedure titled, Dignity, dated 2/21, the policy and procedure indicated, .1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs . 6. Residents' private space and property are respected at all times . Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures . helping the resident to keep urinary catheter bags covered .</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608</p> <p>Based on observation, interview and record review the facility failed to provide a homelike environment for eight of 16 sampled residents (Residents 8,43, 62, 72, 95, 104, 108, and 110), when resident rooms had missing thresh holds (a strip of wood, metal, or stone forming the bottom of a doorway and crossed in entering a house or room), holes in the walls were not repaired, wall paper was torn and missing, blood stains and scuff marks were on the walls, strong urine odor, and curtains with blood stains were left hanging.</p> <p>Thes failures had the potential to cause emotional harm and frustration to the residents.</p> <p>Findings:</p> <p>During a review of Resident 8's Admission Record (AR), dated 4/14/25, the AR indicated Resident 8 was admitted from an acute care hospital on 7/17/24 with the following diagnosis, . history of falling, abnormality of gate, macular degeneration (age related disease that affects the center of the eye that can cause blurry, distorted or darkened center of vision), fracture of right humerus (long bone of the upper arm),fracture of right femur (long bone of upper leg), Diabetes Mellitus (DM-chronic condition in which the body cannot regulate blood sugar), and Polymyalgia rheumatica (a disorder causing muscle pain and stiffness) .</p> <p>During a review of Resident 8's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 8's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status on a scale of 0 to 15 [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 3 out of 15 which indicated Resident 8 had severe cognitive deficit.</p> <p>During a review of Resident 104's AR, dated 4/4/25, the AR indicated Resident 104 was admitted from an acute care hospital on 7/24/23 with the following diagnosis, . muscle weakness, history of falls, major depressive disorder (a serious mental illness that involves persistent feelings of sadness and loss of interest in activities), hypothyroidism (a condition where the thyroid gland does not produce enough thyroid hormone, a crucial hormone for regulating metabolism, energy levels, and body temperature), and osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time) .</p> <p>During a review of Resident 104's MDS assessment dated [DATE], the MDS assessment indicated Resident 104's BIMS score was 7 out of 15 which indicated Resident 104 had severe cognitive deficit.</p> <p>During an interview on 4/1/25 at 9:20 a.m. with Resident 104, Resident 104 stated, . this room always smells like pee, even after it has been cleaned .</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 4/1/25 at 9:24 a.m. with Certified Nursing Assistant (CNA) 2 and the Infection Prevention Nurse (IP), outside of Resident 8 and Resident 104's room, a urine odor was smelled outside of the room. The IP stated, the urine smell did not provide a home like environment for Resident 8 or Resident 104. CNA 2 stated the smell was coming from the urine-soaked pants that were hanging in the bathroom. CNA 2 stated, Resident 104 does not want the facility to wash her clothes, the pants were hung in the bathroom to dry. The IP stated the pants should have been placed in a plastic bag, so the smell of urine did not permeate the room.</p> <p>During a review of Resident 72's AR, dated 4/4/25, the AR indicated Resident 72 was admitted from an acute care hospital on 7/12/24 with the following diagnosis, . chronic respiratory failure, muscle weakness, Alzheimer's Disease (a brain disorder that gradually destroys memory and thinking skills), Dementia (brain disease that cause a decline in thinking, memory, and reasoning abilities), repeated falls, and heart failure .</p> <p>During a review of Resident 72's MDS assessment dated [DATE], the MDS assessment indicated Resident 72's BIMS score was 5 out of 15 which indicated Resident 72 had severe cognitive deficit.</p> <p>During a review of Resident 95's AR, dated 4/4/25, the AR indicated Resident 95 was admitted from an acute care hospital on 9/5/24 with the following diagnosis, . muscle weakness, chronic respiratory failure, dysphasia (a language disorder that affects the ability to produce and understand spoken language, cerebral infarction (a blood vessel stops blood flow to part of the brain), and history of falling .</p> <p>During a review of Resident 95's MDS assessment dated [DATE], the MDS assessment indicated Resident 95's BIMS score was 12 out of 15 which indicated Resident 95 had moderate cognitive deficit.</p> <p>During a concurrent observation and interview on 4/3/24 at 10:15 a.m. with Resident 72's and Resident 95's room, the walls had scuff marks from the beds and other equipment rubbing against the walls, an electrical outlet was dangling from a black cord coming out of hole in the wall approximately two inches (unit of measure) by 3 inches. Resident 72 and Resident 95's room did not have the threshold covering in the bathroom. Resident 95 stated, he did not know he could ask to have the outlet repaired and he had thought about the outlet catching on fire.</p> <p>During an interview on 4/3/24 at 10:30 a.m. with the Director of Maintenance (DM), the DM stated, the electrical socket hanging from the wall needed to be repaired immediately as it could cause a fire in the residents room. The DM stated the missing threshold was a tripping hazard for the residents and staff, and the dirty and torn wall paper was not a homelike environment for the residents in the room.</p> <p>During a review of Resident 43's AR, dated 4/4/25, the AR indicated Resident 43 was admitted from an acute care hospital on 10/13/20 with the following diagnosis, . legal blindness, post traumatic stress disorder, major depressive disorder, and chronic pain .</p> <p>During a review of Resident 43's MDS assessment dated [DATE], the MDS assessment indicated Resident 43's BIMS score was 15 out of 15 which indicated Resident 43 had no cognitive deficit.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 62's AR, dated 4/4/25, the AR indicated Resident 62 was admitted from an acute care hospital on 6/7/22 with the following diagnosis, .traumatic brain injury, repeated falls, chronic pain, heart failure, and major depressive disorder .</p> <p>During a review of Resident 62's MDS assessment dated [DATE], the MDS assessment indicated Resident 62's BIMS score was 3 out of 15 which indicated Resident 62 had severe cognitive deficit.</p> <p>During a concurrent observation and interview on 4/4/25 at 11:00 p.m. in Resident 43's and Resident 62's room with the DM, the wall behind Resident 43's bed was dented in with an approximate 5 inch by 2-inch hole in the wall. The wall behind Resident 62's bed had a large dent from the top of the headboard to the bottom of the wall. The DM stated, the wall should have been repaired when it was damaged, the residents should not have to have dents and holes in their walls.</p> <p>During a review of Resident 108's AR, dated 4/4/25, the AR indicated Resident 62 was admitted from an acute care hospital on 6/7/22 with the following diagnosis, .traumatic brain injury, repeated falls, chronic pain, heart failure, and major depressive disorder .</p> <p>During a review of Resident 108's MDS assessment dated [DATE], the MDS assessment indicated Resident 108's BIMS score was 15 out of 15 which indicated Resident 108 had no cognitive deficit.</p> <p>During a concurrent observation and interview on 4/5/25 at 3:10 p.m. with Resident 108, in Resident 108's room, next to Resident 108's bed had blood splatter stains on the wall and on the privacy curtain. Resident 108, the bathroom threshold was missing, the wall behind the television had white plaster on the blue wall, the wall paper was peeling and missing and the bottom of the walls had scuff marks and areas that were not painted. Resident 108 stated, she felt as if no-one listened to her complaints, she had asked the housekeeper to have her curtain with the blood changed or cleaned, she had asked if the blood stains on the wall could be cleaned, and she was told it would be done as soon as possible but it was never done. Resident 108 stated, . I feel so frustrated, I feel as if no one listens to me and I do not have any family to help me talk to the higher ups, I feel as if no one cares .</p> <p>During an interview on 4/5/25 at 3:25 p.m. with the House Keeping Manager (HM), the HM stated, Resident 108 should not have had to ask to have her curtain changed or the blood cleaned off her wall. The HM stated blood is an infection issue, and it is not a home like environment for the resident. The HM stated Resident 108 room was not cleaned to her expectations.</p> <p>During a review of the facility's policy and procedure (P&P), titled, Homelike Environment dated 2/2021, the P&P indicated, . The facility staff and management maximizes . homelike setting . clean, sanitary and orderly environment . in good condition .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51223</p> <p>Based on observation, interview and record review, the facility failed to report a alleged abuse incident to the California Department of Public Health (CDPH) when two of six sampled residents (Resident 30 and Resident110) were involved in a resident-to-resident altercation without serious injury.</p> <p>This failure resulted in the facility not reporting the alleged violation involving resident to resident abuse within the required timeframe and had the potential for additional allegations of abuse to go unreported.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/1/25 at 3:02 p.m. with Resident 110 in the resident ' s room, Resident 110 was sitting on the edge of her bed facing the window. Resident 110 had six 1.5-inch adhesive strips (small bandages made of breathable material used as an alternative to stitches to help close small cuts and wounds) applied to her left hand. Resident 110 was alert, oriented to person, place, date and time, understood and answered questions appropriately. Resident 110 stated a resident threw a piece of metal towards her and it hit her hand resulting in a skin tear. Resident 110 stated the incident was reported to the police.</p> <p>During a review of Resident 110 ' s Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 4/4/25, the AR indicated Resident 110 admitted to the facility on [DATE] with diagnoses: Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing), acute respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in your body), asthma (a chronic lung disease caused by inflammation and muscle tightening around the airways making it hard to breathe) and influenza (flu-a contagious respiratory infection of the nose, throat and lungs potentially causing mild to severe illness, and sometimes death).</p> <p>During a review of Resident 110 ' s Minimum Data Set assessment tool (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 3/11/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 110 had no cognitive impairment.</p> <p>During a review of Resident 30 ' s Progress Notes dated 3/25/25 at 7:32 a.m., the nurse ' s note indicated the writer contacted all appropriate agencies relating the altercation, Ombudsman (someone who acts as a neutral and independent point of contact for resolving complaints or concerns), local police department, the ADM and the resident ' s representative.</p> <p>During an interview on 4/3/25 at 10:09 a.m. with Certified Nurse Assistant (CNA) 4, CNA 4 stated when a resident-to-resident altercation occurs the staff would intervene, remove both residents from the situation to de-escalate the situation. CNA 4 stated she would alert the licensed nurse of a resident-to-resident altercation for resident assessment and potential treatment. CNA 4 stated the licensed nurse (LN), or administrator (ADM) would report the alleged abuse to the appropriate agencies.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/3/25 11:25 a.m. with the Administrator (ADM), the ADM stated the facility reported the resident-to-resident altercation to the Ombudsman and police. The ADM stated the facility did not need to report the incident to CDPH because Resident 30 had dementia.</p> <p>During a concurrent interview and record review on 4/3/25 at 3:54 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 110 and Resident 30 ' s electronic medical records (EMR) were reviewed. Resident 110 ' s EMR indicated Resident 110 sustained left hand skin tear on 3/25/25 from an alleged resident-to resident altercation. LVN 1 stated Resident 110 ' s roommate was Resident 30 and was re-roomed. Resident 30 ' s EMR indicated Resident 30 room was changed immediately after the alleged resident-to-resident incident. LVN 1 stated when resident-to-resident altercation occurs the staff should separate the individuals, assess the residents for injury, provide each resident with treatment as necessary, notify the physician and the resident representative, and document their incident and findings. LVN 1 stated the licensed nurse (LN) would notify outside agencies of allegations of abuse, if resident to staff altercation the LN would also notify the administrator (ADM), and resident-to-resident incidents the LN would notify local law enforcement. LVN stated altercation incidents should be reported the appropriate agencies due to the involvement of physical contact.</p> <p>During a review of Resident 30 ' s Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 4/4/25, the AR indicated Resident 30 admitted to the facility on [DATE] with diagnoses: idiopathic peripheral autonomic neuropathy (nerve damage in the nerves outside the brain and spinal cord affecting the autonomic nervous system (which controls involuntary functions), where the underlying cause is unknown), personal history of TIA (transient ischemic attack-a temporary disruption of blood flow to the brain that causes stroke-like symptoms) without residual deficits, anxiety disorder, dementia (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 30 ' s Minimum Data Set assessment tool (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 3/10/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of 10 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 30 had moderate cognitive impairment.</p> <p>During an interview on 4/4/25 at 10:11 a.m. with the Director of Nursing (DON), the DON stated when a resident-to-resident altercation occurs the facility would separate the residents to prevent further injury, notify the DON, ADM, and the supervisor. The DON stated the ADM was the facility ' s abuse coordinator (facility staff who initiates investigation of the allegation, responsible for maintaining communication with the resident or responsible party of the status of the investigation, ensures individuals involved in the allegation are protected from retaliation) appropriate agencies to report. The DON stated the aggressor had dementia so the facility would report to the Ombudsman and local law enforcement. The DON stated non-dementia related abuse would be reported to CDPH.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/4/25 at 11:19 a.m. with the Administrator (ADM) in the ADM office, an Assembly [NAME] (AB)-1417 (2023) dated 2/2024 and Resident-to Resident Altercations policy and procedure (P&P), dated 9/2022 were reviewed. AB-1417 (2023) Mandated Reporting System for Elder & Dependent Adult Abuse & Neglect in LTC (Long Term Care) Facilities indicated the mandated reporter observes, has knowledge of, or reasonable suspect abuse or neglect in a long-term care facility, resident with dementia (caused by a resident diagnosed with dementia with no serious bodily injury) within 24 hours (preferably ASAP) SOC-341 (Report of Suspected Dependent Adult/Elder Abuse) to: LTC Ombudsman, Law Enforcement. Abuse of an elder .can include: (1) Physical abuse .with resulting physical harm .NOTE: Facilities may have additional reporting requirements under state and federal law . The Resident-to-Resident Altercations P&P ' s Policy Interpretation and Implementation indicated, 3. Occurrences of such incidents are promptly reported to the nurse supervisor, director of nursing services, and to the administrator. The administrator will report the incident in accordance with the criteria established under Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating .4. If two residents are involved in an altercation, staff .j. report incidents, findings, and corrective measures to appropriate agencies as outline in Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating. The ADM stated when a resident-to-resident altercation occurs, the facility followed the AB 1417 state guidance for mandated reporters which stated if one of the resident ' s has dementia and no serious bodily injury occurred, the facility would report the incident to the Ombudsman and local law enforcement.</p> <p>During a concurrent interview and record review on 4/4/25 at 2:01 p.m. with the ADM in the ADM office, All Facilities Letter (AFL) 24-09 dated 2/28/24, and 42 CFR (Code of Federal Regulations) 483.12 dated 4/2/25 were reviewed. AFL 24-09 indicated the revised process outlines requirements for reporting incidents of known, suspected or alleged abuse committed by residents diagnosed with dementia .For incidents involving resident-on-resident abuse that did not result in bodily harm where the alleged abuser is a resident diagnosed with dementia, facilities are required to notify the ombudsman and local law enforcement in writing within 24 hours. For incidents resulting in physical harm, facilities are required to notify local law enforcement immediately or as soon as possible, but no later than two hours after the incident occurred. Facilities are further required to provide written notice of the incident to, the appropriate state agency, the ombudsman, and local law enforcement. 42 CFR 483.12(C)(1) indicated Ensure that all alleged violations involving abuse . are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse ., or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency .) in accordance with State law through established procedures. The ADM stated the AFL revised the reporting requirements for resident-to resident abuse when one of residents had a diagnosis dementia, so the facility reported the incident to the ombudsman and local law enforcement. The ADM stated 42 CFR 483.12 (C) (1) indicated .if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures and the facility followed the guidance in accordance with State law through established procedures.</p> <p>During a review of the facility documents dated 3/25/25, the fax indicated the facility successfully reported the altercation between two residents to the local police department and the Ombudsman to include: the completed SOC 341 (Report of Suspected Dependent Adult/Elder Abuse) and face sheet for Resident 30 and Resident 110.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Facility Reported Event dated 3/25/25, the describe incident indicated At approximately 10:40 a.m. Resident 30 allegedly threw a rod at her roommate (Resident 110) who was sitting on her bed receiving a breathing treatment. Upon skin assessment, Resident 110 sustained skin tear to left hand. Resident 30 also allegedly shoved a clipboard and hit Resident 110 on her right shoulder. No injuries were noted to the right shoulder at the time of assessment. Resident 30 was noted to be very confused with episodes of yelling at the time of incident. Residents were immediately separated; Resident 30 was moved from room .to room . Respective attending physicians and RP and/or family for both residents were notified of incidents. Skin tear to Resident 110 ' s left hand was treated according to physician orders. Skin tear was superficial, no signs and symptoms of infection noted at this time. Resident 30 is a long-term resident, admitted on [DATE] with BIMS score of 10 (moderately impaired) and diagnose of idiopathic peripheral autonomic neuropathy, chronic pancreatitis, personal history of TIA (transient ischemic attack), paroxysmal atrial fibrillation, CKD (chronic kidney disease), essential HTN (hypertension), anxiety disorder, age-related osteoporosis, heart failure, HLD (hyperlipidemia), dementia, unspecified psychosis. The 5 Day Follow Up indicated the full investigation was completed and the interdisciplinary team determined the root cause of [Resident 30 ' s] behavior is related to increased confusion at the time of assessment related to active ear infection and folliculitis which were being treated with antibiotic therapy as well as new roommate as of 3/21/25. [Resident 30] has a history manifested behavioral issues (i.e. yelling out, spiting, repeating calling out of ' help me God, ' digging out and throwing feces, making false accusations, turning over bedside table), but this is the first incident that involved physical aggression with another resident .</p> <p>During a review of Job Description: Administrator (ADM), dated 12/2018, the General Purpose indicated, .the purpose of your job positions is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to ensure that the highest degree of quality care can be provided to our residents at all times. The Essential Duties indicated . responsible for the overall operational functioning of the facility .Monitors industry regulations, laws, compliance updates and makes changes appropriately .Ensure that all facility personnel, residents, visitors, etc., follow established safety regulations .</p> <p>During a review of Job Description: Director of Nursing (DON), dated 2/2024, the General Purpose indicated, .The DON is a registered nurse who oversees and supervises the care of all residents . The Essential Duties indicated, .implement nursing policies and procedures and ensure compliance. Responsible for ensuring resident safety .Responsible for keeping current on any regulation changes and disseminating this information appropriately .</p> <p>During a review of the facility ' s policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 9/2022, the Policy Statement, indicated All reports of resident abuse .are reported to local, state and federal agencies (as required by current regulations) . The Policy Interpretation and Implementation indicated .The administrator or the individual making the allegations immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility .3. Immediately is defined as: b. within two hours of an allegation involving abuse .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s policy and procedure titled, Resident-to-Resident Altercations, dated 9/2022, the Policy Interpretation and Implementation indicated, 3. Occurrences of such incidents are promptly reported to the nurse supervisor, director of nursing services, and to the administrator. The administrator will report the incident in accordance with the criteria established under Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating .4. If two residents are involved in an altercation, staff .j. report incidents, findings, and corrective measures to appropriate agencies as outline in Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating .</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set Assessment (MDS-assessment of physical and psychological functions and needs of residents) accurately reflected resident's health and functional status of one of four sampled residents (Resident 17) when Resident 17's use of anxiety medication and diagnoses of migraine was not accurately coded on the MDS assessment.</p> <p>This failure had the potential to result in Resident 17's care needs not met.</p> <p>Findings:</p> <p>During a review of Resident 17's Admission Record (document with resident demographic and medical diagnosis information), dated 4/3/25, the AR indicated Resident 17 was admitted in the facility on 7/11/25 and readmitted on [DATE] with diagnoses which included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, rigidity, and slow, imprecise movements), respiratory disorder and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 17's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 17's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 14 out of 15 (0-15 scale, 0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) indicating Resident 17 had no cognitive deficit.</p> <p>During a review of Resident 17's Order Summary Report, undated, the Order Summary Report, indicated . Divalproex Sodium (medication used to treat certain types of seizures-a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) . Give 1 tablet by mouth one time a day for migraine, headache . LORazepam (medication used to treat anxiety disorders) Oral Tablet . order date: 11/14/24 .</p> <p>During a concurrent interview and record review on 4/4/25 at 9:10 a.m. with Minimum Data Set Nurse (MDSN), Resident 17's quarterly MDS assessment dated [DATE], section N (medications) was reviewed by MDSN. The MDSN stated Resident 17 has an order for antianxiety medication and should have been coded in MDS but was not coded. The MDSN stated Resident 17's diagnosis of migraine headache should have been coded in the MDS assessment but was not coded. The MDSN stated she should have reviewed Resident 17's list of medications and diagnosis for an accurate and complete MDS assessment.</p> <p>During a concurrent interview and record review on 4/4/25 at 10:50 a.m. with the Assistant Director of Nursing (ADON) 2, Resident 17's medication orders were reviewed. ADON 2 stated Resident 17's antianxiety medication was ordered on 11/14/24 when admitted to hospice care. ADON 2 stated Resident 17's medication for migraine headache was ordered on 10/19/24. ADON stated she did not find a diagnosis of migraine headache in Resident 17's record. ADON 2 stated it was the MDS responsibility to ensure diagnosis are reviewed and accurately coded in MDS assessments.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/4/25 at 3:05 p.m. with the Administrator (ADM), the ADM stated his expectation was for MDSN to gather all information including medications and diagnosis to accurately code in MDS. The ADM stated MDSN should have made sure and reviewed Resident 17's records to accurately code in MDS assessment.</p> <p>During an interview on 4/4/25 at 3:35 p.m. with the Director of Nursing (DON), the DON stated her expectation was, .[MDSN] to ensure resident MDS assessments are accurate when completing MDS . The DON stated the MDSN is responsible in making sure resident medications and diagnosis are reviewed and coded in the MDS assessments.</p> <p>During a review of professional guideline titled, Long Term Care Facility Resident Assessment Instrument version 1.18.11 Manual (RAI- core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid) dated 10/23, indicated, . Physician-documented diagnoses . that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments . Medical record sources for physician diagnoses include progress notes . Review documentation from other health care settings where resident may have received any of these medications . Code all high-risk drug class medications .</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on observation, interview and record review, the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASRR- The State is required to ensure that every person entering a Medicaid certified Nursing Facility [NF] receives a admission level screening and if necessary a level II evaluation to ensure that their NF residence is appropriate and to identify what specialized services they may need) was completed accurately for one of four sampled residents (Resident 17) when Resident 17 was admitted for hospice care on 11/14/24 and an updated PASRR was not completed.</p> <p>This failure had the potential for Resident 17 not to receive the necessary and appropriate psychiatric treatment and evaluation in the facility.</p> <p>Findings:</p> <p>During a review of Resident 17's Admission Record [AR], dated 4/3/25, the AR indicated, Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, rigidity, and slow, imprecise movements), hypothyroidism (thyroid gland does not produce enough thyroid hormone) and dementia (a progressive state of decline in mental abilities).</p> <p>During an observation on 4/1/25 at 9:25 a.m. in Resident 17's room, Resident 17 was lying in bed, bed in low position, floor mat on one side of the bed. Resident 17's eyes opened when spoken to but did not answer questions when asked.</p> <p>During a concurrent interview and record review on 4/4/25 at 10:15 a.m. with Minimum Data Set Nurse (MDSN), Resident 17's PASRR dated 8/15/24 was reviewed. The MDSN stated the PASRR was completed in the facility when Resident 17 was readmitted to the facility on [DATE]. The MDSN stated Resident 17 was admitted to hospice care on 11/14/24 and a PASRR assessment should have been completed. The MDSN stated it is the practice of the facility to complete PASRR annually, change of condition and when admitted to hospice. The MDSN stated it was the responsibility of MDS to ensure assessment was completed. The MDSN stated Resident 17 did not have PASRR assessment completed when admitted for hospice care, which is considered a change in condition. The MDSN stated Resident 17's last PASRR assessment was dated 8/15/24. The MDSN stated there should have been a PASRR assessment completed when Resident 17 was admitted for hospice care but there was none.</p> <p>During an interview on 4/4/25 at 2:59 p.m. with the Administrator (ADM), the ADM stated his expectation was for the MDSN to do her job and complete a PASRR assessment when needed. The ADM stated it was the responsibility of MDSN to make sure a PASRR assessment was completed for any changes in condition per the facility policy.</p> <p>During an interview on 4/4/25 at 3:35 p.m. with the Director of Nursing (DON), the DON stated the MDSN was responsible in making sure a PASRR assessment was completed for Resident 17's change of condition.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of facility's document titled, Tool Tip Legend, undated, the document indicated, . The screening type Resident Review (RR) is selected for an individual who: (1) Experience a Significant Change in Condition for the same stay .</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51593</p> <p>Based on observation, interview, and record review the facility failed to develop and implement a baseline care plan for one of three sampled residents (Resident 253) when Resident 253 did not have a care plan for oxygen (O2) and medication ciprofloxacin (antibiotic medication used to treat bacterial infections in different parts of the body).</p> <p>This failure resulted in no baseline care plan to address the use of ciprofloxacin and had the potential for Resident 253 to not have her oxygen needs met.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/1/25 at 9:26 a.m. with Resident 253 in her room, Resident 253 was observed to be on oxygen (O2) at 3 liters(measurement) per minute (LPM) via nasal cannula (NC-tube used to administer via the nose). Resident 253 stated, I haven ' t always had oxygen; just since my hospitalization .</p> <p>During a review of Resident 253 ' s Admission Record (AR) dated 4/3/25, the AR indicated, Resident 253 was admitted to the facility on [DATE] with diagnoses which included fracture (break or crack in a bone) of first lumbar (lower region of the spine) vertebra (one of the small, individual bones of the spine) and bronchiectasis (a condition that occurs when the tubes that carry air in and out of the lungs gets damaged, causing them to widen and become loose and scarred).</p> <p>During a review of Resident 253 ' s Order Summary Report (OSR) dated 4/4/25, the OSR indicated, Ciprofloxacin (antibiotic medication used to treat bacterial infections in different parts of the body) [hydrochloride] Oral Tablet 500 mg (milligrams unit of measurement) . Order Date: 3/29/25.</p> <p>During an interview on 4/3/25 at 10:54 p.m. with the Infection Preventionist (IP), the IP stated, There should have been .a care plan for O2. The IP stated, If giving O2, you would get an order, do a care plan, and a nurse ' s note. The IP stated, If a resident is on antibiotics, it should be care planned. The IP stated, It is important to have an action plan for the resident, so we know what to watch for.</p> <p>During an interview on 4/3/26 at 2:56 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, Use of O2 should have a care plan. LVN 3 stated, If a resident is on antibiotics, there needs to be a care plan. LVN 3 stated, The care plan should be initiated after reviewing the order for antibiotics.</p> <p>During an interview on 4/4/25 at 3:09 p.m. with the Director of Nursing (DON), the DON stated there should be a care plan for O2 use. The DON stated, Care plans are important to make sure we are documenting nursing interventions according to the doctor ' s order. The DON stated, Antibiotics should be care planned to document what we are doing for the residents care and the interventions needed. The DON stated, Expectation is, once you put in an order, the nurse should care plan and do nurse ' s notes. The DON stated baseline care plans are initiated within 48 hours of admission.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility LVN job description, dated November 2018, n indicated, Review care plans daily to ensure that appropriate care is being rendered .Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs .</p> <p>During a review of the DON job description, dated February 2024, the DON job description indicated, . Develop and implement nursing policies and procedures and ensure compliance .</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Care Plans - Baseline, dated March 2022, indicated, .A baseline plan of care to meet the resident ' s immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission .The baseline care plan includes instructions needed to provide effective, person-centered care of the resident .</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51223</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for four of 24 sampled residents (Resident 17, 110, 203, 404) when:</p> <p>1. Resident 110's care plan was not updated after droplet isolation (precaution taken for patients with known or suspected to be infected with pathogens transmitted by respiratory droplets that are generate by a patient who is coughing, sneezing or talking) was discontinued.</p> <p>This failure had the potential for Resident 110 to not receive person-centered care to meet his medical and nursing care needs.</p> <p>2. Resident 17 was ordered and administered divalproex (medication used to treat seizure and prevent migraine headache) medication since 10/19/24 and did not have a care plan for the use of medication and diagnosis.</p> <p>This failure placed Resident 17 at risk of not meeting his care needs.</p> <p>3. Resident 203 did not have specific care plan interventions developed for his use of the pain relieving medication oxycodone (a drug used to relieve moderate to severe pain).</p> <p>This failure had the potential to cause Resident 203 to experience unmonitored side effects of the medication such as decreased respiratory rate, constipation (inability to pass stools), nausea, and vomiting.</p> <p>4. The facility did not implement a person-centered care plan for Resident 404, who required oxygen therapy, and this was not addressed in the smoking care plan.</p> <p>This failure of implementing an individualized care plan for Resident 1 had the potential to place Resident 404's safety at risk and her specific needs not being met.</p> <p>Findings:</p> <p>2. During a concurrent observation and interview on 4/1/25 at 3:02 p.m. with Resident 110 in the resident's room, two residents were assigned to the room. Resident 110 wore a yellow mask as she sat on her bed. Resident 110 was alert, oriented to person, place, date, time and was able to understand and answer questions. Resident 110 stated she wore the yellow mask to prevent from catching germs from others. Resident 110 stated her roommate was out of the building for dialysis.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 110's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 4/4/25, the AR indicated Resident 110 admitted to the facility on [DATE] with diagnoses: Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing), acute respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in your body), asthma (a chronic lung disease caused by inflammation and muscle tightening around the airways making it hard to breathe) and influenza (flu-a contagious respiratory infection of the nose, throat and lungs potentially causing mild to severe illness, and sometimes death).</p> <p>During a review of Resident 110's Minimum Data Set assessment tool (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 3/11/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 110 had no cognitive impairment.</p> <p>During a review of Resident 110's Care Plan Report, dated 4/1/25, the Care Plan indicated Isolation Precautions: Resident requires strict single room droplet isolation precautions due to influenza until 2/7/25.</p> <p>During an interview on 4/3/25 at 10:09 a.m. with Certified Nurse Assistant (CNA) 4, CNA 4 stated care plans were managed by the licensed nurse (LN) and provided staff with information to provide resident care. CNA 4 stated the risk of not following the care plan may result in not meeting the resident's needs.</p> <p>During a concurrent interview and record review on 4/3/25 at 3:54 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 110's care plan was reviewed. The care plan indicated the resident was on droplet precautions and should be in a single room. LVN 4 stated the care plan should provide staff with a baseline plan of care (a preliminary care plan developed within 48 hours of a resident's admission to a nursing home, outlining the initial care and services needed) that identified person-centered care needs. LVN 4 stated Resident 110's care plan should include actions staff should take to ensure individualized care was provided by the facility. LVN 4 stated the care plan should be updated when staff receive feedback from the resident, family or other staff to improve the resident's response to care. LVN 4 stated the care plan should include a start and stop date to ensure appropriate care was provided. LVN 4 stated Resident 110 was not on droplet precautions and was not in a room by herself. LVN 4 stated that care plan did not have an end date and should have been updated. LVN 4 stated the licensed nurses, and the Assistant Director of Nursing (ADON) managed the care plans.</p> <p>During a concurrent interview and record review on 4/3/25 at 10:11 a.m. with the Director of Nursing (DON), Resident 110's care plan dated 4/3/25 was reviewed. The care plan indicated, Isolation Precautions: Resident requires strict single room droplet isolation precautions due to influenza until 2/7/25. The DON stated the care plan should be updated, revised, changed weekly, and quarterly to ensure the care plan was current and updated. The DON stated the care plan should include the focus (the actual problem), potential goals and interventions. The DON stated a long-term care plan would include 90 days stop date and a short-term care plan stop date would depend on the issue. The DON stated if a care plan was not updated it would not accurately reflect the condition of the resident or their person-centered care needs. The DON stated the droplet precaution and need for a single room ended 2/7/25 and should have been removed from the active care plan.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Job Description: LVN LPN dated 11/2018, the Care Plan and Assessment Functions indicated Review care plans daily to ensure that appropriate care is being rendered. Inform the Nurse Supervisor of any changes that need to be made on the care plan. Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs .</p> <p>During a review of the Job Description: Director of Nursing, not dated, the general purpose indicated the DON is a registered nurse who oversees and supervises the care of all the residents .Essential Duties . develop and implement nursing policies and procedures and ensure compliance .Coordinate MDS and care planning .Supervisory Requirements -the DON is responsible for supervising and managing the Assistant DON, and entire nursing staff either directly or indirectly .</p> <p>During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the policy interpretation and implementation indicated .7. The comprehensive, person-centered care plan: .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change .</p> <p>During a review of professional reference review retrieved from https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf titled, The American Nurses Association- Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, the professional reference review indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making . Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation .</p> <p>During a review of professional reference review retrieved from https://www.ncbi.nlm.nih.gov/books/NBK499937/ the National Library of Medicine.org titled, Nursing Process, dated 4/10/23, the professional reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid (having two or more medical conditions or diseases present in the same person at the same time) conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition .</p> <p>40641</p> <p>2. During an observation on 4/1/25 at 9:10 a.m. in Resident 17 ' s room, Resident 17 was observed lying in bed, eyes closed, floor mat on one side of the bed. Resident 17 ' s eyes opened when questions asked but did not answer.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 17 ' s Admission Record (document with resident demographic and medical diagnosis information), dated 4/3/25, the AR indicated Resident 17 was admitted in the facility on 7/11/25 and readmitted on [DATE] with diagnoses which included Parkinson ' s Disease (a progressive disease of the nervous system marked by tremor, rigidity, and slow, imprecise movements), respiratory disorder and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 17's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 17's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 14 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 17 had no cognitive deficit.</p> <p>During a review of Resident 17 ' s Order Summary Report [OSR], undated, the OSR, indicated .Divalproex Sodium [medication used to treat certain types of seizures-a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) . Give 1 tablet by mouth one time a day for migraine, headache .</p> <p>During a concurrent interview and record review on 4/4/25 at 9:10 a.m. with Minimum Data Set Nurse (MDSN), Resident 17 ' s OSR was reviewed. The MDSN stated Resident 17 ' s divalproex was ordered on 10/19/24 for migraine headache. The MDSN stated she did not find a care plan for divalproex medication and migraine headache. The MDSN stated there should have been a care plan for medication and diagnosis of migraine headache to care for Resident 17 ' s needs. The MDSN stated a residents care plan was important in order to direct nursing staff to care for residents. The MDSN stated it was the responsibility of all licensed nurses to ensure a care plan was initiated for new medications and diagnosis.</p> <p>During an interview on 4/4/25 at 2:05 p.m. with Assistant Director of Nursing (ADON) 1, she stated charge nurses and DON are responsible to make sure care plan was completed. ADON 1 stated, I am not sure when to complete comprehensive care plan, but it should be completed right away. ADON 1 stated care plan was necessary to direct staff on how to care for residents.</p> <p>During an interview on 4/4/25 at 3:30 p.m. with Director of Nursing (DON), the DON stated MDSN was responsible in completing comprehensive care plan while charge nurses are responsible for initiating a care plan. The DON stated the expectation in completing a comprehensive care plan was within seven days and no more than 21 days. The DON stated care plan are necessary for nursing staff to care for residents.</p> <p>During a review of facility ' s policy and procedure(P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/22. The P&P indicated, . The comprehensive, person-centered care plan is developed within seven (7) days . and no more than 21 days after admission . describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided . any specialized services to be provided . reflects currently recognized standards of practice for problem areas and conditions .</p> <p>51620</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a review of Resident 203's Admission Record(AR), dated 4/3/25, the AR indicated, Resident 203 was admitted to the facility on [DATE] with the following diagnoses: fracture of thoracic vertebrae (a break in one or more of the bones in the mid-back region), spinal stenosis (a condition where the space surrounding the spinal cord, becomes narrowed), ileostomy (a surgical procedure that creates an opening in the abdomen to divert waste from the small intestine), pseudoarthrosis (a condition where a broken bone fails to heal properly).</p> <p>During an interview on 4/1/25 at 3:19 p.m. with Resident 203, Resident 203 stated he takes the pain medication oxycodone for his back pain.</p> <p>During a concurrent interview and record review on 4/3/25 at 4:42 p.m. with Licensed Vocational Nurse (LVN) 6, Resident 203 ' s Order Summary Report (OSR), dated 4/3/25 and Care Plan, dated 4/3/25, were reviewed. The OSR indicated, . [oxycodone] Oral Tablet [extended release] 12 hours . give 1 tablet by mouth every 12 hours for pain to lower back . LVN 6 stated Resident 203 ' s oxycodone should have a care plan. LVN 6 reviewed Resident 203 ' s Care Plan and stated no interventions were listed for Resident 203 ' s oxycodone use. LVN 6 stated oxycodone was a very strong pain reliever, and it needed to be care planned because it could cause side effects like a lowered respiratory rate and possible overdose.</p> <p>During an interview on 4/4/25 at 3:57 p.m. with the Director of Nursing (DON), the DON stated Resident 203 should have had his oxycodone appropriately care planed. The DON stated care planning proper interventions for the oxycodone was required because oxycodone was a high-risk medication and it had the potential to cause respiratory depression, constipation, and even an overdose.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, comprehensive Person-Centered, dated 3/22, the P&P indicated, . The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes, b. describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being .</p> <p>47888</p> <p>4. During a concurrent observation and interview on 4/1/25 at 3:54 p.m., with Resident 404, in Resident 404 ' s room, Resident 404 was lying in bed with a nasal cannula (a simple medical device used to deliver oxygen to the nose) in her nostrils receiving 2L (liters- unit of measurement) ' s of oxygen therapy. Resident 404 stated she received continuous oxygen therapy, but also smoked at the facility.</p> <p>During a review of Resident 404'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 4/4/25, the Admission Record indicated, Resident 404 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD- an ongoing lung condition caused by damage to the lungs that makes it hard to breathe), muscle weakness, displaced fracture of base of neck of left femur (broken thigh bone) and respiratory (breathing) disorders in diseases classified elsewhere.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 404 ' s Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 3/25/25, the MDS assessment indicated Resident 404's Brief Interview for Mental Status (BIMS -assessment of cognitive(define) status for memory and judgment) assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS assessment indicated Resident 404 was cognitively intact.</p> <p>During a review of Resident 404 ' s Order Summary Report (OSR), dated 4/1/25, the OSR indicated, .O2 [oxygen] 2 LPM [Liters per minute- unit of measurement] via nasal cannula . to keep O2 saturation [how well your blood is carrying oxygen] above 90% every 2 hours as needed for COPD .</p> <p>During a review of Resident 404 ' s Care Plan, dated 3/21/25, the Care plan indicated, Focus: Smoking- Resident is a smoker and is at-risk for smoking related injury as evidenced by requires supervision when smoking . Goal: Will continue to demonstrate safe smoking . Intervention/Tasks: Assess ability to smoke safely . Provide education on positive benefits related to smoking cessation . respect residents wishes about smoking within facility guidelines . smoking apron as indicated . supervision provided while resident is smoking .</p> <p>During a concurrent interview and record review on 4/4/25 at 10:42 a.m., with Certified Nursing Assistant (CNA) 10, Resident 404 ' s care plan was reviewed. Resident 404 care plan did include interventions for her oxygen in the smoking interventions. CNA 10 stated she needed to know what to do with the residents oxygen before she goes to smoke. CNA 10 stated this instruction should be within the care plan for the Resident 404 ' s safety. CNA 10 stated CNA ' s are responsible for reading and implementing the care plans.</p> <p>During a concurrent interview and record review on 4/4/25 at 11:33 a.m., with the Respiratory Therapist (RT), Resident 404 ' s care plan was reviewed. The RT stated the oxygen was not care planned for in regard to her smoking. The RT stated a staff member might not know what do with the oxygen before smoking because it is not outlined in the care plan. The RT stated this was a safety issue for the resident and it could hinder her health.</p> <p>During a concurrent interview and record review on 4/4/25 at 2:22 p.m., with the Director of Nursing (DON), Resident 404 ' s care plan was reviewed. The DON stated care plans develop a plan of care for an identified or potential problem and create an intervention for it. The DON stated all staff were to follow the care plan to manage the residents issue. The DON stated Resident 404 ' s smoking care plan was not person centered, or individualized because it did not acknowledge her wearing oxygen and what interventions should take place to keep her safe while she smoked. The DON stated because the care plan did not reference the oxygen therapy, Resident 404 could have been injured. The DON stated, smoking with oxygen could have potentially caused fire and harm. The DON stated the facility did not follow the policy and procedure P&P Care Plans, Comprehensive Person-Centered.</p> <p>During a concurrent interview and record review on 4/4/25 at 5:03 p.m., with the Assistant Director of Nursing (DON), Resident 404 ' s care plan was reviewed. The ADON stated care plans provide daily guidance for the residents care. The ADON stated there was nothing in the smoking care plan that referenced the oxygen Resident 404 was wearing. The ADON stated the resident could suffer burning or blowing up.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 4/4/25 at 5:26 p.m., with Licensed Vocational Nurse (LVN) 11, Resident 404 ' s care plan was reviewed. LVN 11 stated she was Resident 404 ' s current nurse. LVN 11 stated care plans were important because they let us know everything going on with the resident. LVN 11 stated that Resident 404 ' s was not individualized and person centered. LVN 11 stated Resident 404 could blow up and catch on fire.</p> <p>During a review of the facilities P&P Care plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, . a comprehensive person centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident . the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . the comprehensive, person-centered care plan: . reflects currently recognized standards of practice for problem areas and conditions . care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the residents problem areas and their causes, and relevant clinical decision making . when possible interventions address the underlying source of the problem not just symptoms or triggers .</p> <p>During a review of Nursing World.org Professional Reference titled, The American Nurses Association-Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse ' s decision-making . Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer ' s health or the situation .</p> <p>During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition .</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888</p> <p>Based on observation, interview and record review, the facility failed to maintain professional standards of quality for seven of 32 sampled residents (36, 90, 97, 110, 138, 253 and 405) when:</p> <ol style="list-style-type: none"> 1. Resident 405 had medication in a medicine cup on her bedside table (serves as a surface for food trays and can hold personal items such as phones, laptops, or books) without a self-administration of medications assessment completed, nor nursing staff present. <p>This failure had the potential to put Resident 405 ' s and other facility residents, safety at risk and her specific needs not being met.</p> <ol style="list-style-type: none"> 2. Resident 90 ' s Oxygen (O2) order was incomplete and did not specify how many liters (L- a unit of measurement) of O2 she was to receive per minute. <p>This failure had the potential to result in Resident 90 to not receive the required amount of oxygen for her needs.</p> <ol style="list-style-type: none"> 3. The facility failed to follow their Oxygen Administration Policy for one of five sampled residents (Resident 110) when the Oxygen in Use sign was not posted outside or inside the resident ' s room who received physician ordered oxygen therapy. <p>This failure had the potential to place residents at risk for fire if a visitor or resident decided to smoke where oxygen was being administered.</p> <ol style="list-style-type: none"> 4. Licensed Vocational Nurse (LVN) 7 administered insulin (medication used to diabetes) to Resident 36 and Resident 138 and did not follow professional standard of practice with insulin pen administration. 5. Resident 97 ' s handheld nebulizer machine tubing unlabeled and unprotected, and hanging on the back of bedside table touching the floor. 6. Resident 253 did not have a physician order for enhanced barrier precautions (EBP - wearing gowns and gloves during certain high-contact care activities for residents who are at risk of having or spreading germs that are hard to treat). <p>These failures placed Resident 36, Resident 97, Resident 253 and Resident 138 at risk of infection which could result in a serious health condition.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 4/2/25 at 4:55 p.m., with Resident 405, in Resident 405 ' s room, Resident 405 was by herself and there was one orange pill (medications) sitting on her bedside table while she was lying in bed. Resident 405 stated the medication had been there awhile and she thought it was for her blood pressure. Resident 405 stated the nurse left to get her an applesauce to swallow the pill easier and never came back. <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 405'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 4/4/25, the Admission Record indicated, Resident 405 was admitted to the facility on [DATE] with a diagnosis of hypertension (high blood pressure- the force of your blood pushing against your artery walls is consistently too high, potentially damaging your blood vessels and organs over time), malignant neoplasm (cancer) of unspecified female breast, cerebral infarction (a stroke, happens when a part of the brain doesn't get enough blood and oxygen, causing brain cells to die) and generalized muscle weakness.</p> <p>During a review of Resident 405 ' s Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 1/20/25, the MDS assessment indicated Resident 405's Brief Interview for Mental Status (BIMS -assessment of cognitive(define) status for memory and judgment) assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS assessment indicated Resident 405 was cognitively intact.</p> <p>During a review of Resident 405 ' s Medication Administration Record (MAR), dated 4/1/25 to 4/4/25, the MAR indicated, . Hydralazine oral tablet 100 mg (milligram- unit of measurement) . Give 1 tablet by mouth three times a day for hypertension . Start date: 3/26/25 . Administration: . 4/3/25 at 1 p.m., [Medication not administered] . 4/3/25 at 6 p.m. Blood Pressure 158/61 . May crush all crushable medications and mix with applesauce for better tolerance .</p> <p>During an interview on 4/3/25 at 3:28 p.m., with Registered Nurse (RN) 2, RN 2 stated she was responsible for Resident 405 ' s care. RN 2 stated medication should never be left on the bedside table without a nurse in the room. RN 2 stated it was not safe for the medication to be there and another confused resident could have taken it.</p> <p>During an interview on 4/3/25 at 3:44 p.m., with the Assistant Director of Nursing (ADON), the ADON stated RN 3 was the nurse responsible for having left the medication on Resident 405 ' s bedside table. The ADON stated the medication was Hydralazine, a blood pressure medication and was due at 1 p.m. The ADON stated Resident 405 would be able to self-administer medications if a self-administration assessment was done and it was not. The ADON stated this was a medication error for not giving the medication at the appropriate time per the physician order. The ADON stated another resident could have entered the room and took the medication because it was left unattended. The ADON stated if another resident had taken the medication, they could have gotten hypotensive (drop in blood pressure). The ADON stated Resident 405 could have gotten hypertensive (rise in blood pressure) due to the missed dose due to her underlying diagnosis and not taking the medication as prescribed. The ADON stated the facility did not follow the policy and procedure (P&P) Administering Medications.</p> <p>During a concurrent interview and record review on 4/4/25 at 1 p.m., with the Director of Nursing (DON), Resident 405 ' s Electronic Medical Record (EMR), dated 4/4/25 was reviewed. The DON stated the expectation would be for RN 3 to administer the medications according to the physician ' s order and she did not. The DON stated medication should have not been left at Resident 405 ' s bedside. The DON stated Resident 405 does not have a self-administration assessment completed and would not be able to take medications without the nurse present. The DON stated Resident 405 ' s blood pressure would not be managed because the scheduled blood pressure medication was not given. The DON stated these potential implications for leaving the medication on the bedside table would have put Resident 405 ' s safety at risk. The DON stated the facility did not follow the P&P Administering Medications.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/04/25 at 2:12 p.m., the facilities medication self-administration assessment policy and procedure was requested, but was not received.</p> <p>During an interview on 4/4/25 at 3:57 p.m., with RN 3, RN 3 stated she was Resident 405 ' s nurse and she left the medication on her bedside table. RN 3 stated she left the medication with the resident to go and get her pudding to put her pill in, she got distracted and never went back. RN 3 stated by leaving the medication unattended another resident could have taken it, or the resident could have taken it later and been too much. RN 3 stated this was a safety issue for Resident 405 and could have resulted in a hospitalization due to not receiving her medication per the physician order.</p> <p>During a review of the facility ' s P&P titled, Administering Medications, dated April 2019, the P&P indicated, . medications are administered in a safe and timely manner and as prescribed . 4. Medications are administered in accordance with prescriber orders, including in the required time frame . 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely .</p> <p>During a review of the Joint Commssion.org Professional Reference titled, Medication Security- Bedside Medications/Self Administration, dated 10/25/21, (found at https://www.jointcommission.org/standards/standards-faqs/nursing-care-center/medication-management-mm/000002190/#:~:text=The%20Joint%20Commission%20standards%20do,01.) the reference indicated, . organizations must ensure the medications are secure-meaning protected from unauthorized access, tampering, theft, or diversion . Conducting a risk assessment is a helpful way of identifying risks associated with various options under consideration for securing medication. A proactive risk assessment examines a process in detail including sequencing of events, actual and potential risks, and failure or points of vulnerability. The risk assessment prioritizes, through a logical process, areas for improvement based on the actual or potential impact (that is, criticality) of care, treatment, or services provided .</p> <p>51620</p> <p>2. During a review of Resident 90's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 4/3/25, the AR indicated, Resident 90 was admitted to the facility on [DATE] with the following diagnoses: chronic obstructive pulmonary disease, (COPD- a long-term disease that makes it hard to breathe), congestive heart failure (CHF - a condition where the heart is not pumping blood as well as it should be), and acute respiratory failure with hypoxia (when a person ' s lungs are not working well enough to get enough oxygen into the blood).</p> <p>During an observation on 4/1/2025 at 8:56 a.m. in Resident 90 ' s room, Resident 90 had O2 via nasal canula (a small flexible tube that delivers oxygen through a person ' s nose). The flow meter (a device that shows how much oxygen is flowing through the tube) was set to two liters per minute.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 4/3/25 at 11:41 a.m. with the Respiratory Therapist (RT), Resident 90 ' s Order Summary Report (OSR), dated 4/3/25 was reviewed. The OSR did not have the specific oxygen rate on Resident 90 ' s O2 order. The RT stated Resident 90 received oxygen and breathing treatments as part of her therapy. The RT stated Resident 90 had a history of COPD and CHF. The RT stated he does an assessment and then starts the oxygen if warranted. The RT stated Resident 90 came over from the acute care hospital with orders for oxygen at two liters per minute (LPM). The RT stated Resident 90 was placed on three LPM on admission due to her labored breathing and fatigue with the transfer. The RT stated Resident 90 ' s O2 order should have specified the O2 delivery rate in order to properly deliver the amount of O2 Resident 90 required. The RT stated if a nurse or RT was unfamiliar with her O2 delivery rate, Resident 90 could have retained carbon dioxide (a waste product produced by the lungs which can cause harm if not expelled from the body) since she had COPD.</p> <p>During an interview on 4/4/25 at 11:41 a.m. with Registered Nurse (RN) 1, RN 1 stated nurses and RTs should have noticed the oxygen therapy order was incomplete and contacted the doctor to clarify orders. RN 1 stated incomplete O2 orders could have caused Resident 90 to receive more or less O2 than she needed, and it could be harmful to her health.</p> <p>During an interview on 4/4/2025 at 3:47 p.m. with the Director of Nursing (DON), the DON stated Resident 90 ' s oxygen order should have indicated the rate of delivery since her admission on 3/13/25. The DON stated nurses should have called the doctor to clarify the order once they noticed it was not specific.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Oxygen Administration, dated October 2010, the P&P stated .verify that there is a physician order for this procedure. Review the physician ' s order or facility protocol for oxygen administration .</p> <p>During a review of the facility ' s P&P titled, Medication and Treatment Orders, dated July 2016, the P&P indicated, . 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe medication in this state . 9. Orders for medication must include: . c. dosage and frequency of administration .</p> <p>51223</p> <p>3.During a concurrent observation and interview on 4/1/25 at 3:02 p.m. with Resident 110 in the resident ' s room, Oxygen in Use/No Smoking signs were not posted outside or inside of the resident ' s room. Resident 110 was sitting on the edge of the bed next to an oxygen concentrator (an oxygen concentrator continuously purifies the air around you (atmospheric air) to deliver 90% to 95% pure oxygen) with a flow rate set at two liters (L-a measurement of how much oxygen you're getting through the cannula.) Resident 110 was alert, oriented to person, place, date, time and was able to understand and answer questions. Resident 110 stated the physician ordered continuous oxygen use.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 110 ' s Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 4/4/25, the AR indicated Resident 110 admitted to the facility on [DATE] with diagnoses: Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing), Acute Respiratory Failure (a condition where there is not enough oxygen or too much carbon dioxide in your body), and asthma (a chronic lung disease caused by inflammation and muscle tightening around the airways making it hard to breathe).</p> <p>During a review of Resident 110 ' s Minimum Data Set assessment tool (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 3/11/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 110 had no cognitive impairment.</p> <p>During a concurrent observation and interview on 4/3/25 at 4:12 p.m. with Licensed Vocational Nurse (LVN) 1 at Resident 110 ' s room and at nurses ' station two, the Oxygen in Use/No Smoking sign was not posted on Resident 110 ' s doorway or in the resident ' s room. LVN 1 stated Resident 110 had physician ordered oxygen and there should have been an Oxygen in Use/No Smoking sign on the door. LVN 1 stated the risk of not having proper signage on the door could result in a fire if a resident or visitor tried to smoke in the facility in the presence of oxygen.</p> <p>During a concurrent interview and record review on 4/4/25 at 10:11 a.m. with Director of Nursing (DON) in the DON office, Resident 110 ' s Order Summary dated 2/3/25 and a photo taken 4/1/25 at 8:13 a.m. of Resident 110 ' s doorway was reviewed. The Order Summary indicated; the physician ordered continuous oxygen at 2 LPM (liters per minute). The photo indicated the facility did not post an Oxygen in Use/No Smoking sign on the doorway. The DON stated the Oxygen in Use/No Smoking sign should have been on the doorway and in the room to indicate the resident was using oxygen. The DON stated the Licensed Nurse and Respiratory Therapists were responsible to ensure the signage was properly displayed. The DON stated the facility did not follow their policy. The DON stated there would be a potential risk of fire if someone were to smoke in the presence of oxygen.</p> <p>During a review of the Job Description: LPN LVN, dated 11/2018, administrative functions indicated ensure all nursing service personnel comply with the procedures set forth in the Nursing Service Procedures Manuals . Interpret the department ' s policies and procedures to personnel, residents, visitors and government agencies as required . Nursing Care Functions indicated .Implement and maintain established nursing objectives and standards .Ensure that direct nursing care be provided by licensed nurse .qualified to perform the procedure .Administer professional services .as required .Safety and Sanitation monitor your assigned personnel to ensure that they are following established safety regulations in the use of equipment and supplies. Ensure that established departmental policies and procedures .are followed by your assigned nursing personnel .Ensure that your unit ' s resident care rooms, treatment rooms, etc., are maintained in a clean, safe, and sanitary manner.</p> <p>During a review of the Job Description: Director of Nursing, not dated, the general purpose indicated the DON is a registered nurse who oversees and supervises the care of all the residents . Essential Duties . develop and implement nursing policies and procedures and ensure compliance .Supervisory Requirements-the DON is responsible for supervising and managing the Assistant DON, and entire nursing staff either directly or indirectly .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s policy and procedure titled, Oxygen Administration, dated 10/2010, the Steps in the Procedure indicated .The purpose of this procedure is to provide guidelines for safe oxygen administration .2. Place an ' Oxygen in Use ' sign on the outside of the room entrance door. Close the door. 3. Place an ' Oxygen in Use ' sign in a designated place on or over the resident ' s bed .</p> <p>During a review of American Health Care Association & National Center For Assisted Living Professional Reference titled, Simplifying Oxygen Signage Requirements, published 3/4/25, (found at https://www.ahcancal.org/News-and-Communications/Blog/Pages/Simplifying-Oxygen-Signage-Requirements-.aspx) the reference indicated, a facility that allows smoking must provide precautionary signage wherever supplemental oxygen is in use, including the aisles and walkways leading to such areas .the signage must be readable from a distance of five feet away .</p> <p>40641</p> <p>4.During a review of Resident 36 ' s Admission Record, (AR) dated 4/3/25, the AR indicated Resident 36 was readmitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar), muscle weakness and depression (persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 36's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 36's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 15 out of 15 (0-15 scale,0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) indicating Resident 37 had no cognitive deficit.</p> <p>During a review of Resident 36 ' s Order Listing Report, undated, the Order Listing Report indicated, . [brand name insulin] Auto cover Pen Needle . (Insulin Pen Needle) . [brand name insulin] Pen [medication used to treat diabetes] .</p> <p>During an observation on 4/2/25 at 11:38 a.m. with Licensed Vocation Nurse (LVN) 7 in Station 2 front end, LVN 7 prepared Resident 36 ' s medication including insulin pen. LVN 7 attached insulin needle to insulin pen and did not wipe the pen tip with alcohol pad. LVN 7 administered Resident 36 ' s insulin, removed insulin needle, placed insulin pen cap and did not wipe insulin pen tip before replacing the insulin cap.</p> <p>During a review of Resident 138 ' s AR, dated 4/3/25, the AR indicated Resident 138 was admitted to the facility on [DATE] with diagnoses which included multiple fractures (break in the bone), diabetes and weakness.</p> <p>During a review of Resident 138 ' s MDS assessment dated [DATE], indicated Resident 138 ' s BIMS assessment score was 15 out of 15 indicating Resident 138 had no cognitive deficit.</p> <p>During a review of Resident 138 ' s Order Listing Report, undated, the Order Listing Report indicated, . [brand name] Solution [treat diabetes]100 unit/ML (milliliter-unit of measure) Inject as per sliding scale .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 4/2/25 at 12:16 p.m. with LVN 7 in Station 2, LVN 7 prepared Resident 138 ' s insulin. LVN 7 did not wipe insulin pen tip with alcohol pad prior to attaching insulin needle. LVN 7 administered Resident 38 ' s insulin, removed insulin pen needle, did not wipe insulin pen tip with alcohol wipe and replaced insulin cap.</p> <p>During an interview with LVN 7 on 4/4/25 at 3:59 p.m. LVN 7 stated she administered insulin to Residents ' 36 and 138. LVN 7 stated she did not wipe the insulin pen tip with alcohol wipe prior to attaching insulin needles and after she administered insulin and removed the insulin needles.</p> <p>LVN 7 stated, I should have wiped the insulin pen tip with alcohol wipe before I attached the needle and after I removed the needle, but I did not. LVN 7 stated not wiping the insulin tip with alcohol wipe was an infection control issue which could cause infection not only to injection site which could lead to more serious health condition.</p> <p>During an interview on 4/4/25 at 1:55 p.m. with Assistant Director of Nursing (ADON) 1, ADON 1 stated the facility practice for insulin pen administration was, .wipe insulin pen tip with alcohol wipe before attaching the needle, administer the insulin then clean insulin tip again with alcohol wipe then put the lid on . ADON 1 stated not cleaning the insulin pen tip is an infection control issue which could lead to serious health issues.</p> <p>During an interview on 4/4/25 at 3:25 p.m. with the Director of Nursing (DON), the DON stated, Licensed Nurses just had their skills check on medication administration recently and I was expecting more from them . The DON stated LVN 7 should have made sure she wiped the insulin pen tip with alcohol wipe before she attached the insulin pen needle and after she removed the insulin pen needle before placing the insulin pen cover. The DON stated it was the expected professional practice when preparing insulin pen. The DON stated it was an infection control issue which could result to serious health issues for residents receiving insulin.</p> <p>During a review of facility ' s policy and procedure (P&P) titled Insulin Administration, dated 9/14, the P&P indicated, .The type of insulin, dosage requirements, strength, and method of administration must be verified before administration . Pens - containing insulin cartridges deliver insulin subcutaneously through a needle . Disinfect the top of the vial with an alcohol wipe .</p> <p>5.During a review of Resident 97 ' s AR, dated 4/3/25, the AR indicated Resident 97 was readmitted to the facility on [DATE] with diagnoses which included respiratory failure (lungs cannot adequately oxygenate the blood), muscle weakness and dementia.</p> <p>During a review of Resident 97 ' s MDS assessment dated [DATE], indicated Resident 97 ' s BIMS assessment score was 13 out of 15 indicating Resident 97 had no cognitive deficit.</p> <p>During a concurrent observation and interview on 4/1/25 at 8:59 a.m. in Resident 97 ' s room, Resident 97 was lying in bed, covered with blanket and watching television. Nebulizer machine (a machine used to change medication from a liquid to a mist so you can inhale it into your lung) was observed on top of bedside table, nebulizer tubing (plastic tubes used from the machine to the resident) were not labeled and were hanging at the back of bedside table. Resident 97 stated he did not remember how long he had been in the facility. Resident 97 stated he did not remember using oxygen or medicine using a nebulizer machine.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 4/1/25 at 12:36 p.m. in Resident 97 ' s room with Assitant Director of Nursing (ADON) 2, ADON 2 stated The tubing is on the floor, it not labeled and not placed in a privacy bag. ADON 2 stated licensed nurses are responsible in making sure nebulizer tubing is changed every seven days, labeled and placed in a privacy bag. ADON 2 stated CNAs are also responsible in making sure nebulizer tubing are not touching the floor and placed in a privacy bag. ADON 2 stated Respiratory Therapist (RT) are also responsible in making sure nebulizer tubing are dated and not touching the floor. ADON 2 stated labeling nebulizer tubing with dates was important to ensure the tubing are not too old for patient use because bacteria could gather in the tubing causing infection when placed in resident nostrils.</p> <p>During an interview on 4/4/25 at 1:57 p.m. with ADON 1, she stated oxygen and nebulizer tubing are changed weekly and labeled with date to ensure tubing are not used over a week. ADON 1 stated bacteria could get in the oxygen and nebulizer tubing causing respiratory infection or other health issues to residents.</p> <p>During an interview on 4/4/25 at 3:18 p.m. with the Director of Nursing (DON), the DON stated the practice was to change oxygen and nebulizer tubing every seven days and labeled with date and name of resident. The DON stated tubing should also be placed in a privacy bag when not in use to prevent resident from getting sick. The DON stated the oxygen and nebulizer tubing when used goes in the nasal cannula and or mouth straight in the lungs which could cause serious health issues if tubing were not replaced and kept in a privacy bag. The DON stated her expectation was for nursing to staff to ensure oxygen and nebulizer tubing labeled and placed in a privacy bag.</p> <p>During a review of facility policy and procedure titled, Respiratory Therapy- Prevention of Infection, dated 11/11, the P&P indicated, .7. Change the oxygen cannulas and tubing every seven (7) days, or as needed . Infection Control Consideration Related to Medication Nebulizers/Continuous Aerosol: .Store the circuit in plastic bag, marked with date and resident ' s name, between uses . Discard the administration set-up every seven (7) days .</p> <p>51593</p> <p>6. During an interview on 4/1/25 at 9:26 a.m. with Resident 253, Resident 253 stated, I have a wound on my bottom. Resident 253 stated, The skin is broken from laying on my bathroom floor at home for 16 hours.</p> <p>During a review of Resident 253 ' s OSR dated 4/4/25, the OSR indicated, Cleanse stage 2 (pressure wounds classified in stages with the least damage stage 1, to wounds which deepen all the way down to the bone, stage 4) to right buttock . The OSR indicated, [Enhanced Barrier Precautions] (EBP - wearing gowns and gloves during certain high-contact care activities for residents who are at risk of having or spreading germs that are hard to treat):. Resident requires enhanced barrier precautions during high contact care activities due to the presence of: chronic wound .Order Date: 4/2/25.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 4/3/25 at 10:54 a.m. with (Infection Preventionist (IP), Resident 253 ' s Admission/ Re-admission Summary Note dated 3/29/25 was reviewed. The Admission/ Re-admission Summary Note indicated Resident 253 had an open wound to the right hip and buttock. The IP stated, For any open areas on the skin, contact the doctor and request an order for EBP. The IP stated, The need for EBP came to my attention when I did a chart review yesterday morning. The IP stated, This resident should have been placed on EBP upon admission. The IP stated, If the admissions nurse doesn ' t catch skin issues, I will follow up. The IP stated, Admissions nurse can put in an order for EBP. The IP stated, There is a potential for cross contamination to other residents and for the resident to be further exposed to other residents and staff.</p> <p>During an interview on 4/4/25 at 3:09 p.m. with the Director of Nursing (DON), the DON stated, Admission assessment includes skin assessment. The DON stated, Whatever if found on the skin assessment, admission nurse will put in the orders and the physician will confirm. The DON stated, Expectation for EBP orders is that if a resident has open wounds, EBP is implemented upon admission. The DON stated, It ' s important to identify residents who need to be on precautions to avoid the spread of any infection. The DON stated, Admission nurse communicates with the IP nurse.</p> <p>During a review of the Registered Nurse (RN) job description, dated February 2024, the RN job description indicated, Admit .residents as required. The RN job description indicated, Participate in the development of written preliminary and comprehensive assessments of the nursing needs of each resident as necessary. The RN job description indicated, Assist the .Infection Control Coordinator in identifying, evaluating, and classifying routine and job-related functions to ensure that tasks in which there is potential exposure to blood/ bodily fluids are properly identified and recorded.</p> <p>During a review of the IP job description, undated, the IP job description indicated, Help review potential resident admissions . The IP job description indicated, Monitor and ensure that all nursing services personnel follow established infection prevention and control practices .when caring for residents.</p> <p>During a review of the facility ' s P&P titled, Enhanced Barrier Precautions dated February 2025, indicated, EBPs are indicated .for residents with wounds .wounds generally include chronic wounds (i.e. pressure ulcers .)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888</p> <p>Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 128) was free from accidents, when Resident 128 was smoking and had ashes fall on her shirt and into her wheelchair.</p> <p>This failure put Resident 128 ' s safety at risk and the ashes had the potential to burn the resident.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/2/25 at 11:40 a.m., with Resident 128, Resident 404, Activities Assistant (AA) 2 and AA 1, outside in the atrium designated smoking area of the facility, Resident 128 smoked two cigarettes and dropped ashes on her shirt and between her legs on her wheelchair. AA 2 was sitting on a bench to the right of the resident conversating with both residents and another Activities Assistant (AA 1). Resident 128 brushed the ashes off her body with her hand that had a cigarette in it. Resident 128 was not wearing a smoking apron and stated she was not offered one prior to smoking.</p> <p>During a review of Resident 128'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 4/4/25, the Admission Record indicated, Resident 128 was admitted to the facility on [DATE] with a diagnosis of congestive heart failure (a person ' s heart can't pump enough blood to meet your body's needs, leading to fluid buildup in the lungs and other parts of the body), polyneuropathy (a condition involving damage or malfunction of many peripheral nerves, which are the nerves outside of the brain and spinal cord, often resulting in symptoms like numbness, tingling, and pain) and muscle weakness.</p> <p>During a review of Resident 128 ' s Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 1/31/25, the MDS assessment indicated Resident 128 ' s Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 14 out of 15 (a score of 13-15 indicates cognitively intact (a person is able to think clearly, remember things well, and make sound decisions, essentially having normal brain function with no significant problems with thinking, learning, or reasoning abilities), 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 128 was cognitively intact.</p> <p>During a review of Resident 128 ' s Smoking Observation/Assessment (SOA), dated 4/2/25 at 12:41 p.m., the SOA indicated, .Smoking Assessment: Resident is a smoker . Type of Smoking Device: Cigarette . Safety: . Smoking adaptive equipment needed: [Checkmark] Smoking Apron . Level of Assistance: . [Checkmark] Supervision Required . IDT Rationale/Concerns: Resident will be supervised to help prevent burns. Offer resident smoking apron .Print name of resident educated: [Resident 128] .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 128 ' s Progress Notes (PN), dated Late Entry 4/2/25, the PN indicated, . Activities staff supervised patient with smoke break at 11:30, activities staff did not observe any ashes falling on patient . Author: [AA 2] .</p> <p>During an interview on 4/3/25 at 1:19 p.m., with AA 2, AA 2 stated she was out there with Resident 128 when she was smoking. AA 2 stated the expectation was to offer a smoking apron (worn over the front of the body to prevent burns in clothing and keep hot ashes from burning the skin) prior to smoking, but her nor AA 1, had not done that. AA 2 stated she was keeping more of an eye now after Resident 128 dropped ashes on herself the previous day. AA 2 stated the resident dropping ashes on herself was an issue because the ashes could be hot and she could have burned her skin or clothes. AA 2 stated Resident 128 ' s safety was put at risk.</p> <p>During an interview on 4/3/25 at 1:41 p.m., with the Activities Director (AD), the AD stated her department oversees smoking activities at the facility. The AD stated the expectation was that residents were observed by activities staff for safe smoking practices, which meant ashes go in the ash tray. The AD stated after the incident Resident 128 was reassessed on 4/2/25 and now offered a smoking apron.</p> <p>During an interview on 4/3/25 at 3:44 p.m., with the Assistant Director of Nursing (ADON), the ADON stated she had been made was aware of Resident 128 dropping ashes on herself while she smoked on 4/2/25. The ADON stated that shouldn ' t happen ever. The ADON stated Resident 128 could burn herself and it was dangerous for the ashes to have fallen on her. The ADON stated a fire could have started because the ashes were not going in an ash tray. The ADON stated Resident 128 should have had a smoking apron on and offered prior to smoking. The ADON stated staff members should have been watching and made sure Resident 128 was smoking safely and they weren ' t. The ADON stated the facilities policy and procedure (P&P) Smoking Policy- Residents was not followed.</p> <p>During an interview on 4/4/25 at 2:06 p.m., with the Director of Nursing (DON), the DON stated Resident 128 should not be dropping ashes on herself and the ashes go in the ash tray. The DON stated the expectation was Resident 128 was free from ashes on her body. The DON stated Resident 128 could have been burned, as the ashes could go through clothes or fall on her skin. The DON stated the ashes could have potentially caused a fire as well. The DON stated the ashes that fell on Resident 128 put her safety at risk. The DON stated Resident 128 should have had a smoking apron offered prior to smoking and she did not. The DON stated the facilities P&P Smoking Policy- Residents was not followed.</p> <p>During a review of the facility ' s P&P titled Smoking Policy- Residents, dated 10/2023, the P&P indicated, . The facility has established and maintains safe resident smoking practices . The staff consults with attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident smoking privileges based on the Safe Smoking Evaluation . The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision . Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member . at all times while smoking .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51593</p> <p>Based on observation and interview, the facility failed to ensure drugs and biologicals used in the facility were labeled and stored in accordance with current accepted professional principles for three of 20 sampled residents (Resident 29, Resident 33 and Resident 79) when:</p> <p>1. Resident 79 ' s brand name eye medication used to relieve dryness or pain in the mouth or throat solution was without an open date (date it was opened and first used) and Resident 29 ' s brand name insulin (medication used to control high blood sugar) was without an open date.</p> <p>This failure had the potential for Resident 79 and Resident 29 to receive expired medication and could have resulted in uncontrolled blood sugar, and eye irritation.</p> <p>2. Resident 33 ' s lorazepam (medication used to control anxiety [a feeling of fear, dread, and uneasiness]) did not have a complete legible medication label.</p> <p>This failure had the potential to result in Resident 33 to be administered an incorrect dose of medication.</p> <p>3. An unattended medication cart was observed in the hallway near nurse ' s station two with a set of keys and a clear, plastic cup containing five unidentified, loose pills sitting on top.</p> <p>This failure had the potential for residents and visitors to ingest unidentified medication of unknown potency which could lead to overdosing, under dosing, allergic reaction, or death.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on [DATE], at 9:56 a.m., with Assistant Director of Nursing (ADON) 1 and the Director of Staff Development (DSD) at nurse ' s station two medication cart, Resident 79 ' s open bottle of [brand name eye medication] was observed without an open date. ADON 1 stated, [brand name eye medication] is not dated with an open date. ADON 1 stated, Medication should have an open date. ADON 1 stated, The medication should be discarded. The DSD stated, Licensed nurses are to check the dates on medications in the carts every shift.</p> <p>During a review of Resident 79 ' s Admission Record (AR) dated [DATE], the AR indicated, Resident 79 was admitted to the facility on [DATE] with a diagnosis of mild protein malnutrition (condition that develops when the body is deprived of vitamins, minerals and other nutrients).</p> <p>During a review of Resident 79 ' s Order Summary Report (OSR) dated [DATE], the OSR indicated, [brand name] Throat Solution (Artificial Saliva) .Order Date: [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on [DATE], at 2:04 p.m., with Licensed Vocational Nurse (LVN) 1 at nurse ' s station two medication cart, Resident 29 ' s [brand name] insulin pen was observed with a label indicating Date Opened . [lined area underneath that was blank] . Discard Date: [DATE]. LVN 1 stated whoever opened the medication should have put the open date. LVN 1 stated, You can only assume the open date based on the discard date. LVN 1 stated, Insulin should have a discard date of 28 days.</p> <p>During a review of Resident 29 ' s AR dated [DATE], the AR indicated, Resident 29 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus (disease that occurs when your blood sugar is too high).</p> <p>During a review of Resident 29 ' s OSR dated [DATE], the OSR indicated, Insulin Glargine . Subcutaneous (layer of tissue beneath the skin ' s upper layers) Solution .Order Date: [DATE].</p> <p>During an interview on [DATE] at 3:09 p.m. with the Director of Nursing (DON), the DON stated, If a medication is opened, it should have an open date and a discard date.</p> <p>During a review of the LVN job description, dated [DATE], the LVN job description indicated, Review medication cards for completeness of information . The LVN job description indicated, Dispose of . drugs as required, and in accordance with established procedures.</p> <p>During a review of the DON job description, dated February 2024, the DON job description indicated, Develop and implement nursing policies and procedures and ensure compliance.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Medication Labeling and Storage, undated, indicated, Multidose vials that have been opened or accessed . are dated and discarded within 28 days .</p> <p>2. During a concurrent observation and interview on [DATE], at 2:32 p.m., with Registered Nurse (RN) 1 at nurse ' s station one medication cart, Resident 33 ' s lorazepam was observed without a legible medication label. RN 1 stated, The label is not legible. RN 1 stated, The label should be legible, and a new medication should be ordered.</p> <p>During a review of Resident 33 ' s AR dated [DATE], the AR indicated, Resident 33 was admitted to the facility on [DATE] with a diagnosis of anxiety.</p> <p>During a review of Resident 33 ' s OSR dated [DATE], the OSR indicated, lorazepam .Order Date: [DATE].</p> <p>During an interview on [DATE] at 3:09 p.m. with the DON, the DON stated medication labels should include, Prescription number, doctor ' s name, date filled, expiration date, name of medication with the order, and resident ' s identifying information. The DON stated, The medication label should be legible. The DON stated, The nurse should call the pharmacy as soon as they notice they can ' t see the label to get a replacement.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the LVN job description, dated [DATE], the LVN job description indicated, Verify the identity of the resident before administering the medication . The LVN job description indicated, Order prescribed medications . as necessary . The LVN job description indicated, Dispose of drugs . as required .</p> <p>During a review of the RN job description, dated February 2024, the RN job description indicated, Ensure that all RNs and LVNs on your shift comply with written procedures for . storage . of medications . The RN job description indicated, Monitor medication passes . to ensure that medications are being administered as ordered .</p> <p>During a review of the DON job description, dated February 2024, the DON job description indicated, Develop and implement nursing policies and procedures and ensure compliance.</p> <p>During a review of the facility ' s P&P titled, Medication Labeling and Storage, undated, indicated, .The medication label includes, at a minimum: medication name, prescribed, dose, strength, expiration date when applicable, resident ' s name, route of administration, and appropriate instructions and precautions .If medication containers have missing, incomplete, improper, or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items.</p> <p>3. During a concurrent observation an interview on [DATE], at 10:52 a.m., with Licensed Vocational Nurse (LVN) 2 in the hallway near nurse ' s station two, there was an unattended medication cart. The medication cart had a set of keys and a clear, plastic cup containing five unidentified, loose pills sitting on top. LVN 2 was observed to be at the nurse ' s station on the phone, with his back turned to the medication cart. LVN 2 stated, Keys and medication should not have been left unattended.</p> <p>During an interview on [DATE] at 2:52 p.m. with LVN 2, LVN 2 stated, I should have taken the keys and medications with me or put it in the cart and locked it while my back was turned. LVN 2 stated, A resident could grab the keys or medications. LVN 2 stated, If a resident takes unknown medications, they could have adverse reactions that could lead to death.</p> <p>During an interview on [DATE] at 3:09 p.m. with the Director of Nurse (DON), the DON stated, Medications and keys should not be left on the cart, that is unacceptable. The DON stated, Anyone can walk away with the keys and cause a security issue. The DON stated, If a resident takes unknown medications, they could have adverse reactions.</p> <p>During a review of the LVN job description, dated [DATE], the LVN job description indicated, .Implement and maintain established nursing objectives and standards .</p> <p>During a review of the DON job description, the DON job description indicated, Develop and implement nursing policies and procedures and ensure compliance. The DON job description indicated, .Responsible for ensuring resident safety .</p> <p>During a review of the facility ' s P&P titled, Medication Labeling and Storage, undated, indicated, . Compartments (including but not limited to . carts .) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others .</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51223</p> <p>Based on observation, interview and record review, the facility failed to provide food prepared in a form designed to meet individual needs for two of nine sampled residents (Resident 20 and Resident 8) when:</p> <p>1. Resident 20 was not served pureed (food that are pudding-like texture that is smooth, blended) banana and had a physician order for a pureed diet.</p> <p>This failure placed residents with difficulty chewing and swallowing and, on a physician, prescribed pureed diet at risk of choking.</p> <p>2. Resident 8 served minced meat for lunch on 4/1/25 instead of regular textured diet as ordered by medical doctor (MD).</p> <p>This failure had the potential for Resident 8 to not eat her food which could result to weight loss.</p> <p>Findings:</p> <p>1. During a concurrent observation and record review on 4/1/25 at 12:15 p.m. with Certified Nurse Assistant (CNA) 4 and Resident 20 in the assisted dining room, Resident 20 ' s lunch meal ticket was reviewed. The meal ticket indicated Resident 20 ' s diet order: pureed, fortified, thin liquids, and standing order: 1 piece banana pureed. Resident 20 ' s meal tray displayed a plate of pureed lasagna, pureed green vegetables, and pureed roll, a cup of pureed cookie and a cup with chunky mashed banana. CNA 4 prepared to provide feeding assistance to Resident 20.</p> <p>During a concurrent observation and interview on 4/1/25 at 12:24 p.m. with CNA 4 and Resident 20 in the assisted dining room, CNA 4 was feeding Resident 20 lunch. CNA 4 stated pureed food is broken up, not whole, and should not have chunks. CNA 4 stated the pureed banana placed on the resident ' s tray had chunks and was not smooth. CNA 4 stated the resident would be at risk of choking if she ate the wrong textured food.</p> <p>During a review of Resident 20 ' s Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 4/4/25, the AR indicated Resident 20 admitted to the facility on [DATE] with diagnoses: Alzheimer ' s Disease (a disease characterized by a progressive decline in mental abilities), unspecified protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), anorexia (an eating disorder that causes people to weigh less than is considered healthy for their age and height, usually by excessive weight loss), and vitamin deficiency (lack of essential vitamins in the body).</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 20 ' s Minimum Data Set assessment tool (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 2/19/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of 99 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment, 99 resident unable to complete the interview), indicating Resident 20 was unable to complete the interview.</p> <p>During an interview on 4/3/25 at 2:50 p.m. with the [NAME] (COOK) in the kitchen, the COOK stated pureed diet foods should have a mashed potato consistency, soft but firm. The COOK stated the pureed food should not have lumps or chunks. The COOK stated banana puree should be completely smooth, liquified, not runny. The COOK stated there would be a potential of choking if a resident was not served the correct pureed texture food.</p> <p>During a concurrent interview and record review on 4/3/25 at 2:58 p.m. with the Certified Dietary Manager (CDM) in the CDM office, Resident 20 ' s diet order was reviewed. The diet order indicated the resident had a pureed diet order. The CDM stated pureed foods should be pudding thick, not hard. The CDM stated pureed food would be prepared in the blender until soft and smooth. The CDM stated she was aware Resident 20 was served chunky mashed bananas on 4/1/25 which was not pureed texture. The CDM stated the resident would be at risk of choking if not served pureed texture food as ordered.</p> <p>During an interview on 4/3/25 at 3:17 p.m. with the Registered Dietician (RD) in the CDM office, the RD stated the role of the RD was to provide clinical oversight of the kitchen and ensure the staff follow therapeutic diets as per the standard of care. The RD stated pureed texture should be smooth, like mashed potato. The RD stated pureed bananas should not be chunky, pureed food should not have chunks. The RD stated the resident on a pureed diet who received chunky mashed banana did not receive the correct textured food. The RD stated if the resident was not served the correct texture, the resident would be at risk of choking.</p> <p>During a concurrent interview and record review on 4/4/25 at 10:11 a.m. with the Director of Nursing (DON) in the DON office, Resident 20 ' s order summary report was reviewed. The diet order indicated the resident had a fortified diet, pureed texture, thin liquid consistency. The DON stated she expects the facility to serve residents with the exact texture diet as ordered by the physician. The DON stated if a resident received an alternate textured food that did not match the diet order there could be a potential risk of choking, difficulty swallowing, inability to chew food, may impact intake that could lead to weight loss if the resident is unable to eat. The DON stated Resident 20 was not served the correct textured diet when chunky mashed banana was served instead of pureed per the physician order.</p> <p>During a review of Job Description: [NAME] (COOK), dated 10/2016, the essential duties indicated the COOK should have the ability to prepare special diets accurately, prepare pureed foods .</p> <p>During a review of Job Description: Dietary Manager (CDM), dated 2/2024, the essential duties indicated the CDM supervise staff in the day-to-day facility operations of assigned areas, direct and participate in food preparation and service of food that is safe .hires, trains .dietary employees .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Willow Creek Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 650 W. Alluvial Clovis, CA 93611	
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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Job Description: Registered Dietician (RD), dated 9/2017, the general purpose indicated the RD assists in coordination of nutrition care services with the Dietary Manager. The essential duties indicated the RD will monitor food control systems such as .preparation methods .to ensure that food is prepared and presented in an acceptable manner . Inspect diet trays for conformance to physician ' s diet orders prior to delivery.</p> <p>During a review of Job Description: Director of Nursing (DON), dated 2/2024, the general purpose indicated the DON is a registered nurse who oversees and supervises the care of all residents. The essential duties indicated the DON .develop and implement nursing policies and procedures and ensure compliance . responsible for ensuring resident safety .works closely with all other departments to ensure excellent overall resident care.</p> <p>During a review of Recipe: Pureed (IDDSI Level 4) Fruit, dated 2024, the directions indicated .3. The finished pureed item should be smooth and free of lumps, hold its shape, while not being firm or sticky .</p> <p>During a review of the facility ' s policy and procedure titled, Therapeutic Diets, dated 2001, the policy stated indicated Therapeutic diets are prescribed by the attending physician to support the resident ' s treatment and plan of care an in accordance with his or her goals and preferences.</p> <p>40641</p> <p>2. During a review of Resident 8 ' s Admission Record, dated 4/3/25, the admission record indicated, Resident 8 was admitted to the facility on [DATE] with diagnoses which included, diabetes (low blood sugar in the blood), weakness and fracture of right femur (break in the long bone).</p> <p>During a review of Resident 8 ' s Order Summary Report, dated 4/3/25, the Order Summary Report, indicated, .Bland diet Regular texture, Thin Liquids consistency .</p> <p>During a concurrent observation and interview on 4/1/25 at 12:15 p.m. in the assisted dining room with Certified Nursing Assistant) (CNA) 6, Resident 8 was served noodles, chopped green beans, whole bread and minced meat with gravy on top. CNA 6 assisted Resident 8 and stated Resident 8 ' s diet was bland, regular texture. CNA 6 stated Resident 8 ' s food is not regular texture, the meat was chopped or minced. CNA 6 stated Resident 8 did not receive the diet texture as ordered by her doctor. CNA 6 stated Resident 8 may not eat her food because it was not the right texture.</p> <p>During a concurrent observation and interview on 4/1/25 at 12:23 p.m. with Licensed Vocational Nurse (LVN) 5 in the assisted dining room, LVN 5 stated Resident 8 ' s food is chopped and not regular texture. LVN 5 stated Resident 8 ' s diet was not followed and could result to Resident 8 losing weight because she may refuse to eat the food.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/4/25 at 9:57 a.m. with Dietary Manager (DM), the DM stated Resident 8 ' s diet order is bland diet, regular texture. The DM stated Resident 8 should have received regular texture with no added spices. The DM reviewed picture of Resident 8 ' s food plate served on 4/1/25 and stated, the meat is not regular texture, it appeared minced or shredded. The DM stated Resident 8 did not received the diet texture as ordered by her doctor which could result in aspiration or choking and even weight loss. The DM stated her expectation was for her staff to check each food plate to make sure residents are served the correct diet before the food cart was pushed out of the kitchen.</p> <p>During an interview on 4/4/25 at 3:15 p.m. with the Director of Nursing (DON), the DON stated her expectation was for the nursing staff to make sure residents are served food that are ordered for them. The DON stated, . Licensed nurses trained to make sure they are checking foods before it was served to residents making sure it was the correct diet and food consistency . The DON stated Resident 8 may not want to eat the food because it was the wrong consistency which could result to weight loss.</p> <p>During a review of facility ' s policy and procedure titled, Therapeutic Diets, dated 2001, the policy and procedure indicated, .Diet will be determined in accordance with the resident ' s informed choices, preferences, treatment goals and wishes . A therapeutic diet must be prescribed by the resident ' s physician . If a mechanically altered diet is ordered, the provider will specify the texture modification .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608</p> <p>Based on observation, interview and record review, the facility failed to store and distribute food in accordance with professional standards for food service safety when:</p> <ol style="list-style-type: none"> 1. The facility had a large clear plastic container with red gelatinous (jelly like substance) without any labels to identify product in container, open date or expiration date was in the kitchen refrigerator. 2. The facility had a large, opened container of mayonnaise without open date or expiration date was in the kitchen refrigerator. 3. The cook did not take the temperature of the tray of cauliflower taken out of the oven during the lunch tray line service. 4. The facility failed to store food in Resident 146's room in a safe manner. <p>These failures had the potential for exposure of microorganisms (a microscopic organism, especially a bacterium, virus, or fungus) that harbor foodborne pathogens (a bacterium, virus, or other microorganism that can cause disease) of residents' food, staff lunch bags and cups resulting in food-borne illness (stomach illness acquired from ingesting contaminated food).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on [DATE] at 7:30 a.m. with the Dietary Manager (DM), in one of two refrigerators, red gelatinous (jelly like substance) without any labels to identify product in container, open date or expiration date was in the kitchen refrigerator. The DM stated, the container should have been labeled identifying what was in the container and when it was opened and when it expired to prevent the residents from being served expired foods which could lead to food born illness. 2. During a concurrent observation and interview on [DATE] at 7:35 a.m. with the DM, in one of two refrigerators, a large, opened container of mayonnaise without open date or expiration date was in the refrigerator. The DM stated the mayonnaise should have had the opened date and the expiration date on the container. 3. During a concurrent observation and interview on [DATE] at 11:30 a.m. with the DM in the kitchen, the cook did take the temperature of the pan of cauliflower during the lunch tray line service. The DM stated, the cook should have checked the temperature of the cauliflower prior to serving to the residents to prevent food born illness from undercooked food. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on [DATE] at 2:41 p.m. with the Registered Dietitian (RD), the facility's policy and procedure (P&P) titled, Food and Storage dated ,d+[DATE] was reviewed. The P&P indicated, . All food .shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption .Date and rotate items; first in first out .discard food past the use-by or expiration date . must be stored in containers that have tight fitting lids . The RD stated all food should be handled following the food and safety codes to help prevent residents from food borne illness.</p> <p>During a review of California Code of Regulations (CCR), Title 22 Security, Division 5 - Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies, Chapter 8.5 - Intermediate Care Facilities/Developmentally Disabled-Habilitative, Article 3 - Services Section 76888 - Food and Nutrition Services-Food Storage dated, [DATE], the CCR indicated, . All readily perishable foods or beverages shall be maintained at temperatures of 7 C (45 F) or below, or at 60 C (140 F) or above . except during necessary periods of preparation and service . Keep hot food hot-at or above 140 F. Place cooked food in chafing dishes, preheated steam tables, warming trays, and/or slow cookers .</p> <p>47888</p> <p>4. During a concurrent observation and interview on [DATE] at 9:20 a.m., with Resident 146 in her room, Resident 146 had an undated, not labeled bowl with cooked, perishable (food that is likely to decay, spoil, or become unsafe to eat if not kept refrigerated or frozen) cabbage and onions on her bedside table. Resident 146 stated the food had been brought in by a family member the day before. Resident 146 stated the cabbage and onions had been by her bedside since her family member brought it in.</p> <p>During a review of Resident 146's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated [DATE], the MDS assessment indicated Resident 146's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 14 out of 15 (a score of ,d+[DATE] indicates cognitively intact (a person is able to think clearly, remember things well, and make sound decisions, essentially having normal brain function with no significant problems with thinking, learning, or reasoning abilities), ,d+[DATE] indicates moderately impaired, and ,d+[DATE] indicates severe impairment). The BIMS assessment indicated Resident 146 was cognitively intact.</p> <p>During a review of Resident 146'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 [DATE], the Admission Record indicated, Resident 146 was admitted to the facility on [DATE] with a diagnosis of generalized muscle weakness (harder to perform everyday tasks and movements), unspecified fracture of the left pubis (break in the pelvis), history of falling and vitamin D deficiency (vitamin D plays is critical for maintaining strong bones, teeth, and muscles).</p> <p>During an interview on [DATE] at 3:45 p.m., with the Assistant Director of Nursing (ADON), the ADON stated perishable or cooked food needed to be thrown away right after consumption. The ADON stated Resident 146 could have gotten sick from bacterial grown due to the food being left out. The ADON stated that would have caused vomiting and diarrhea for the resident. The ADON said Resident 146 could have been hospitalized from this potential sickness.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 4:37 p.m., with the Registered Dietician (RD), the RD stated a cooked or perishable food needed to be consumed within two hours of arriving at the facility. The RD stated that the cabbage and onions could have had bacterial growth because of the length of time being left out not refrigerated. The RD could have gotten gastrointestinal [stomach] distress [problems] that would have resulted in foodborne illness [food poisoning]. The RD stated the facility did not follow the policy and procedure (P&P) Food for Residents from Outside Sources.</p> <p>During an interview on [DATE] at 1:59 p.m., with the Director of Nursing (DON), the DON stated the food on Resident 146's bedside table should not be there. The DON stated the food was old, perishable and could have been spoiled [bad]. The DON stated availability of that food put the resident at risk for gastrointestinal issues and she could have gotten sick. The DON stated from her sickness she ultimately could have required a hospitalization .</p> <p>The DON stated the P&P Food for Residents from Outside Sources was not followed by staff members.</p> <p>During an interview on [DATE] at 3:26 p.m., Certified Nursing Assistant (CNA) 8, CNA 8 stated food should not be at the bedside from the day before. CNA 8 stated Resident 146 could have gotten sick from eating that food because it could have been bad.</p> <p>During a review of facility's P&P titled, Food for Residents from Outside Sources, dated [DATE], the P&P indicated, . staff will monitor the intake of outside foods to support effectiveness of this intervention . prepared food brought in for the resident must be consumed within one hour after removal from temperature control to minimize risk of foodborne illness. Unused food will be disposed of immediately thereafter .</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>41608</p> <p>Based on observation, interview and record review, the facility failed to follow their policy and procedure Food-Related Garbage and Refuse Disposal for one of three outside trash bins, when one of the trash bins was uncovered, and a large amount of plastic and debris was noted on the ground behind the trash bin.</p> <p>This failure had the potential to attracts animals, insects and pests which could lead to infestations, unsanitary conditions, and the spread of disease.</p> <p>Findings:</p> <p>During an observation on 4/4/25 at 2:59 p.m., three of three trash bins were uncovered with paper and plastic bags littering the ground surrounding the bins.</p> <p>During an interview on 4/1/25 at 2:30 p.m. with the Certified Dietary Manager (CDM), the CDM stated, the trash bins should be closed at all times and there should not be trash on the ground or around the trash bins. The CDM stated, the open trash bin and trash on the ground around the trash bins could attract rats and bugs.</p> <p>During an interview on 4/2/25 at 2:45 p.m. with the Registered Dietitian (RD), the RD stated, the trash bins should always be closed, and there should never be trash on the ground to prevent an infestation of pests.</p> <p>During an interview on 7/24/24 at 2:22 p.m. with the Director of Maintenance (DM), the DM stated, the lid of the trash should not have been open and there should never be trash on the ground around the trash bins. The DM stated trash around the trash bin can attract animals and insects which could cause infestation.</p> <p>During a review of the facilities policy and procedure titled, Food Related Garbage and Refuse Disposal dated 10/2017, indicated, .Food Related Garbage and Refuse Disposal indicated . 1. All food waste shall be kept in containers . garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests . outside dumpsters will be kept closed ad free of surrounding litter .</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51223</p> <p>Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident 102) had access to a call light when the tap button (a large square button that can be easily triggered by pressure from a hand, elbow used when residents have limited finger strength) call light was found hanging off the left handrail three inches above the floor.</p> <p>This failure resulted in Resident 102 not being able to directly call for help.</p> <p>Findings:</p> <p>During an observation on 4/1/25 at 8:08 a.m. with Resident 102 in the resident's room, Resident 102 laid asleep in bed. Resident 102's bed had an air mattress, and the head of the bed was elevated while enteral feeding (nutrition delivered using the gut) infused as it hung from the intravenous (IV-within the vein) pole at the right side of the bed. Resident 102 tap button call light hung from the left handrail inches above the floor.</p> <p>During a review of Resident 102's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 4/4/25, the AR indicated Resident 102 admitted to the facility on [DATE] with diagnoses: left hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of one entire side of the body) following a cerebral infarction (when the blood supply to part of the brain is blocked or reduced), dysphagia (difficulty swallowing), generalized muscle weakness, gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status, aphasia (a disorder that makes it difficult to speak) following cerebral infarction.</p> <p>During a review of Resident 102's Minimum Data Set assessment tool (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 3/10/25, the MDS indicated a Brief Interview for Mental Status (BIMS- an assessment of cognitive function) score of blank (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment). Section C1000 indicated Resident 102 had severe cognitive impairment.</p> <p>During a review of Resident 102's Care Plan Report, dated 4/4/25, the Focus, Goal, Interventions indicated the .Focus-Resident at high risk for fall and injuries related to unsteady gait, pain, weakness, history of falling and recent fall, hemiplegia affecting left side . initiated 3/26/23 .Goal-reoccurrence of falls and injuries will be minimized through review date . initiated 3/26/23 with target date 6/29/25 .Interventions- .be sure call light is within reach and encourage to use it for assistance as needed . initiated 3/26/23.</p> <p>During an interview on 4/3/25 at 10:32 a.m. with Certified Nurse Assistant (CNA) 4, CNA 4 stated Resident 102's call light should be within reach due to his left sided weakness so he can call for help. CNA 4 stated a touch pad may be used if a resident is unable to push the call light button if unable to use their fingers. CNA 4 stated Resident 102 would need to tap or push the touch pad to trigger the call light. CNA 4 stated if Resident 102 could not reach his call light, he would not be able to call for help which may make the resident feel upset.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/3/25 at 4:28 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 102's the call light should be within reach and should not be on the floor. LVN 1 stated facility staff should round on Resident 102 to ensure his call light was in reach. LVN 1 stated if the call light not within reach the resident may be at risk of falling if they tried to get out of bed without assistance or at risk of feeling neglected because no one was paying attention to them.</p> <p>During an interview on 4/4/25 at 10:11 a.m. with the Director of Nursing (DON), the DON stated call lights should be within the resident's reach. The DON stated residents with mobility issues or arthritic hands like Resident 102 may be offered an alternate from the push button call light to a tap button. The DON stated staff should ensure Resident 102's call light was in reach at all times. The DON stated the call light that hung from Resident 102's bed would not be accessible to Resident 102 as it would not have been in reach. The DON stated when the call light was not accessible to Resident 102 there would be a potential risk of a delay of care or the resident's needs may not be met.</p> <p>During a review of Job Description: Certified Nursing Assistant (CNA), dated 2/2024, the essential duties indicated .perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors .personnel functions .make daily rounds of your unit/shift to ensure that nursing service personnel are performing their work assignments in accordance with acceptable nursing standards .Ensure that department personnel, residents and visitors follow the department's established policies and procedures at all times.</p> <p>During a review of Job Description: LPN LVN, dated 11/2018, the essential duties indicated .ensure that all nursing personnel assigned to you comply with the written policies and procedures established by this facility .ensure that your assigned CNAs are aware of the resident care plans. Ensure that the CNAs refer to the resident's care plans prior to administering daily care to the resident .</p> <p>During a review of Job Description: Director of Nursing (DON), dated 2/2024, the essential duties indicated the DON is responsible for ensuring resident safety .</p> <p>During a review of the facility's policy and procedure titled, Answering the Call Light, dated 10/2010, the general guidelines indicated . When the resident is in bed .be sure the call light is within easy reach of the resident .</p> <p>During a review of the facility's policy and procedure titled, Resident Rights, dated 12/2016, the policy interpretation and implementation indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .communication with and access to people and services, both inside and outside the facility .</p>		