DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555652	A. BUILDING _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HEALTHCARE CENTER	650 W. ALLUVIAL CLOVIS, CA 93611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED survey for Complaints: CA00832114 and CA00833752. Representing the California Department of Public Health by Federal ID: 38961 RN, HFEN. The ABBREVIATED survey was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for Complaints: CA00832114 and CA00833752.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure licensed nurses administered medications in accordance with professional standards of practice for one of four sampled residents (Resident 1), when Resident 1's night dose of quetiapine (used to treat depression), venlafaxine (used to treat depression and anxiety), and donepezil (treatment of Alzheimer disease) medication was not given as prescribed by the physician and left at the bedside unattended on 3/26/23.	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 5/18/2023

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.

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F 658	Continued From page 1 This failure resulted in Resident 1 not receiving the medications as prescribed by the physician, which had the potential to place Resident 1 at risk for symptoms of depression and had the potential for other facility residents to ingest the medications that were left unattended. Findings: During an observation on 3/27/23, at 9:25 a.m., in room Resident 1's room, a medication cup with five medications sitting on the bedside table, within reach of Resident 1 were observed. During a concurrent observation and interview on 3/27/23, at 9:40 a.m., with Licensed Vocational Nurse (LVN) 1, in Resident 1's room, a medication cup with five medications was observed sitting on the bedside table within reach of Resident 1. LVN 1 stated, these are not morning medications for Resident 1. LVN 1 stated, "medications should not be left sitting on the table " . During an interview on 3/27/23, at 9:50 a.m., with LVN 1, LVN 1 stated, Resident 1 did not receive her medications as ordered by her physician. LVN 1 stated, "This is not good practice for medications to be left bedside unattended " . During an interview on 3/27/23, at 10:05 a.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated, she was assigned to Resident 1 on morning shift. CNA 1 stated, she went into Resident 1's room this morning (3/27/23) and saw a medication cup sitting on the bedside table with medications inside. CNA 1 stated, she reported the medication cup with medications to LVN 1.	F 658		

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F 658	Continued From page 2 During a concurrent observation and interview on 3/27/23 at 10:45 a.m., with Assistant Director of Nursing (ADON) in Resident 1's room, a medication cup with medications inside was observed sitting on the bedside table next to Resident 1. ADON stated, medications are not to be left unattended. ADON stated, Resident 1 did not receive her medications as ordered by the physician. ADON stated, other residents could enter Resident 1's room and ingest the medications. ADON stated, Resident 1 may try to take the medications herself and could had choked on them. During a concurrent interview and record review, on 3/27/23, at 11a.m., with ADON, Resident 1's electronic Medication Administration Record (MAR) was reviewed. Resident 1's electronic MAR indicated, Resident 1 takes quetiapine (used to treat depression), 50 milligrams (mg-unit of measure) two times daily at 9 a.m. and 9 p.m. Resident 1 takes venlafaxine (used to treat depression and anxiety) 75 mg two times daily at 9 a.m. and 8 p.m. and donepezil (treatment of Alzheimer disease) 23 mg one time daily at 9 p.m. Resident 1's electronic MAR indicated, Licensed Vocational Nurse (LVN) 4 administered Resident 1's medication on 3/26/23 at 9:36 p.m. ADON stated, she was able to identify three of the five medications found in the medication cup on Resident 1's bedside. ADON stated, these medications were left on Resident 1's bedside table. During an interview on 3/27/23, at 1:50 p.m., with Director of Staff Development (DSD), DSD stated, I did not provide in-service for medication administration. DSD stated "I was under the assumption the LVN's were knowledgeable about	F 658		

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F 658	Continued From page 3 the standards of practice for medication administration and documentation when they come to us. " During an interview with on 3/27/23, at 3:30 p.m., with ADON, ADON stated she has been unable to identify the two of the five medications left in Resident 1's medication cup. ADON stated, if Resident 1 was not prescribed two of the five medications, it can cause harm if medication was taken by Resident 1. During an interview on 3/28/23, at 9 a.m., with LVN 4, LVN 4 stated, she worked at the facility on 3/26/23 from 3 p.m. until 7 a.m. on 3/27/23. LVN 4 stated "I have no explanation as to why I left the medications at [Resident 1's] bedside then documented in the MAR that I administered the medication. " LVN 4 stated, it is not good practice to leave medications by the bedside. LVN 4 stated, "I should of documented, that I did not give the medication. " LVN 4 stated, if another resident who was confused wandered into Resident 1's room and saw the medication and taken them, it could cause them great harm. LVN 4 stated, "I put [Resident 1] at risk by not administering her medications. " LVN 4 stated, "I am responsible for the medications I pass. " LVN 4 stated, "I documented that I gave [Resident 1] her medications when I did not administer them, I was falsifying the records. " LVN 4 stated, she did not receive in-service from the facility for medication administration or care of residents. LVN 4 stated, "What I did, endangered residents in this facility. " During an interview on 3/28/23 at 10 a.m., with Administrator (ADM), ADM stated, LVN 4 did not follow nursing protocols or the standards of	F 658		

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F 658	Continued From page 4	F 658		

practice. ADM stated, the care of the residents is the facility's responsibility, and we did not meet the needs of Resident 1. ADM stated, we are currently trying find out what the two unidentified medications in the cup are and whom they belong to. ADM stated, this is a serious situation and had the potential for a high-risk health and safety concern for the residents at the facility.

During a review of the facility document titled, "Job Description: Director of Staff Development. " Dated 7/2018 was reviewed " ...responsible to plan and implement orientation, job skills training ...In-Service education ...ensure that the highest degree of quality care is maintained at all times ... "

During a review of the facility document titled, "Licensed Practical Nurse/Licensed Vocational Nurse JOB DESCRIPTION" dated11/2018 was reviewed, the "Licensed Practical Nurse/Licensed Vocational Nurse JOB DESCRIPTION " indicated, " ...Prepare and administer medications as ordered by the physician ...Verify the identity of the resident before administering the medication ...Ensure that prescribed medication for one resident is not administered to another ...Must be knowledgeable of nursing and medical practices and procedures as well as laws, regulations, and guidelines that pertain to the nursing home ...Ensure accurate documentation of all medical records and reporting forms ... "

During a review of the facility's policy and procedure titled "Administering Medications " dated 4/2019, indicated " ...Medications are administered in a safe and timely manner, and as prescribed ... Only licensed persons permitted to administer and document the administration of

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F 658	Continued From page 5 medications ...Medications are administered in accordance with prescriber orders, including required time frames ...The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication before administering the next ones ... " During a review of Professional Reference from https://www.cms.gov, titled, "Nursing Home Staff Competency Assessment for Registered Nurse and Licensed Vocational Nurse", undated, indicated, " ... Competency Assessments are an important tool ... which leads to higher quality of care and life for residents ... Medication Administration ... has a basic understanding of medications and related diagnoses ... prescription medications ... properly delivers medication as directed by the medical practitioner's orders ... Follows safe medication administration practices, such as adhering to accepted processes around medication use and documentation ..." During a professional reference review of "Lippincott Manual of Nursing Practice" 10th Edition, dated 2014, indicated, " ...Standards of Practice ...General Principles ...Common Departures from the Standards of Nursing Care ...Legal claims most commonly made against professional nurses include the following departures from appropriate care...failure to...follow physician orders ...adhere to facility policy or procedure ...administer medications as ordered ..."	F 658		

The following represents the plan of correction for the alleged deficiencies cited during an Abbreviated Survey for complaints that was conducted on March 27, 2023 thru March 28, 2023 The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the nursing center, its owners, operators, employees or agents or an agreement with any of the facts set forth in the Statement of Deficiencies. The plan of correction is completed in good faith and in keeping with the facility's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as required by law.

F 658 – Services Provided Meet Professional Standard

How corrective action(s) will be accomplished for residents found to have been affected by the deficient practice?

Resident 1 was monitored by the nursing staff for changes or increased in behaviors related to the miss dose every shift x 72 hours from 3/28/2023 – 3/31/2023. There were no behaviors noted .

Resident 1 was assessed by her physician on 3/28/2023 for side effects of not receiving her prescribed medication on 3/26/2023 . There were no untoward side effects related to missed dose.

Resident 1 was discharged from the facility on 3/31/2023

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken ?

All residents have the potential to be affected by the deficient practice

Department Head room rounds were completed on 3/28/2023 that included checking medications left @ bedside. There were no other residents affected by the deficient practice

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

During the change of shift rounds , the nurses will check for medications left at bedside and initial/ sign a shift endorsement form labeled (Shift Endorsement for Medications left at bedside) Any identified issue will be corrected immediately and reported to the Director of Nursing (DON) / Assistant Director of Nursing (ADON) for follow up

An Inservice for the Licensed Nurses were provided by the Director of Staff Development (DSD) on 3/28/2023 regarding not leaving medications at bedside, checking for medications at bedside during the change of shift rounds and completing the form.

Department Head daily room rounds which include bedside inspection for medications will be continued, any identified issue will be reported to the nurse on duty for immediate correction then during the Daily Stand up Meeting for DON/ADON follow up.

How the facility plans to monitor its performance to make sure that solutions are lasting

The Director of Nursing (DON)or designee (ADON , Nursing Supervisor) will do random checks on the completion of the shift endorsement form for medications left at bedside weekly x 8 then monthly .Any identified issues will be corrected immediately

Trends will be reported to the monthly QA monthly x 2 months for further review and action plan.

Dates Corrective Action will be completed

5/20/2023