Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S 000	Opening Comments Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Boarding Homes, Chapter 8, effective 12/11/1998. Rules and Regulations for Licensure of Boarding Homes, Chapter 7, effective 12/10/1998. A complaint survey was conducted by Healthcare Licensing and Surveys on 7/1/21. The survey was prompted by complaint intakes WY LIC-24-047, LIC-24-061, LIC-24-064, and LIC-24-071.	S 000		
S4003	Ch 8 Sec 5 (d) Management (d) Admission, Transfer, and Discharge (i) The written admission policy shall include restrictions to admission to the boarding home. (ii) Residents shall not be accepted, nor retained, if: (A) Their condition indicates the need for assisted or skilled nursing care; (B) They have reportable communicable diseases or infectious conditions; (C) They have physical limitations preventing ambulation. Persons requiring wheelchairs or walkers shall be able to exit the building without staff assistance. (D) They require assistance in transferring to and from a wheelchair; (E) They have mental defects which interfere with their ability to understand and follow	S4003		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4003	Continued From page 1 instructions relating to rules of the boarding home; (F) They require intravenous therapy; (G) They are incapable of self-administration of medications; or (H) They are wanderers, or have destructive, aggressive or violent behavior toward shelf or others. (iii) Each resident shall designate a personal physician and dentist to be called in case of an emergency. The boarding home shall make necessary arrangements to secure the services of a licensed physician if the resident's own physician is not available. (iv) In the event of illness or injury of a resident, the resident's personal physician and the resident's designated representative shall be called. This State Rule and Regulation is not met as evidenced by: Based on observation, resident record review, and staff interview, the facility failed to ensure residents were appropriate to be retained at the facility for 2 of 10 sample residents (#4, #10). The findings were: 1. Observation on 6/19/24 at 2:34 PM showed staff member #1 assisted resident #10 into his/her room, where incontinence products were observed on the bed, and assisted the resident to stand and transfer to bed by placing her arms under the resident's arms. The staff member physically lifted the resident to a standing	S4003		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4003	Continued From page 2 position, then assisted the resident to pivot and sit on the bed. Interview with staff member #1 on 6/19/24 at 2:37 PM revealed the resident needed physical assistance with transfers, was incontinent of urine and bowel, and had physically violent behaviors. Further interview revealed the staff member provided transfers, incontinence care, and bathing to residents at the facility. 2. Observation on 6/19/24 at 3:20 PM showed a home health nurse notified staff of a decline for resident #4. The home health nurse said the facility staff would need to "get [resident #4] up from now on." Interview with the home health nurse on 6/19/25 at 3:35 PM revealed she assisted some residents at the facility with medications; however, the facility staff was responsible for incontinence care and transfers. 3. Interview with staff member #1 on 6/19/24 at 3:40 PM revealed all residents at the facility "except 2" required physical assistance with bathing and resident #10 and resident #4 required incontinence care and transfers. Further interview revealed home health notified her resident #4 would now require 2 staff members for all transfers. 4. Observation on 6/19/24 at 4:59 PM showed staff member #2 assisted resident #10 to stand from the bed with a walker and directed the resident into the bathroom. The staff member assisted the resident to sit on the toilet and remained with the resident to provide personal hygiene. 5. Observation on 6/19/24 at 5:15 PM showed staff member #2 attempted to provide verbal cues to resident #10 in attempt to get the resident to eat.	S4003		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4003	Continued From page 3 6. Interview with staff member #2 on 6/19/24 at 5:25 PM revealed she normally provided incontinence care, which included physically cleansing resident #10 while s/he was still in bed. 7. Observation on 6/20/24 at 9:33 AM showed staff member #3 was seated at the table next to resident #10, who was in a wheelchair. The staff member was physically assisting the resident to eat by providing the resident bites of food. The resident continued to ask the staff member who she was. Continued observation showed the resident refused to eat and placed a blanket over his/her head. 8. Observation on 6/20/24 at 10:36 AM showed resident #10 requested to lay down and verbalized complaints of back pain. Staff member #3 said the resident needed to stay up. 9. Observation on 6/20/24 at 10:39 AM showed staff member #3 and a visitor assisted resident #10 to stand and transfer into a recliner in the living room area. 10. Review of a progress note for resident #10 dated "6/18" and timed "7-3" showed "Brief changed 9 am w/ [with] assistance. Ate 1/2 a bannana [sic] [and] 1/2 [his/her] shake. Brief changed at 2 PM w/ assistance. Resident asked [at] 11 AM and 1 PM but did not need to go." 11. Review of the "Activities of Daily Living" sheets for resident #10 showed 2 documents dated "June 2024." The sheets had the same areas for documentation; however, one was completed through 6/18/24 with no documentation on 6/1, 6/2, 6/8, 6/9, 6/14, 6/15, and 6/16 and the other was completed for all	S4003		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4003	Continued From page 4 days in the month including "6/31." Attempts to interview the manager were made via telephone on 7/12/24, and 7/18/24 and messages were left; however, no return calls were received. Further review showed staff performed bathing, dressing, oral care, nail care, toileting, and brief changes for the resident. 12. Interview with the facility manager on 6/20/24 at 11:30 AM revealed facility staff were able to provide assistance with toileting or standing and could take the medication containers to residents for assistance; however, she revealed staff should not perform medication administration, resident transfers, perineal care, or bathing. Further interview revealed resident #10 and #4 were being evaluated for appropriateness at the facility.	S4003		
S4005	Ch 8 Sec 5 (f) Management (f) Resident Records and Reports. (i) Resident's records shall be current, organized and maintained in individual folders which shall be available on the premises. Resident records shall be made available to the resident and the Long Term Care Ombudsman, Program Division and the Licensing Division upon request and include the following: (A) The resident's history and physical and the current physician's statement or certificate of resident's health and suitable placement. The physician's statement or certificate of resident's health shall be updated annually. (B) Individual admission form shall	S4005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4005	Continued From page 5 contain, but not necessarily be limited to, the following information: (I) Full name of resident and former address; (II) Date of admission; (III) If applicable, name, home address, telephone number of interested family member, designated representative, power of attorney, or guardian; (IV) Medicare number or other medical insurance; and (V) Sex, race, date of birth, social security number, and former occupation. (ii) Written records of all accidents, injuries and illnesses, and subsequent treatment occurring after admission. (iii) The boarding home shall notify the Program Division within Seventy-Two (72) hours of an unusual death, serious injury or accident, fire or other emergency situations. All such occurrences shall be documented. (iv) A written account of all personal possessions and funds deposited with the boarding home. (v) A signed copy of the resident's rights. (vi) The resident shall be assured of confidential treatment of all information in his/her records, and his/her written consent (or consent of family or guardian) shall be required for the	S4005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4005	Continued From page 6 release of information to persons not otherwise authorized to receive it. (vii) All resident's records shall be retained for a minimum of six (6) years after the resident has left the home and may be disposed of after that time, unless litigation is pending. (viii) All records shall be protected from damage by fire, water and other hazards. This State Rule and Regulation is not met as evidenced by: Based on resident record review and staff interview, the facility failed to ensure current medical records were maintained for 8 of 10 sample residents (#2, #3, #4, #5, #6, #7, #9, #10). The findings were: 1. Review of the "Activities of Daily Living" sheets for resident #10 showed 2 documents dated "June 2024." The sheets had the same areas for documentation; however, one was completed through 6/18/24 with no documentation on 6/1, 6/2, 6/8, 6/9, 6/14, 6/15, and 6/16 and the other was completed for all days in the month including "6/31." Attempts to interview the manager were made via telephone on 7/12/24, and 7/18/24 and messages were left; however, no return calls were received. 2. Review of the resident record on 6/20/24 at 11:29 AM showed resident #10 did not have a history and physical in the record. Interview with the facility manager at that time revealed she thought the family had the history and physical so they could schedule a new physician's visit for an updated history and physical. 3. Review of the resident record on 6/20/24 at	S4005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4005	Continued From page 7 11:02 AM showed resident #2 did not have a history and physical in the record. Interview with the facility manager at that time confirmed there was no record of a history and physical for the resident. 4. Review of the resident record on 6/20/24 at 11:06 AM showed resident #3 did not have a history and physical in the record or an incident report for hospitalization on 5/15/24. Interview with the facility manager at that time confirmed there was no record of a history and physical for the resident. 5. Review of the resident record on 6/20/24 at 11:10 AM showed resident #4 did not have a history and physical in the record. Interview with the facility manager at that time confirmed there was no record of a history and physical for the resident. 6. Review of the resident record on 6/20/24 at 11:14 AM showed resident #5 did not have a history and physical in the record. Interview with the facility manager at that time confirmed there was no record of a history and physical for the resident. 7. Review of the resident record on 6/20/24 at 11:18 AM showed resident #6 did not have a history and physical in the record. Interview with the facility manager at that time confirmed there was no record of a history and physical for the resident. 8. Review of the resident record on 6/20/24 at 11:21 AM showed resident #7 did not have a history and physical or in the record. Interview with the facility manager at that time confirmed there was no record of a history and physical for	S4005		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4005	Continued From page 8 the resident. 9. Review of the resident record on 6/20/24 at 11:25 AM showed resident #9 did not have a history and physical in the record. Interview with the facility manager at that time confirmed there was no record of a history and physical for the resident. 10. The manager was not onsite on 6/19/24 from 2 PM to 5:25 PM and on 6/20/24 from 9:33 AM to 10:46 AM and documents were not accessible. 11. Additional documents were requested via email on 6/20/24, 6/25/24, 6/28/24, and 7/1/24; however, the information was not provided. Interview with the facility manager via telephone on 7/2/24 at 3:17 PM revealed she would have the President, Elder Care, Inc. send additional information. Interview with the facility manager on 7/9/24 at 11:17 AM revealed she sent the information to the President, Elder Care, Inc. and he would send them to the state licensing agency on that day; however, no documentation was received. In addition, attempts to call the manager were made on 6/25/24, 6/28/24, 7/12/24, and 7/18/24 and messages were left for the manager; however, no return calls were received.	S4005		
S4018	Ch 8 Sec 8 (a)(xi) Residents' Rights (a) Every resident in a boarding home shall have the right to: (xi) Receive adequate and appropriate care within the capacity of the boarding home.	S4018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4018	Continued From page 9 This State Rule and Regulation is not met as evidenced by: Based on observation, resident record review, and staff interview, the facility failed to ensure residents received appropriate care within the capacity of the facility for 2 of 10 sample residents (#4, #10). The findings were: 1. Observation on 6/19/24 at 2:34 PM showed staff member #1 assisted resident #10 into his/her room, where incontinence products were observed on the bed, and assisted the resident to stand and transfer to bed by placing her arms under the resident's arms. The staff member physically lifted the resident to a standing position, then assisted the resident to pivot and sit on the bed. Interview with staff member #1 on 6/19/24 at 2:37 PM revealed the resident needed physical assistance with transfers, was incontinent of urine and bowel, and had physically violent behaviors. Further interview revealed the staff member provided transfers, incontinence care, and bathing to residents at the facility. 2. Observation on 6/19/24 at 3:20 PM showed a home health nurse notified staff of a decline for resident #4. The home health nurse said the facility staff would need to "get [resident #4] up from now on." Interview with the home health nurse on 6/19/25 at 3:35 PM revealed she assisted some residents at the facility with medications; however, the facility staff was responsible for incontinence care and transfers. 3. Interview with staff member #1 on 6/19/24 at 3:40 PM revealed all residents at the facility "except 2" required physical assistance with bathing and resident #10 and resident #4 required incontinence care and transfers. Further interview revealed home health notified her	S4018		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4018	Continued From page 10 resident #4 would now require 2 staff members for all transfers. 4. Observation on 6/19/24 at 4:59 PM showed staff member #2 assisted resident #10 to stand from the bed with a walker and directed the resident into the bathroom. The staff member assisted the resident to sit on the toilet and remained with the resident to provide personal hygiene. 5. Observation on 6/19/24 at 5:15 PM showed staff member #2 attempted to provide verbal cues to resident #10 in attempt to get the resident to eat. 6. Interview with staff member #2 on 6/19/24 at 5:25 PM revealed normally she provided incontinence care, which included physically cleansing resident #10 while s/he was still in bed. 7. Observation on 6/20/24 at 9:33 AM showed staff member #3 was seated at the table next to resident #10, who was in a wheelchair. The staff member was physically assisting the resident to eat by providing the resident bites of food. The resident continued to ask the staff member who she was. Continued observation showed the resident refused to eat and placed a blanket over his/her head. 8. Observation on 6/20/24 at 10:36 AM showed resident #10 requested to lay down and verbalized complaints of back pain. Staff member #3 said the resident need to stay up. 9. Observation on 6/20/24 at 10:39 AM showed staff member #3 and a visitor assisted resident #10 to stand and transfer into a recliner in the living room area.	S4018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4018	Continued From page 11 10. Review of a progress note for resident #10 dated "6/18" and timed "7-3" showed "Brief changed 9 am w/ [with] assistance. Ate 1/2 a bannana [sic] [and] 1/2 [his/her] shake. Brief changed at 2 PM w/ assistance. Resident asked [at] 11 AM and 1 PM but did not need to go." 11. Review of the "Activities of Daily Living" sheets for resident #10 showed 2 documents dated "June 2024." The sheets had the same areas for documentation; however, one was completed through 6/18/24 with no documentation on 6/1, 6/2, 6/8, 6/9, 6/14, 6/15, and 6/16 and the other was completed for all days in the month including "6/31." Attempts to interview the manager were made via telephone on 7/12/24, and 7/18/24 and messages were left; however, no return calls were received. Further review showed staff performed bathing, dressing, oral care, nail care, toileting, and brief changes for the resident. 12. Interview with the facility manager on 6/20/24 at 11:30 AM revealed facility staff were able to provide assistance with toileting or standing and could take the medication containers to residents for assistance; however, she revealed staff should not perform medication administration, resident transfers, perineal care, or bathing. She confirmed the removal of medications and placement in the little red cups was not appropriate. Further interview revealed resident #10 and #4 were being evaluated for appropriateness at the facility.	S4018		
S4026	Ch 8 Sec 10 (b) Food Service and Nutrition (b) Individuals with food preparation	S4026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4026	Continued From page 12 responsibilities shall be in good health and shall practice safe food handling techniques in accordance with the current edition of Food Code published by the U.S. Public Health Service, Food and Drug Administration. (i) Such food handling techniques include preparing, holding, and storing food at safe temperatures. (ii) Reheating potentially hazardous leftover foods shall meet HACCP (Hazard Analysis Critical Control Point) temperature guidelines for safety. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and food code review, the facility failed to ensure safe food handling techniques during 1 of 1 meal preparation observations. The census was 10. The findings were: 1. Observation on 6/19/24 at 4:50 PM showed staff member #2 was plating food for all residents. No hair restraint was worn at that time. 2. Interview with the facility manager on 6/20/24 at 11:30 AM confirmed staff hair should be restrained during meal preparation and service. 3. According to Food Code 22, U.S. Public Health Service: 2-402 Hair Restraint 2-402.11 "Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from FDA Food Code 2022 Chapter 2. Management and Personnel Chapter	S4026		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4026	Continued From page 13 2 - 22 contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES."	S4026		
S4045	Ch 8 Sec 12 (a) Medications (a) Drugs shall be self-administered. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure self-administration of medications for 10 of 10 sample residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10). The findings were: 1. 4. Observation on 6/19/24 at 4:36 PM showed staff member #1 removed the medication containers from the storage cabinet. The staff member opened individual medication containers and placed the medications in a small red cup labeled with a resident's name. All medications were prepared and then stored back in the storage cabinet. Interview with the staff member at that time revealed she put the medications in cups because that was how she was taught. She was unable to say if residents were able to take medications independently and revealed when she worked the other shift it was "easier" if the day shift set up the 8 PM medications. Further interview revealed she prepared the medications for all residents in the facility. 2. Observation on 6/19/24 at 5:15 PM showed staff member #2 provided medications in small red cups, prepared by staff member #1, to each resident in the facility. Interview with staff member #2 on 6/19/24 at 5:25 PM revealed she was not	S4045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4045	Continued From page 14 sure what medications were prepared in the small red cups. 3. Interview with the facility manager on 6/20/24 at 11:30 AM revealed facility staff were able to provide assistance with medications and could take the medication containers to residents for assistance; however, she revealed staff should not perform medication administration. She confirmed the removal of medications and placement in the little red cups was not appropriate.	S4045		
S4062	Ch 7 Sec 5 (f) Licensure (f) Posting of License. (i) The current license issued by the Licensing Division shall be displayed in a public area within the Boarding Home. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the posting of a current facility license in a public area. The census was 10. The findings were: 1. Observation between 6/19/24 at 2 PM through 6/20/24 at 10:46 AM showed the facility's license was in a frame laying on the piano bench near the front entrance. Further observation showed the license was not current and had expiration date of "June 2023." 2. Interview with the facility manager on 6/20/24 at 11:30 AM confirmed the license in the frame was expired. Further interview revealed the current license was not printed or posted until	S4062		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH004	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF GILLETTE	2300 HARDER DRIVE GILLETTE, WY 82718

(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) COMPLETE DATE
S4062	Continued From page 15 earlier that day.	S4062		

Willow Creek ElderCare Communities

Gillette

Survey Date: July 19, 2024

Corporate office Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by Willow Creek Community, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. The POC shall only be a required effort to respond to the unsubstantiated and subjectively biased allegations alleged in the survey document. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by Willow Creek Community of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Willow Gillette-7/19/24

Deficiency: Admission, Transfer, and Discharge Policies (S4003)

- Regulatory Requirement: Residents shall not be accepted or retained if they require assistance in transferring or have mental defects that interfere with their ability to understand and follow the rules of the boarding home.

Corrective Action:

- Immediate Action: The facility will immediately evaluate the current residents (#4 and #10) for their appropriateness to remain in the facility. Any residents not meeting the admission criteria, such as needing assistance with transfers or incontinence care, will be appropriately relocated to a facility that can meet their care needs.
- Staff Training: All staff will receive retraining on the facility's admission policies, particularly regarding accepting and retaining residents requiring skilled care beyond the capacity of the facility. Staff will be trained to identify residents whose care needs have escalated and how to follow proper procedures for initiating transfers or discharges.
- Monitoring: The facility will implement a quarterly review of resident care needs to ensure that no residents are retained if they exceed the care capabilities of the facility.

Completion Date: 14 days from the issuance of the plan. DOC- 10/30/24

Deficiency: Resident Records and Reports (S4005)

- Regulatory Requirement: Resident records must be current, organized, and maintained on the premises. Records must include the resident's history, physicals, and other pertinent documentation.

Willow Creek ElderCare Communities

Corrective Action:

- Immediate Action: Resident records for all identified residents (#2, #3, #4, #5, #6, #7, #9, and #10) will be updated to include current history and physical reports. The facility will ensure that these records are completed and available for review within 72 hours of admission.
- Monitoring and Ongoing Compliance: A bi-weekly audit of all resident files will be implemented to ensure that records are up-to-date. The facility manager or designee will be responsible for ensuring all records, including physician statements, are reviewed and updated annually.

Completion Date: 14 days from the issuance of the plan. - DOC - 10/30/24

Deficiency: Residents' Rights and Care (S4018)

- Regulatory Requirement: Residents must receive adequate and appropriate care within the capacity of the boarding home. The facility failed to provide appropriate care for residents #4 and #10, who required more assistance than the facility could provide.

Corrective Action:

- Immediate Action: The facility will assess the care needs of residents #4 and #10 and determine whether they can continue receiving care within the boarding home. For residents requiring skilled care or assistance with transfers, appropriate placement in a higher level of care facility will be arranged.
- Staff Training: Staff will be retrained to identify and report residents who exhibit care needs beyond the scope of the facility. All staff will be trained on proper procedures for handling transfer requests for residents who need advanced care.
- Facility will perform monitoring and report results to QA.

Completion Date: 10 days from the issuance of the plan. DOC - 10/26/24

Deficiency: Food Service and Nutrition (S4026)

- Regulatory Requirement: Safe food handling techniques must be practiced in accordance with the U.S. Public Health Service Food Code. Staff failed to wear hair restraints while preparing food.

Corrective Action:

- Immediate Action: The facility will provide hair restraints to all kitchen staff and ensure compliance with safe food handling practices. The facility will reinforce food safety protocols during meal preparation.
- Staff Training: All kitchen staff will undergo mandatory training on the U.S. Public Health Service Food Code, including the use of hair restraints and maintaining safe food preparation environments.
- Monitoring: A designated staff member will perform daily checks during meal preparations to ensure compliance with food safety guidelines. Any violations will be addressed immediately.

Willow Creek
ElderCare Communities

Completion Date: 7 days from the issuance of the plan. DOC - 10/23/24

Deficiency: Medication Administration (S4045)

- Regulatory Requirement: Residents must self-administer medications. Facility staff inappropriately prepared and administered medications to all residents in red cups, violating self-administration rules.

Corrective Action:

- Immediate Action: The practice of staff pre-preparing medications for residents will cease immediately. Medications will be provided directly to residents in their original containers to support self-administration.
- Staff Training: Staff will receive additional training on the rules surrounding medication self-administration and will be reminded that they are only to assist with medications as per the facility's policy and state regulations.
- Monitoring: The facility will implement random audits of medication administration to ensure compliance. Any staff found violating these procedures will undergo corrective action.

Completion Date: 7 days from the issuance of the plan. DOC - 10/23/24

Deficiency: Facility License Posting (S4062)

- Regulatory Requirement: The current facility license must be posted in a public area. The facility's license was expired and not posted appropriately.

Corrective Action:

- Immediate Action: The current facility license will be printed and posted in a prominent location immediately. Any future renewals will be printed and posted as soon as they are received.
- Monitoring: The facility manager will be responsible for ensuring that the license is renewed on time and remains posted. A calendar reminder will be set for the manager to renew the license before expiration.

Completion Date: 5 days from the issuance of the plan. DOC - 10/21/24

Monitoring and Ongoing Compliance:

- Weekly Audits: For the first month, the facility will conduct weekly audits to ensure that all corrective actions are in place and functioning correctly. These audits will focus on resident care, medication administration, and food safety practices.

- Monthly QAPI Meetings: Results from the audits will be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings. This will allow for ongoing monitoring and adjustments to ensure continued compliance with state regulations.

Responsible Party: The Director of Nursing (DON) or designee will oversee all corrective actions, monitoring, and ongoing compliance efforts.

Completion Date: The facility aims to complete all corrective actions and achieve full compliance within 30 days of the issuance of the plan.

Willow Gillette-5/23/24

Deficiency: Emergency Lighting (S8012)

- Regulatory Requirement: The facility must maintain emergency lighting in accordance with NFPA 101, Life Safety Code. Failure to maintain emergency lighting could result in injury or death during an emergency.

Corrective Action:

- Immediate Action: The facility will immediately repair or replace the faulty emergency light near the deep freeze storage closet.
- Preventative Action: A routine maintenance schedule will be implemented to test emergency lighting monthly. Maintenance staff will receive training on testing procedures and documentation requirements.
- Monitoring: The facility caretaker will be responsible for conducting monthly tests of all emergency lighting and keeping detailed records. The administrator will review these records quarterly during safety meetings to ensure compliance.

Completion Date: 7 days from the issuance of the plan.

Deficiency: Fire Alarm Systems (S8017)

- Regulatory Requirement: Fire alarm systems must be maintained and tested in accordance with NFPA 101 and NFPA 72. Failure to maintain fire alarms could delay detection of a fire, leading to injury or death.

Corrective Action:

- Immediate Action: A licensed contractor will be hired to test and inspect the fire alarm system, and any deficiencies will be addressed promptly.

- Preventative Action: The facility will establish a contract with a licensed fire alarm inspection company to perform semi-annual inspections. Documentation of these inspections will be maintained onsite and reviewed quarterly by the administrator.

- Monitoring: The facility caretaker will be responsible for scheduling and documenting all fire alarm tests. Audits of these records will be conducted by the administrator to ensure compliance.

Completion Date: 14 days from the issuance of the plan.

Deficiency: Fire Sprinkler Systems (S8018)

- Regulatory Requirement: Fire sprinkler systems must be inspected, tested, and maintained in accordance with NFPA 101, NFPA 13, and NFPA 25. Failure to maintain sprinkler systems could result in injury or death during a fire.

Corrective Action:

- Immediate Action: A licensed contractor will inspect and test the fire sprinkler system to ensure it is functioning correctly.
- Preventative Action: The facility will establish a quarterly and annual inspection schedule with a certified fire sprinkler system contractor. Documentation of these inspections will be maintained onsite and reviewed during quarterly safety meetings.
- Monitoring: The facility caretaker will be responsible for ensuring that inspections are completed on time and that proper records are maintained.

Completion Date: 14 days from the issuance of the plan.

Deficiency: Portable Fire Extinguishers (S8019)

- Regulatory Requirement: Portable fire extinguishers must be inspected and maintained monthly and annually in accordance with NFPA 101. Failure to maintain fire extinguishers could lead to equipment failure during a fire, causing injury or death.

Corrective Action:

- Immediate Action: All portable fire extinguishers will be inspected, and any necessary maintenance will be completed. Monthly and annual inspections will be conducted moving forward.

- Preventative Action: The facility will contract with a licensed fire safety company to conduct annual fire extinguisher maintenance and ensure compliance with NFPA guidelines. Monthly in-house inspections will also be documented.
- Monitoring: The caretaker will conduct monthly inspections of all fire extinguishers and keep detailed logs. The administrator will audit these logs quarterly.

Completion Date: 10 days from the issuance of the plan.

Deficiency: Emergency Plan and Drills (S8025, S8027)

- Regulatory Requirement: The facility must have a documented emergency preparedness plan and conduct regular emergency egress and relocation drills in accordance with NFPA 101.

Corrective Action:

- Immediate Action: The facility will draft and implement an emergency preparedness plan and a fire disaster procedure. The plan will include detailed evacuation routes and protocols.
- Preventative Action: Emergency egress and relocation drills will be conducted quarterly, with one drill per shift, including two night drills annually. A designated staff member will be responsible for documenting the drills and ensuring staff participation.
- Monitoring: The administrator will review the drill documentation during monthly safety meetings to ensure drills are conducted regularly and that staff are familiar with emergency procedures.

Completion Date: 14 days from the issuance of the plan.

Deficiency: Floor Plan, Smoking Policy, and Fire Watch (S8999)

- Regulatory Requirement: The facility must have a documented floor plan, smoking policy, and fire watch plan.

Corrective Action:

- Immediate Action: The facility will develop and post a current floor plan, smoking policy, and fire watch plan in a common area.
- Preventative Action: These documents will be reviewed annually to ensure they remain up to date and comply with state and federal regulations.
- Monitoring: The administrator will be responsible for ensuring that these documents are posted and maintained, and will review them quarterly during safety meetings.

Completion Date: 7 days from the issuance of the plan.

Willow Creek
ElderCare Communities

Monitoring and Ongoing Compliance:

- Weekly Audits: For the first month, the facility will conduct weekly audits to ensure that all corrective actions are implemented. These audits will focus on emergency lighting, fire safety systems, and emergency preparedness.
- Monthly QAPI Meetings: Audit results and compliance data will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings. Any deficiencies identified will be addressed promptly, and corrective actions will be taken.

Responsible Party: The Director of Nursing (DON) or designee will oversee all corrective actions and ensure that all deficiencies are corrected within the specified timeframes.

Completion Date: The facility aims to complete all corrective actions within 30 days of the issuance of the plan.

Eric McMillan, President

Date

10/23/24 at 1:30 PM - The plan was accepted with agreed upon changes via telephone with Eric McMillan. The alleged date of compliance is 11/30/24.