STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555151	A. BUILDING _____ B. WING _____	**03/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS POST ACUTE	**320 NORTH CRAWFORD STREET WILLOWS, CA 95988**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to report an allegation of abuse for two of two residents (Residents 1, and 2) within two-hours, when a resident to resident altercation that occurred at 12:45 pm, was not reported until 3:46 pm on 2/3/20 (one hour late). This failure had the potential to delay abuse reporting to the California Department of Public Health (CDPH), and their investigation into the incident. Findings: On 2/3/20 at 3:46 pm, CDPH received a report from the facility that Resident 1 allegedly threatened Resident 2 in the dining room on 2/3/20 at 12:45 pm. The facility's policy titled, Abuse Prohibition, revised 7/1/19, was reviewed and indicated that the reporting of abuse to CDPH was required within 2-hours of an allegation of suspected abuse. Resident 1's medical record was reviewed on 2/11/20. Resident 1 was admitted to this facility on 4/24/19, with [DIAGNOSES REDACTED]. Resident 1 was unable to make his own healthcare decisions. Resident 2's medical record was reviewed on 2/11/20. Resident 2 was admitted to this facility on 4/2/19, with [DIAGNOSES REDACTED]. Resident 2 was able to make his own healthcare decisions. Resident 1 and Resident 2's medical record indicated that they had been involved in a verbal altercation in the dining room which had occured at 2/3/20 at 12:45 pm. During an interview, and record review, on 2/11/20 at 10:50 am, the Director of Staff Development (DSD) stated that she instructs the staff to report abuse within two-hours to CDPH. The DSD confirmed that this incident was reported one hour late to CDPH. During an interview, on 2/11/20 at 11:20 am, the Administrator (Admin) stated that they are required to report abuse to CDPH within two-hours, and confirmed that this incident had been reported one hour late to CDPH.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement care planned interventions for two of four sampled residents (Residents 1, and 2), when Social Services (SS) failed to complete well-being visits following an altercation between the two residents. This failure had the potential to contribute to a loss of well-being for Resident 1 and Resident 2, which could lead to negative clinical outcomes. Findings: Resident 1's medical record was reviewed on 2/11/20. Resident 1 was admitted to this facility on 4/24/19, with [DIAGNOSES REDACTED]. Resident 2's medical record was reviewed on 2/11/20. Resident 2 was admitted to this facility on 4/2/19, with [DIAGNOSES REDACTED]. Resident 1's care plan dated 2/3/20, was reviewed and indicated that SS would provide Resident 1 one-on-one visits for three days, following the altercation with Resident 2 on 2/3/20. Resident 1's progress notes, were reviewed and indicated that SS met with Resident 1 on 2/3/20 at 5:13 pm, and on 2/4/20 at 1:45 pm. Resident 2's progress notes, were reviewed and indicated that SS met with Resident 2 on 2/3/20 at 5:14 pm. During a concurrent interview, and record review, on 3/10/20 at 9:02 am, SS confirmed that Resident 1 received visits on 2/3/20 at 5:13 pm, and on 2/4/20 at 1:45 pm. SS also confirmed that Resident 2 received a visit on 2/3/20 at 5:14 pm, and that neither residents had received the three visits that were care planned. During a concurrent interview, and record review on 3/10/20 at 9:45 am, the Director of Nursing (DON) confirmed that Resident 1 only received two SS visits, and Resident 2 had only received one SS visit after their altercation on 2/3/20, thus their care plans had not been fully implemented. The facility's policy titled, Person-Centered Care Plan, revised 7/1/19, was reviewed and indicated that the facility must implement a resident's care plan, which includes the interventions.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement treatment consistent with physician orders, when one of four sampled residents (Resident 1) was not provided mental health treatment as ordered. This failure had the potential to contribute to Resident 1 verbally assaulting another resident on 2/3/20 at 12:45 pm. (Refer to F 609, and F 656). Findings: Resident 1's medical record was reviewed on 2/11/20. Resident 1 was admitted to this facility on 4/24/19, with [DIAGNOSES REDACTED]. Resident 1 was unable to make his own healthcare decisions. Resident 1's physician orders [REDACTED]. During a concurrent interview, and record review, on 3/10/20 at 9:02 am, Social Services (SS) stated that she did not know about the order for Resident 1 to go to the mental health facility. SS confirmed that he had not gone to the mental health facility, and the order had not been carried out. During a concurrent telephone interview, and record review, on 3/12/20 at 3:48 pm, the Licensed Nurse (LN) confirmed that there was a physician order [REDACTED].

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

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.