althcare Licensing and Surveys

ATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF010	A. BUILDING: _____ B. WING _____	07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF EVANSTON	1949 WEST UINTA STREET EVANSTON, WY 82930

(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 Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A complaint survey was conducted on 7/6/26 through 7/7/26 which was prompted by complaint intakes #LIC-26-043 and #LIC-26-059. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency	S 000		
S5005	Ch 12 Sec 7 (a) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (i) Meals, housekeeping, personal and other laundry services; (A) Provision of mechanically altered diets and dietary supplements, if required. (ii) A safe and clean environment;	S5005		

9/16/26- ~~BOS~~POKE with facility Manager on 9/16/26 at 2:28 pm. Plan was accepted with an alleged date of compliance of 9/1/26. TM

Healthcare Licensing and Surveys

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S5005	Continued From page 1	S5005		

(iii) Assistance with local transportation;

(iv) Assistance with obtaining medical, dental, and optometric care, in addition to social services;

(v) Assistance in adjusting to group living activities;

(vi) Maintenance of a personal fund account, if requested by the resident or resident's responsible party, showing any and all deposits, withdrawals, and transactions of the account;

(vii) Provision of appropriate recreational activities in/out of the assisted living facility;

(viii) Care of individuals who require any or all of the following services:

(A) Partial assistance with personal care, e.g. bathing, shampoos;

(B) Limited assistance with dressing;

(C) Minor non-sterile dressing changes;

(D) Stage I skin care - skin integrity intact;

(E) Infrequent assistance with mobility. The resident may use an assistive device; e.g., wheel chair, walker, cane;

(F) Cuing guidance with ADLs for the visually impaired resident, or the intermittently confused and/or agitated resident requiring occasional reminders to time, place and person;

EM 7/24/26

Healthcare Licensing and Surveys

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S5005	Continued From page 2	S5005		

(G) Care of the resident who can independently manage his own catheter or ostomy, e.g., resident who can change his own catheter bags, able to clean and care for his ostomy;

(H) Care of the resident incontinent of bowel or bladder if the condition can be managed independently;

(ix) Assessments completed by a Registered Nurse;

(A) Registered Nurse medication review every two (2) months or sixty-two (62) days or whenever new medication is prescribed or the residents' medication is changed;

(x) Twenty-four (24) hour monitoring of each resident.

This State Rule and Regulation is not met as evidenced by:

Based on observation, resident and staff interview, and policy review, the facility failed to ensure resident rooms were clean for 3 of 12 resident rooms (#6, #8, #11). The findings were:

1. Observation on 7/6/26 at 3:48 PM showed resident #4 was in his/her room, #11, in bed, and the room had a foul musty smell. Further review showed there was a white and yellow dried substance on the carpet near the bed and small debris all over the floor. Interview with the resident at that time revealed staff cleaned the room the day prior. Interview with CNA #1 on

Sm 7/24/26

Healthcare Licensing and Surveys

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S5005	Continued From page 3	S5005		

7/6/26 at 4:08 PM revealed she was aware of the stains on the resident's floor and revealed the stains had been there "for a while." She revealed the floor needed to be shampooed and she had notified the manager "multiple" times about the carpet. The CNA revealed she discussed the dirty room with the resident's family as well due to the resident throwing items on the floor.

2. Observation of room #6 on 7/6/26 at 4:09 PM showed a vacant room with dark colored stains on the carpet. Interview with CNA #1 at that time revealed a resident had recently moved out of the room.

3. Observation of room #8 on 7/6/26 at 4:15 PM showed an unsanitary, vacant room with dark brown, black, and white stains on the carpeted area and splattered on the wall and various dirt and debris on the floor throughout. Observation showed the bed in the room had brown debris on the top and sides and a bed side table near the door had a large black/brown dried liquid on the top and sides. Observations showed the room had additional items stored in it which included a recliner, wheelchair, dining chairs, an oxygen concentrator, and a Christmas tree which were damaged and/or stained. Further observation showed the bathroom floor had brown stains on the linoleum and a build of dirt and debris. Interview with CNA #1 at that time revealed the room had been "condemned" since prior to her working at the facility and a company came to the facility to clean the carpets; however, they said they were unable to clean it and the room would need the flooring torn out and replaced.

4. Interview with CNA #1 on 7/6/26 at 4:08 PM revealed she was the only staff member who cleaned the facility.

7/24/26

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S5005	Continued From page 4	S5005		

5. Interview with the facility manager on 7/7/26 at 9:30 AM revealed he was aware the carpet in resident #4's room needed to be cleaned. Further interview revealed the facility was going to remodel room #8; however, nothing had been done. He revealed he "knows" the carpet in room #8 was "shampooed once or twice" and revealed he had not looked in room #8 in a "long time." Further interview revealed the manager declined to enter room #8.

6. Review of a policy titled "Ancillary Services" last revised on 12/31/17 showed "...A. Resident Apartment Housekeeping 1. Housekeeping services are provided routinely once weekly to each resident... Carpets in resident apartments are normally cleaned (extracted) upon move-out. Before carpet is extracted, vacuum thoroughly after resident furnishings are moved out... 9. Report any damage to a resident's carpet or vinyl floor to the executive director... 11. Spots on walls should be wiped off when noticed. Note any needed repairs on a maintenance request form..."

S5009 Ch 12 Sec 7 (b)(iv) Assisted Living Facility (ALF) Core Services — S5009

(b) (iv) Frequency of assessment. An assessment must be conducted:

(A) No earlier than one (1) week prior to admission;

(B) Immediately upon any significant

Em 7/24/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5009	Continued From page 5	S5009		

change in the resident's mental or physical condition; or

(C) No less than once every twelve (12) months.

This State Rule and Regulation is not met as evidenced by:

Based on observation, medical record review, and representative and staff interview, the facility failed to ensure an assessment was conducted with a change of condition for 2 of 6 sample residents (#4, #6) reviewed. The findings were:

1. Review of the medical record for resident #6 showed the last "Assisted Living Facility Type I & II Resident Assessment" was completed on 4/13/25. The following concerns were identified:

a. Review of an "Incident Reporting" form dated 1/4/26 showed the resident "went to the store without notifying anyone. Fell down while away and had paramedics bring [him/her] back. blood ox [sic] was 72 and heart rate was 88 after laying down." Further review showed no evidence an RN assessment was completed following the change in condition.

b. Review of an "Incident Reporting" form dated 3/12/26 showed "Resident was laying down went to do my regular checks, and noticed [s/he] didn't seem to be doing well, offered [him/her] to go to emergency room [s/he] refused." Further review showed no evidence an RN assessment was completed following the change of condition.

c. Review of an "Incident Reporting" form dated 3/12/26 showed "In bed, [s/he] has dried blood on [his/her] face/mouth and on [his/her] pillow. [S/he] keeps denying staff, [s/he] keeps

Em 7/24/26

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S5009	Continued From page 6	S5009		

saying no to go to the hospital. I have asked [him/her] all night. [S/he] continues to say 'No.'" Further review showed no evidence an RN assessment was completed following the change of condition.

d. Review of an "Incident Reporting" form dated 3/13/26 showed "Resident stayed in bed, [S/he]'s not doing well. [S/he] continued to stay in bed, I asked [him/her] if [s/he] wanted to go to the hospital. I asked through the night, [s/he] is still saying 'no.' [S/he] refused every time." Further review showed no evidence an RN assessment was completed following a change in condition.

e. Review of an "Incident Reporting" form dated 3/16/26 showed "Was found in [his/her] room was asked if [s/he] wanted to go to the hospital [s/he] agreed to go EMS was called @ [at] 10:30 AM Left facility for the hospital @ 10:40 AM."

f. Interview with the resident's representative on 7/7/26 at 10:46 AM revealed the resident passed away after transferring to the hospital.

g. Interview with the facility manager on 7/7/26 at 9:40 AM confirmed an RN assessment was not performed for the resident and should have been.

2. Interview with resident #4 on 7/6/26 at 3:48 PM revealed the resident had fallen the previous day and revealed s/he was not sent to the hospital for evaluation or assessed by a nurse. Observation at that time showed the resident appeared to have dried blood on his/her head. The following concerns were identified:

a. Review of the medical record showed an incident report for the resident's fall dated 7/6/26 which indicated the resident had fallen in his/her room in the early morning hours. Further review showed no evidence of an RN assessment following the fall on 7/6/26.

b. Interview with the facility manager on 7/7/26

Em 7/24/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5009	Continued From page 7 at 8:42 AM revealed he was the staff member who found and assisted the resident following the fall. Further interview revealed the resident was not assessed by a nurse, EMS, or the hospital after the fall. He revealed the resident did sustain a "bump" his/her head. c. Interview with the facility manager on 7/7/26 at 9:40 AM revealed he did not know the resident had wounds on his/her head following the fall on 7/6/26. Observation with the manager at that time confirmed the presence of head wounds to the resident. Further interview revealed the resident should of had an assessment completed.	S5009		
S5020	Ch 12 Sec 7 (e) Assisted Living Facility (ALF) Core Services (e) Resident Records and Reports. Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request. (i) Each folder shall include the following: (A) Information from the referring agent, if applicable; (B) History and physical performed by a physician or physician extender; (C) Individual admission form. This form shall, at a minimum, contain the following information:	S5020	Em 7/24/26	

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S5020	Continued From page 8 (I) Full name of resident and former address; (II) Date of admission; (III) Sex, race, date of birth, social security number, and former occupation; (IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian; (V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number or other medical insurance identifying data; (VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing; (D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare of safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and	S5020	Em 7/24/26	

Healthcare Licensing and Surveys

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S5020	Continued From page 9	S5020		

follow up must also be present in the resident records;

(E) An accounting of all personal funds deposited with and disbursed by the facility;

(I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client.

(1.) The facility must deposit any personal funds in the excess of $100 in an interest bearing account.

(2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility.

(3.) Upon the death of a resident with personal funds deposited with the facility, the facility must convey, within 30 days, the resident's funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid of Medicare except for applicable deductible and coinsurance amounts.

(F) A signed copy of the resident's rights;

(G) The resident's assessment and individualized assistance plan;

(H) Copies of al applicable resident

Em 7/24/26

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S5020	Continued From page 10	S5020		

assistance contracts, signed by both parties;

(I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies;

(J) Copy of all ALF 102's; and

(K) Copy of outside contractual responsibilities, if applicable.

(ii) The resident shall be assured of confidential treatment of all information in the record, and the resident's written consent (or the consent of the guardian) shall be required for the release of information to persons not otherwise authorized for receive it.

(iii) All residents' records shall be retained in a physically secure area for a minimum of six (6) years after the resident has left the facility and may be disposed of, by shredding or burning, after that time.

(iv) In the event of dissolution of the facility, the manager shall notify the Licensing Division as to the location of all residents' records.

(v) All records shall be protected from damage by fire, water and other hazards.

(vi) All entries in each resident's record shall be made in ink, signed and dated.

This State Rule and Regulation is not met as evidenced by:

Ewr 7/24/26

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S5020	Continued From page 11	S5020		

Based on observation, medical record review, representative and staff interview, state survey incident database review, and policy review, the facility failed to ensure accidents, injuries, incidents, illnesses, and investigations were reported to appropriate entity for follow up and resolution for 2 of 6 sample residents #4, #6) reviewed for accidents, incidents, and injuries. The findings were:

1. Review of the medical record for resident #6 showed the last "Assisted Living Facility Type I & II Resident Assessment" was completed on 4/13/25. The following concerns were identified:

a. Review of an "Incident Reporting" form dated 1/4/26 showed the resident "went to the store without notifying anyone. Fell down while away and had paramedics bring [him/her] back. blood ox [sic] was 72 and heart rate was 88 after laying down." Further review showed no evidence the RN was notified. Review of the state survey agency incident database showed no evidence the incident was reported.

b. Review of an "Incident Reporting" form dated 3/12/26 showed "Resident was laying down went to do my regular checks, and noticed [s/he] didn't seem to be doing well, offered [him/her] to go to emergency room [s/he refused." Further review showed no evidence the RN was notified.

c. Review of an "Incident Reporting" form dated 3/12/26 showed "In bed, [s/he] has dried blood on [his/her] face/mouth and on [his/her] pillow. [S/he] keeps denying staff, [s/he] keeps saying no to go to the hospital. I have asked [him/her] all night. [S/he] continues to say 'No.'" Further review showed no evidence the RN was notified.

d. Review of an "Incident Reporting" form dated 3/13/26 showed "Resident stayed in bed,

Emr 7/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5020	Continued From page 12	S5020		

[S/he]'s not doing well. [S/he] continued to stay in bed, I asked [him/her] if [s/he] wanted to go to the hospital. I asked through the night, [s/he] is still saying 'no.' [S/he] refused every time." Further review showed no evidence the RN was notified.

e. Review of an "Incident Reporting" form dated 3/16/26 showed "Was found in [his/her] room was asked if [s/he] wanted to go to the hospital [s/he] agreed to go EMS was called @ [at] 10:30 AM Left facility for the hospital @ 10:40 AM." Further review showed no evidence the RN was notified.

f. Review of an "Incident Reporting" form dated 3/21/26 showed staff found another resident in resident #6's room, digging in the night stand with the change bag in his/her hand. The incident reporting form showed when staff asked what the resident was doing, s/he replied s/he thought resident #6 was gone.

g. Review of an "Incident Reporting" form dated 3/24/26 showed a large bag of change belonging to resident #6 had "disappeared."

h. Review of the state survey agency incident database showed the facility reported an allegation of exploitation on 3/27/26 at 6:32 PM. Further review showed no evidence the facility's investigation was reported as of 7/7/26.

i. Interview with the resident's representative on 7/7/26 at 10:46 AM revealed he had reported an allegation of missing change and missing wallet after the resident had discharged from the facility. The representative indicated the total amount of money missing was over $600. He revealed the facility had contacted him to let him know they found the change, but did not indicate they had found the wallet which he believed had $600 in it.

j. Interview with the facility manager on 7/7/26 at 8:42 AM revealed the resident's money was found and was being stored in the facility safe.

Jm 7/24/26

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S5020	Continued From page 13 The manager revealed the money missing was a bag of change in the amount of "19 or 30 dollars." h. Interview with the facility manager on 7/7/26 at 9:30 AM revealed he did not know incident investigations had to be reported to the survey agency. k. Interview with the facility manager on 7/7/26 at 9:40 AM confirmed the RN was not notified of the resident's change in conditions and should have been. 2. Interview with resident #4 on 7/6/26 at 3:48 PM revealed the resident had fallen the previous day and revealed s/he was not sent to the hospital for evaluation or assessed by a nurse. Observation at that time showed the resident appeared to have dried blood on his/her head. The following concerns were identified: a. Review of the medical record showed an "Incident Reporting" form for the resident's fall dated 7/6/26 which indicated the resident had fallen in his/her room in the early morning hours. Further review showed no evidence of an RN was notified of the fall. b. Interview with the facility manager on 7/7/26 at 8:42 AM revealed he was the staff member who found and assisted the resident following the fall. Further interview revealed the resident was not assessed by a nurse, EMS, or the hospital after the fall. He revealed the resident did sustain a "bump" his/her head. c. Interview with the facility manager on 7/7/26 at 9:40 AM revealed he did not know the resident had wounds on his/her head following the fall on 7/6/26. Observation with the manager at that time confirmed the presence of head wounds to the resident. Further interview revealed the the RN should have been notified.	S5020	Sm 7/24/26	

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	ALF010	A. BUILDING _____ B. WING _____	07/07/2026

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S5020	Continued From page 14 3. Review of the policy titled "Incident" last revised on 12/31/17 showed "An incident report should be completed to report any incident, situation, or unusual occurrence that involves potential injury or harm to a resident, visitor, or staff. Incident reports should be completed for the following reasons: Resident Issues: falls, elopements, resident to resident altercations, resident to staff altercations, unexplained bruising, bleeding or skin injury... Review incident and state regulations to determine if it requires reporting to the state health or regulatory agency..." 4. Review of the policy titled "Missing Items or Theft" last revised on 12/31/26 showed "...7. If the situation is not quickly resolved or if theft is clearly indicated, an incident report should be completed. Be alert to state regulations regarding the reporting of theft. Theft of a resident's property may be defined as exploitation of the elderly and require reporting under a state's requirement for reporting abuse, neglect, and exploitation..."	S5020		
S5043	Ch 12 Sec 7 (n) Assisted Living Facility (ALF) Core Sevices (n) Furnishings, Buildings, Physical Plant (i) One half of the licensed beds shall be private rooms; (ii) Sleeping rooms shall be homelike, well lighted, ventilated and equipped in compliance with the requirements below;	S5043	Em 7/24/26	

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S5043	Continued From page 15	S5043		

(A) All windows shall have drapes, curtains, shades or blinds to assure privacy;

(B) Beds (if provided by the facility) shall be at least standard size in width (39"), and shall be equipped with comfortable, clean mattresses and pillows. Mattresses shall be professionally renovated or replaced as needed. Extra long beds shall be used to accommodate tall residents. Rollaway-type beds, cots and folding beds shall not be used unless the resident brings these items from home for personal use;

(I) Two residents may, by consent of both parties, or by approval of the appropriate responsible party, be permitted to use one bed no smaller than double size, and occupy a single-bed sleeping room.

(C) Cabinet or bedside table;

(D) Non-combustible wastebasket;

(E) Chair; and

(F) If common closets are utilized by two (2) or more residents, dividers shall be provided for separation of each resident's clothing. All closets shall be equipped with doors. Free-standing closets shall be deducted from the square footage in the sleeping room.

(G) The size and arrangement of the residents' beds, furnishings, possession or equipment shall allow the resident to gain fire emergency access to windows and doors, and access the toilet room. Multiple-bed rooms shall have at least three (3) feet between beds.

Em 7/24/26

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S5043	Continued From page 16	S5043		

(H) Residents shall be encouraged to bring personal items and furniture for their rooms, (e.g., beds, chairs, and pictures);

(I) There shall be at least one (1) bedside screen per double room available to provide resident privacy when needed;

(J) There shall be an adequate supply of hot and cold water available at each lavatory, bathtub/shower, kitchen sink, dishwasher, and laundry equipment. Hot water for bathing, and resident handwashing, and laundry should be no hotter than one hundred and twenty (120°) degrees Fahrenheit.

(K) All plumbing shall be maintained in good repair and according to the requirements of the Uniform Plumbing Code;

(I) Private water systems shall be safe, potable, and have an adequate supply. Testing shall be done monthly an records of tests shall be retained at the facility.

(II) Private water systems shall be tested and found safe and potable before Licensure is granted.

(L) Fireplaces shall be securely screened and glassed in;

(M) The facility shall be maintained so that it is free of hazards, such as loose or broken window glass, loose or cracked floors or floor coverings, or cracked or loose plaster on wall or ceilings;

(N) At least one primary grade level

7/24/26

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S5043	Continued From page 17 entrance tot he building shall be freely accessible for wheelchairs; (O) Each resident shall have his individual comb, toothbrush, towels, and wash cloths; (P) Clean drinking glasses shall be available for the residents. Common drinking cups are prohibited; (Q) Bathrooms shall have soap and toilet paper. The facility shall provide paper towels or a blow dryer for hands, or rack space adequate for each resident using the bathroom to hang his/her personal towel. Use of a common towel is prohibited; (R) Provisions shall be made for privacy in all bath an toilet rooms; (S) Automatic deodorizers or aerosol fresheners shall not be used except in bathrooms; and (T) Residents shall not use a common bar of soap. The facility shall provide either soap dispensers or individual bars of soap for each resident. (U) Housekeeping. (I) Housekeeping practices and procedures shall be employed to keep the home free from offensive odors, accumulations of dirt, and dust. (II) Floors shall be maintained and clean.	S5043		

Jm 7/24/26

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S5043	Continued From page 18	S5043		

(III) Polish of floors shall provide a non-slip finish.

(IV) Throw or scatter rugs shall not be used. Non-slip mats may be used.

(V) Covered containers with tight lids shall be used for garbage storage.

(W) The facility shall be maintained free of insects and rodents. All windows shall be screened. All exit doors opening inward shall have a screen door.

(X) Linens and Laundry.

(I) Laundry service for linen and residents' personal clothing shall be provided. The manager shall take measures to ensure that residents' clothing is not lost or misplaced while laundering.

(II) All linen shall be bagged or placed in a hamper before being transported to the laundry area.

(III) Bed linen shall be changed as necessary but at least weekly. Additional blankets or pillows shall be provided. Rubber or water protective sheets shall be used if indicated.

(IV) Two (2) complete changes of clean bed linen shall be on hand for each licensed bed.

(1.) Torn, worn, or unclean bed linen shall not be used.

Em 7/24/26

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S5043	Continued From page 19	S5043		

(V) All bleaches, detergents, disinfectants, and other cleaning agents shall be separated from medicines and foods.

(VI) Soiled linen shall not be transported through, sorted, processed, or stored, in kitchens, food preparation areas, or food storage areas.

(Y) The heating system shall be inspected yearly, before the heating season, and maintained according to manufacturer's instructions.

(Z) Portable space heaters shall not be used, (e.g. electric or kerosene).

(AA) Equipment Maintenance and Testing.

(I) The devices, equipment, systems, conditions, arrangements, levels of protection, or any other features that are required for compliance with the provisions of the Life Safety Code shall be permanently maintained for the building housing the facility.

This State Rule and Regulation is not met as evidenced by:

Based on observation, resident and staff interview, and policy review, the facility failed to ensure housekeeping practices and procedures were employed to keep the home free from offensive odors, accumulations of dirt, and dust and failed to ensure floors were maintained and

Em 7/24/26

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S5043	Continued From page 20	S5043		

clean for 3 of 12 resident rooms (#6, #8, #11). The findings were:

1. Observation on 7/6/26 at 3:48 PM showed resident #4 was in his/her room, #11, in bed, and the room had a foul musty smell. Further review showed there was a white and yellow dried substance on the carpet near the bed and small debris all over the floor. Interview with the resident at that time revealed staff cleaned the room the day prior. Interview with CNA #1on 7/6/26 at 4:08 PM revealed she was aware of the stains on the resident's floor and revealed the stains had been there "for a while." She revealed the floor needed to be shampooed and she had notified the manager "multiple" times about the carpet. The CNA revealed she discussed the dirty room with the resident's family as well due to the resident throwing items on the floor.

2. Observation of room #6 on 7/6/26 at 4:09 PM showed a vacant room with dark colored stains on the carpet. Interview with CNA #1 at that time revealed a resident had recently moved out of the room.

3. Observation of room #8 on 7/6/26 at 4:15 PM showed an unsanitary, vacant room with dark brown, black, and white stains on the carpeted area and splattered on the wall and various dirt and debris on the floor throughout. Observation showed the bed in the room had brown debris on the top and sides and a bed side table near the door had a large black/brown dried liquid on the top and sides. Observations showed the room had additional items stored in it which included a recliner, wheelchair, dining chairs, an oxygen concentrator, and a Christmas tree that were damaged and/or stained. Further observation showed the bathroom floor had brown stains on

fm 7/24/26

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S5043	Continued From page 21 the linoleum and a build of dirt and debris. Interview with CNA #1 at that time revealed the room had been "condemned" since prior to her working at the facility and a company came to the facility to clean the carpets; however, they said they were unable to clean it and the room would need the flooring torn out and replaced. 4. Interview with CNA #1 on 7/6/26 at 4:08 PM revealed she was the only staff member who cleaned the facility. 5. Interview with the facility manager on 7/7/26 at 9:30 AM revealed he was aware the carpet in resident #4's room needed to be cleaned. Further interview revealed the facility was going to remodel room #8; however, nothing had been done. He revealed the he "knows" the carpet in room #8 was "shampooed once or twice" and revealed he had not looked in room #8 in a "long time." Further interview revealed the manager declined to enter room #8. 6. Review of a policy titled "Ancillary Services" last revised on 12/31/17 showed "...A. Resident Apartment Housekeeping 1. Housekeeping services are provided routinely once weekly to each resident... Carpets in resident apartments are normally cleaned (extracted) upon move-out. Before carpet is extracted, vacuum thoroughly after resident furnishings are moved out... 9. Report any damage to a resident's carpet or vinyl floor to the executive director... 11. Spots on walls should be wiped off when noticed. Note any needed repairs on a maintenance request form..."	S5043		

Willow Creek
Elder Care Communities

Evanston

Survey Date: July 15, 2026

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.

Prefix Tag

S5005 Ch 12 Sec 7 (a) Assisted Living Facility (ALF) Core Services.

1. The facility manager & assistant manager will schedule a staff meeting to train and review with staff & residents as to the responsibilities of residents and staff regarding room cleanliness & responsibilities of residents in between weekly cleaning schedules.
2. Corporate will schedule services to clean the carpets and floors and living space of the unoccupied rooms #6 & #8. Additionally, they will clean and address the areas identified in room #4 & #11.
3. QA including previous complaints will occur by 9/1/2026.
4. Corporate officer and manager will review documentation weekly for 1 month then monthly for 3 months.
5. Date of compliance 9/1/2026.

S5009 Ch 12 Sec 7 (c) Assisted Living Facility (ALF) Core Services.

1. The facility manager & assistant manager will schedule a staff meeting to train and review staff on our incident reporting, documentation and related policies.



2. Corporate officer will review with Nurse & management team, residents rights to refusal for medical care and the facilities strategies and processes in navigating these issues. Additionally, we will cover resident change of condition & incident reporting documentation.
3. QA including previous complaints will occur by 9/1/2026.
4. Manager and Assistant manager will review documentation weekly for 1 month then monthly for 3 months.
5. Date of compliance 9/1/2026.

S5020 Ch 12 Sec 7 (n) Assisted Living Facility (ALF) Core Services.

1. The facility manager & assistant manager will schedule a corporate meeting to train and review management staff on completing the incident reporting process. Appropriately documenting all necessary paperwork and related policies.
2. Corporate officer will retrain the Manager & show the Assistant Manager how to complete the filed incident report from 3/27/26.
3. Corporate Officer will retrain all staff on incident reporting and documentation relating to all applicable incidents including injury, theft, and change of condition.
4. QA including previous complaints will occur by 9/1/2026.
5. Corporate officer and manager will review documentation weekly for 1 month then monthly for 3 months.
6. Date of compliance 9/1/2026.

S5043 Ch 12 Sec 7 (e) Assisted Living Facility (ALF) Core Services.

1. The facility manager & assistant manager will schedule a staff meeting to train and review with staff & residents as to the responsibilities of residents and staff regarding room cleanliness & responsibilities of residents in between weekly cleaning schedules.
2. Corporate will schedule services to clean the carpets and floors and living space of the unoccupied rooms #6 & #8. Additionally, they will clean and address the areas identified in room #4 & #11.
3. QA including previous complaints will occur by 9/1/2026.
4. Corporate officer and manager will review documentation weekly for 1 month then monthly for 3 months.
5. Date of compliance 9/1/2026.

Eric McMillan 7/24/26

Eric McMillan, President Date