Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH007	A. BUILDING: _____ B. WING _____	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF SHERIDAN	561 AVOCA AVENUE SHERIDAN, WY 82801

(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 11/17/25 through 11/18/25. The survey was prompted by complaint intake #LIC-26-003.	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		

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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 not accepted or retained if they had mental defects which interfere with their ability to follow instructions relating to rules of the boarding home or were wanderers for 2 of 8 sample residents (#1, #3) reviewed for admission, transfer, and discharge. The findings were: 1. Observation on 11/17/25 at 4:58 PM showed resident #3 appeared confused and was unsure where to go. The following concerns were	S4003		

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S4003	Continued From page 2 identified: a. Review of a progress note dated 8/2/25 and timed "3-11" showed the resident "Filled toilet with garbage..." b. Review of a progress note dated 8/27/25 and timed "7-3" showed the resident was "Constantly asking for food, then would not eat." c. Review of a progress note dated 8/30/25 and timed "3-11" showed the resident paced and made statements to another resident which upset the other resident and made him/her "really mad." d. Review of a progress note dated 9/3/25 and timed "7-3" showed "Rough day. Ate meals. Very antsy and pacy [sic]..." e. Review of a progress note dated 9/4/25 and timed "7-3" showed "Not a good day. Being mean to others and staff." f. Review of progress notes dated 9/6/25 and timed "3-11," 9/7/25 and timed "7-3," and 9/8/25 and timed "7-3" showed "Not a good day." g. Review of a progress note dated 9/13/25 and timed "3-11" showed "Very rough day, disoriented, not eating, struggling." h. Review of a progress note dated 10/17/25 and timed "3-11" showed the resident was "very confused." i. Review of a progress note dated 11/6/25 and timed "7a-3p" showed the resident was "very lost" and concerned his/her representative had died. 2. Review of the resident record for resident #1 showed a physician's note dated 8/29/25 which indicated the resident had a recent fall, family was making arrangements for assisted living with home health support, and the resident had diagnoses which included dementia, depression, diabetic peripheral neuropathy, glaucoma, osteoarthritis, and type II diabetes mellitus. Further review of the resident record showed the	S4003		

Healthcare Licensing and Surveys

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S4003	Continued From page 3 resident admitted to the facility on 9/20/25 and discharged on 9/21/25. There was no documentation of an incident, incident investigation, or incident reporting and no documentation why the resident discharged or where the resident discharged to. 3. Interview with the facility's interim manager on 11/18/25 at 9:10 AM revealed resident #3 required help with toileting, dressing, and showers, and wandered into other resident rooms. She revealed the resident was unaware of what s/he was doing due to dementia and the manager had spoken with the resident's representative; however, a discharge notice had not been issued. The manager revealed resident #1 had discharged from the facility following a fall after the resident left the facility independently and staff were not aware the resident was gone. The fall resulted in an injury and hospitalization and the resident did not return from the hospital. Further interview revealed resident #1 should not have admitted to the facility because s/he was not appropriate; however, the previous manager accepted the resident to "fill rooms."	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	S4005		

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S4005	Continued From page 4 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 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.	S4005		

Healthcare Licensing and Surveys

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S4005	Continued From page 5 (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 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, staff interview, and policy and procedure review, the facility failed to ensure resident records contained a written record of all accidents, injuries, and illnesses, and subsequent treatment occurring after admission or documentation the Program Division was notified within Seventy-Two (72) hours of a serious injury or accident for 2 of 8 sample residents (#1, #2) reviewed for accidents and injuries. The findings were: 1. Review of the resident record for resident #1 showed a physician's note dated 8/29/25 which indicated the resident had a recent fall and family was making arrangements for assisted living with home health support. The physician's note showed the resident had diagnoses which included cancer of the lower lobe of his/her right lung, degenerative disc disease, dementia, depression, diabetic peripheral neuropathy,	S4005		

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S4005	Continued From page 6 glaucoma, osteoarthritis, and type II diabetes mellitus. Further review of the resident record showed the resident admitted to the facility on 9/20/25 and discharged on 9/21/25. The following concerns were identified: a. Interview with the facility manager on 11/18/25 at 10:17 AM revealed the hospital notified the facility of the resident's fall. She revealed on the day of the incident, the resident had eaten dinner in the dining room and staff thought s/he had returned to his/her room. When the staff member went to the resident's room, the bathroom light was on and the door was closed, so the staff member assumed the resident was in the bathroom. Further interview revealed the staff member thought the hospital called 2 hours after dinner was complete. b. Review of the resident's record showed there was no documentation of an incident, incident investigation, or incident reporting and no documentation why the resident discharged or where the resident discharged to. 2. Review of the resident record for resident #2 the resident was unable to walk and his/her balance was "shaky." Review of a progress note dated 8/16/25 and timed "3-11" showed "Ate dinner- fell- helped [him/her] get up- went right to bed." The following concerns were identified: a. Review of the resident's record showed there was no additional documentation of the incident, incident investigation, or incident reporting. 3. Interview with the facility's interim manager on 11/18/25 at 9:10 AM revealed resident #1 had discharged from the facility following a fall when the resident left the facility independently and staff were not aware the resident was gone. The fall resulted in injury and hospitalization and the	S4005		

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S4005	Continued From page 7 resident did not return from the hospital. The interim manager confirmed resident #2 had a fall in August. She revealed the facility did not have an incident report or investigation for either incident and confirmed neither of the incidents were reported to the Program Division. 4. Review of the facility's "Policy Manual" dated 10/1/17 showed "...Willow Creek will notify the Wyoming Division on Aging and the Long Term Care Ombudsman within 72 hours of all formal complaints that have been submitted in writing (as is stated in the rules and Regulations, Chapter Eight, Section Six). Willow Creek will document upon request, any occurrence, such as unusual death, serious injury or accident, fire or other emergency situation..."	S4005		
S4006	Ch 8 Sec 6 (a)-(c) Complaint Investigations (a) Formal complaints and problems of residents shall be referred in writing to the Long Term Care Ombudsman. (b) The office of the Ombudsman shall complete all complaint investigations within an appropriate time frame depending upon the seriousness of all allegations. (c) Written reports of investigations and the status of resolutions shall be provided to the Department's Director designee, which is the Licensing Division, within thirty (30) days after the investigation. This State Rule and Regulation is not met as evidenced by: Based on resident record review, staff interview, state survey agency incident database review,	S4006		

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S4006	Continued From page 8 and policy and procedure review, the facility failed to ensure reports of investigations were provided to the Licensing Division witthin thirty (30) days after the investigation for 1 of 8 sample residents (#1) reviewed for accidents and injuries. The findings were: 1. Review of the resident record for resident #1 showed a physician's note dated 8/29/25 which indicated the resident had a recent fall and family was making arrangements for assisted living with home health support. The physician's note showed the resident had diagnoses which included cancer of the lower lobe of his/her right lung, degenerative disc disease, dementia, depression, diabetic peripheral neuropathy, glaucoma, osteoarthritis, and type II diabetes mellitus. Further review of the resident record showed the resident admitted to the facility on 9/20/25 and discharged on 9/21/25. The following concerns were identified: a. Interview with the facility manager on 11/18/25 at 10:17 AM revealed the hospital notified the facility of the resident's fall. She revealed on the day of the incident, the resident had eaten dinner in the dining room and staff thought s/he had returned to his/her room. When the staff member went to the resident's room, the bathroom light was on and the door was closed, so the staff member assumed the resident was in the bathroom. Further interview revealed the staff member thought the hospital called 2 hours after dinner was complete. b. Review of the resident's record showed there was no documentation of the incident, incident investigation, or incident reporting and no documentation why the resident discharged or where the resident discharged to. c. Review of the state survey agency incident database showed no evidence an incident or	S4006		

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S4006	Continued From page 9 investigation involving resident #1 was reported. 2. Interview with the facility's interim manager on 11/18/25 at 9:10 AM confirmed resident #1 had discharged from the facility following a fall when the resident left the facility independently and staff were not aware the resident was gone. The fall resulted in an injury and hospitalization and the resident did not return from the hospital. Further she confirmed there was no evidence the incident was investigated or reported. 3. Review of the facility's "Policy Manual" dated 10/1/17 showed "...Willow Creek will notify the Wyoming Division on Aging and the Long Term Care Ombudsman within 72 hours of all formal complaints that have been submitted in writing (as is stated in the rules and Regulations, Chapter Eight, Section Six). Willow Creek will document upon request, any occurrence, such as unusual death, serious injury or accident, fire or other emergency situation..."	S4006		

Willow Creek
ElderCare Communities

Sheridan

Survey Date: November 18, 2025

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

S4003 - Management - Admission, Transfer, Discharge

1. The manager and support staff will track progress notes to determine if residents are meeting the boarding home criteria.
    a. We will contact the POA and request the resident be evaluated by a doctor.
    b. Once the doctor determines the status, we will ensure orders are followed.
    c. QA Monitor resident files monthly for 3 months.
    d. Date of compliance Jan 15, 2026.

2. The manager and support staff will review and update the vetting process for all incoming residents.
    a. The vetting process will include a face to face interview with the inquiring person, and reading current and past medical history.
    b. The manager and support staff will prioritize staff education.
        i. Incident reporting and documentation.
            1. Binder with step by step instructions.
            2. Incident reports easily accessible.
        ii. Visual/verbal checks regarding new residents for the first 72 hours.
        iii. State Incident reporting.
    c. QA Monitor staff documentation monthly for three months.
    d. Date of compliance Jan 15, 2026.

S4005 - Management - Resident records/reports

1. The manager and support staff will review and update the vetting process for all incoming residents.

Manager initials JM

12/19/25 - Facility Manager and owner notified that the plan was accepted with an alleged date of compliance of 1/15/26. Tim Todd

Willow Creek
ElderCare Communities

a. The vetting process will include a face to face interview with the inquiring. person, and reading current and past medical history.
b. QA Monitor and follow with each new inquiry for 3 months.
c. Date of compliance Jan 15, 2025.

1. The manager and support staff will prioritize staff education.
    a. Incident reporting and documentation.
        i. Binder with step by step instructions.
        ii. Incident reports easily accessible.
    b. Visual/verbal checks regarding new residents for the first 72 hours.
    c. State incident reporting.
    d. QA Monitor staff documentation monthly for three months.
    e. Date of compliance Jan 15, 2025.

S4006 - Complaint Investigations

1. The manager and support staff will prioritize staff education.
    a. Incident reporting and documentation.
        i. Binder with step by step instructions.
        ii. Incident reports easily accessible.
    b. Visual/verbal checks regarding new residents for the first 72 hours.
    c. State incident reporting.
    d. QA Monitor staff documentation monthly for three months.
    e. Date of compliance Jan 15, 2025.

Joen Huggins
Joen Huggins/Manager

12.11.2025
Date

Manager initials JH