Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

(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 by Healthcare Licensing and Surveys on 6/18/25. The survey was prompted by complaint intake WY LIC-25-044.	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; (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,	S5005		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

(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
S5005	Continued From page 1 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; (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;	S5005		Sm 6/26/25

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

(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
S5005	Continued From page 2 (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, medical record review, and staff and resident interview, the facility failed to provide the core service of housekeeping and failed to ensure a clean environment for 3 of 4 sample residents (#1, #2, #3). The findings were: 1. Interview with resident #1 and resident #3 on 6/18/25 at 2:31 PM revealed residents were expected to clean their own rooms and staff did not perform routine cleaning of the facility. 2. Observation on 6/18/25 at 2:51 PM showed resident #2 was wearing incontinence briefs and the resident's room smelled strongly of urine. Interview with the resident at that time revealed the staff were supposed to clean his/her room. 3. Review of the resident assessment for resident #2 dated 8/28/24 and "updated" on 10/29/24 showed the resident required housekeeping weekly and as needed. 3. Interview with the facility manager on 6/18/25 at 2:51 PM revealed staff were expected to clean resident rooms each week.	S5005		6/25/25

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

(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
S5009	Continued From page 3	S5009		
S5009	Ch 12 Sec 7 (b)(iv) Assisted Living Facility (ALF) Core Services (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 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 staff interview, the facility failed to ensure assessments were completed following a change in resident condition for 1 of 3 sample residents (#2). The findings were: 1. Observation on 6/18/24 at 2:51 PM showed resident #2 was wearing incontinence briefs and the resident's room smelled strongly of urine. 2. Interview with the facility manager on 6/18/25 at 2:55 PM revealed resident #2 had a stroke in January and has had an increase in confusion. The manager revealed she did not think the resident had urinary sensation anymore which resulted in urinary incontinence and staff performed incontinence care for the resident. 3. Review of the medical record for resident #2 showed the last assessment was performed on 8/28/24 and "updated" on 10/19/24. Further review showed the only recorded shower for June	S5009		6/26/25

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

(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
S5009	Continued From page 4 2025 was on 6/4/25. 4. Interview with the facility manager on 6/18/25 at 3:04 PM revealed resident #2 refused showers and she confirmed the last shower the resident had was on 6/4/25. Further interview confirmed an assessment should have been completed following the resident's stroke and it wasn't performed.	S5009		
S5047	Ch 12 Sec 8 (a) Services Which Cannot Be Provided By Level 1 (a) The following services cannot be provided: (i) Continuous assistance with transfer and mobility; (ii) Care of the resident who is unable to feed himself independently and/or; monitoring of diet is required; (iii) Total assistance with bathing and dressing; (iv) Invasive catheter or ostomy care, such as changing of catheter or irrigation of ostomy; (v) Care of resident who is on continuous oxygen, if; (A) Continuous monitoring is required; or (B) Oxygen is ordered by the physician of physician extender to be titrated based on oxygen saturation levels; (vi) Care of resident whose wandering jeopardizes the health and safety of the resident;	S5047		6/20/25

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

(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
S5047	Continued From page 5 (vii) Incontinence care by facility staff; (viii) Wound care requiring sterile dressing changes; (ix) Stage II skin care and beyond; (x) Care of the resident with inappropriate social behavior; e.g. frequent aggressive, abusive, or disruptive behavior; and (xi) Care of resident demonstrating chemical abuse that puts him and/or other at risk; (xii) Monitoring of acute medical conditions. This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure services which cannot be provided by the facility were not performed for 1 of 4 sample residents (#2) reviewed for incontinence. The findings were: 1. Observation on 6/18/24 at 2:51 PM showed resident #2 was wearing incontinence briefs and the resident's room smelled strongly of urine. 2. Interview with the facility manager on 6/18/25 at 2:55 PM revealed resident #2 had a stroke in January and had an increase in confusion. The manager revealed she did not think the resident had urinary sensation anymore which resulted in urinary incontinence and staff performed incontinence care to clean the resident. 3. Review of the medical record for resident #2 showed the last assessment was performed on	S5047		6/24/25

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

(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
S5047	Continued From page 6 8/28/24 and "updated" on 10/19/24. Further review showed the resident had incontinence and was independent with toileting and toilet hygiene.	S5047		

6/26/25

Willow Creek
ElderCare Communities

Buffalo

Survey Date: June 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.

Tag S5005 – Chapter 12, Section 7(a) & 8(a)(H): Core Services & Incontinence Care

Regulatory Requirement:

Facilities may care for residents who are incontinent only if the condition can be managed independently by the resident (Ch. 12 §7(a)(H)); providing incontinence care by staff is not permitted in Level I facilities (Ch. 12 §8(a)(vii)).

Corrective Action & Plan:

Resident #2 is able to independently toilet, though occasional accidents occur. Staff provide environmental support only (e.g., housekeeping and laundry) in accordance with the resident's care plan. No direct incontinence care is provided. Incontinence products are made available for the resident's use.

Willow Creek
ElderCare Communities

On June 20, 2025, Willow Creek implemented a room care schedule assigning each resident a weekly deep clean/laundry/shower day. A tracking form now requires:

- Resident room number
- Date of service
- Staff signature
- House manager signature
- Resident acknowledgment (optional, when appropriate)

Daily tasks such as trash removal, surface disinfection, and vacuuming are documented on a Master Daily Task Schedule. This reinforces accountability and environmental cleanliness.

Because some residents are highly independent, these forms also ensure that cleaning services are consistently offered and accepted or declined with clear documentation.

Ongoing Monitoring:

- Weekly review of cleaning logs by (Manager)
- Monthly review of hygiene/cleanliness practices during staff meetings
- Resident feedback tracked via Resident Council Meetings, led by (Assistant Manager)

Tag S5009 – Chapter 12, Section 7(b)(iv): Resident Assessments

Regulatory Requirement:

A full assessment must be completed:

(B) Immediately upon any significant change in the resident's physical or mental condition

(C) At least once every twelve (12) months

Corrective Action & Plan:

Willow Creek's Registered Nurse completed new assessments, Care plans and documentation for all residents. This aligns with our goal of maintaining current nursing documentation for all residents.

She also implemented a formal Resident Assessment System including:

- Mini-Mental Status Exams (MMSE)

- Functional Screening Tool (ALF 102) with staff guide

- Comprehensive physical assessments

- Medication review sheets, individualized plans of care, and tracking logs

Assessment dates are now tracked centrally to ensure all are completed on time and when significant changes occur.

Ongoing Monitoring:

- (RN) will perform weekly resident reviews and initiate assessments when necessary

- (Manager) and (Assistant Manager) will help track assessment schedules and organize care plan updates

- Staff will be retrained quarterly on identifying changes in resident condition and triggering reassessment

Willow Creek
ElderCare Communities

Resident #2 Support Plan

During the June 2025 Resident meeting, Resident #2 expressed feelings of depression and a desire for more support with hygiene.

As a result:

- Staff were directed to provide regular encouragement for personal hygiene

- Resident #2 is now offered assisted showers more regularly

- (Assistant Manager) is performing weekly personal wellness check-ins to assess mood and encourage engagement

Date of Full Compliance: All corrective actions completed by July 12, 2025. Ongoing systems are in place to ensure full regulatory compliance.

o Monthly QAPI meetings for at least three months or until substantial compliance is achieved.

Responsible Party: Manager or designee will be responsible for overseeing all corrective actions, system changes,

monitoring, and QAPI involvement to ensure compliance .

Date: 6/26/25

Eric McMillan, President

Submitted By: Mngr, Assistant Mngr, RN

Phone: (307) 684-8669 **Email:** Willowcreekofbuffalo@gmail.com

Willow Creek
ElderCare Communities

ELDER CARE, INC
Casper, WY 82609
Phone: 307-215-0282
willowcreekcommunities@gmail.com

FAX TRANSMITTAL SHEET

Date: 7/8/25

To: Tim C. Fax No. _____

From: Eric Fax No. 307-333-2125

Total Number of Pages (including cover sheet) _____

Comments: Willow Creek of Buffalo

Buffalo

Survey Date: June 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.

Tag S5005 – Chapter 12, Section 7(a) & 8(a)(H): Core Services

1. The facility Manager will create a document for the residents to sign when they have received their weekly room, trash & bathroom cleaning. This will go to provide a 3rd party verification that services have been provided.

2. The facility manager will get written surveys from the residents asking if the residents prefer the current condition, they have kept their room in or if they prefer it to allow staff to change their current arrangement.

3. QA regarding residents housekeeping will occur by 6/25/2025.

4. Corporate officer and manager will verify resident housekeeping has been completed with & all necessary documentation for 1 month.

5. Date of compliance ~~6/25/2025~~. 7/12/25

Tag S5009 – Chapter 12, Section 7(b)(iv): Resident Assessments

Regulatory Requirement:

A full assessment must be completed:

(B) Immediately upon any significant change in the resident's physical or mental condition

(C) At least once every twelve (12) months

Corrective Action & Plan:

Willow Creek's Registered Nurse completed new assessments, Care plans and documentation for all residents. This aligns with our goal of maintaining current nursing documentation for all residents.

She also implemented a formal Resident Assessment System including:

- Mini-Mental Status Exams (MMSE)

- Functional Screening Tool (ALF 102) with staff guide

- Comprehensive physical assessments

- Medication review sheets, individualized plans of care, and tracking logs

Assessment dates are now tracked centrally to ensure all are completed on time and when significant changes occur.

Ongoing Monitoring:

- (RN) will perform weekly resident reviews and initiate assessments when necessary

- (Manager) and (Assistant Manager) will help track assessment schedules and organize care plan updates

- Staff will be retrained quarterly on identifying changes in resident condition and triggering reassessment

Resident #2 Support Plan

During the June 2025 Resident meeting, Resident #2 expressed feelings of depression and a desire for more support with hygiene.

As a result:

- Staff were directed to provide regular encouragement for personal hygiene

- Resident #2 is now offered assisted showers more regularly

- (Assistant Manager) is performing weekly personal wellness check-ins to assess mood and encourage engagement

Date of Full Compliance: All corrective actions completed by July 12, 2025. Ongoing systems are in place to ensure full regulatory compliance.

o Monthly QAPI meetings for at least three months or until substantial compliance is achieved.

Responsible Party: Manager or designee will be responsible for overseeing all corrective actions, system changes,

monitoring, and QAPI involvement to ensure compliance .

DOC- 7/12/25

Tag S5047 – Chapter 12, Section 7(a) & 8(a)(H): Core Services & Incontinence Care

Regulatory Requirement:

Facilities may care for residents who are incontinent only if the condition can be managed independently by the resident (Ch. 12 §7(a)(H)); providing incontinence care by staff is not permitted in Level I facilities (Ch. 12 §8(a)(vii)).

Corrective Action & Plan:

Resident #2 is able to independently toilet, though occasional accidents occur. Staff provide environmental support only (e.g., housekeeping and laundry) in accordance

with the resident's care plan. No direct incontinence care is provided. Incontinence products provided by family are made available for the resident's use.

On June 20, 2025, Willow Creek implemented a room care schedule assigning each resident a weekly deep clean/laundry/shower day. A tracking form now requires:

- Resident room number
- Date of service
- Staff signature
- House manager signature

Willow Creek
ElderCare Communities

- Resident acknowledgment (optional, when appropriate)

Daily tasks such as trash removal, surface disinfection, and vacuuming are documented on a Master Daily Task Schedule. This reinforces accountability and environmental cleanliness.

Because some residents are highly independent, these forms also ensure that cleaning services are consistently offered and accepted or declined with clear documentation.
DOC - 7/12/25

Ongoing Monitoring:

- Weekly review of cleaning logs by (Manager)
- Monthly review of hygiene/cleanliness practices during staff meetings
- Resident feedback tracked via Resident Council Meetings, led by (Assistant Manager)

Eric McMillan, President

Date: _____

Submitted By: Mngr, Assistant Mngr, RN

Phone: (307) 684-8669 **Email:** Willowcreekofbuffalo@gmail.com

7/30/25- 11:30 AM The plan was accepted via conference with the facility owner, Eric McMillan, and facility Manager, Shelby Young, with agreed upon Changes