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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056074	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Creek Post Acute	587 Rio Lindo Avenue Chico, CA 95926

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41715 Based on interview and record review, the facility failed to protect one of five sampled residents (Resident 1) from being injured by staff. This resulted in a skin tear to the resident and had the potential to cause psychosocial (mental/socializing) harm. Findings Resident 1 was admitted to the facility with difficulty in walking, falls and a fractured leg, colon cancer, and vascular dementia, a type of memory loss from insufficient blood flow to the brain. Resident 1 was unable to complete a mental assessment conducted on 8/6/24 and was assessed with moderate impairment of her cognitive ability (mental health). A review of the facility ' s policy titled Abuse Prevention and Management, dated 1/1/12, indicated that the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, or mistreatment. A review of a nearby hospital ' s admission record indicated that on 8/18/24 at 8:30 AM, Resident 1 was seen in the emergency room for a repair of a skin tear. Review of a report dated 8/19/24, filed by the facility to the California Department of Social Services, indicated that Resident 1 was found to have an extensive skin tear (separation of the upper layer of skin) to her left hand on 8/18/24 at approximately 7:20 AM. In an interview on 8/20/24 at 11:48 AM, Facility Administrator (ADM A) stated that Resident 1 ' s skin tear occurred after CNA (Certified Nursing Assistant) B was caring for her and abandoned her shift. ADM A stated that CNA B worked on the night shift of 8/17/24 and was assigned to Resident 1. ADM A stated that CNA B was a registry (temporary help) CNA from a staffing agency. (continued on next page)

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.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADM A stated that later that night, LVN C relieved the night shift nurse that morning. LVN C came in to see the Resident 1 and gave her her morning medications at 6:00 AM, assessed the resident, there was no skin tear present on her hand. ADM A stated that CNA G clocked out at 7:08 am, without reporting off to anyone. At 7:20, the next shift CNA D began rounding on his resident rooms, he was assigned to Resident 1. ADM A stated that CNA D couldn't find CNA B to get report from her. He went into Resident 1 ' s room and saw her left hand had a large skin tear and was bleeding onto the sheet into a red pool of blood. He came out immediately and notified the charge nurse, and filed a report to the state, to the police, and to the ombudsman. ADM A stated, We tried calling [CNA B] to see what happened, but she wouldn't answer her phone. In an interview on 8/20/24 at 12:30 PM, Resident 1 stated, I got attacked by a woman. She tore my hand up. I had no idea why she attacked me. Resident 1 was concurrently observed to have a curved, approximately 5 cm x 2 cm, thumb-shaped skin tear that appeared to be consistent with having been grabbed from behind. The skin tear has a deep bruise beneath the lower portion. Resident 1 stated that CNA B who injured her was dark skinned, Dark complected. Resident stated that on first night of incident she didn't sleep much and was [NAME] about staying. In a telephone interview on 8/20/24 at 1:30 PM, CNA B denied injuring Resident 1 or being aware the resident was injured, but confirmed that she had been assigned to Resident 1 on 8/18/24. CNA G stated that Resident 1 could be characterized as having dementia and combative. In an interview on 8/20/24 at 2:05 PM, LVN C stated that she came in to work on the morning of 8/18/24 LVN C stated that she passed Resident 1 ' s medications at 6 AM and that there was no skin tear on her hand. Shortly thereafter, LVN C stated that the day CNA D came in and started to round on his residents and reported to LVN C that he had noticed nobody had (had their diapers or briefs) changed. CNA D went into Resident 1's room and came right out, saying there was a big skin tear on her hand and fresh blood on the blanket. LVN C stated that CNA B was nowhere to be found. LVN C stated, Usually registry CNAs come to me at the end of the shift to get a sign-off for their employer. She had left, wasn't interested in giving report, but it was clear she was having a rough night and was upset. LVN C described CNA B as tall and dark-skinned, never worked here before. LVN C stated that it appeared that perhaps CNA B went into the room to change Resident 1 hurriedly and grabbed Resident 1's hand to prevent her from resisting. In an interview on 8/20/24 at 3:50 PM, CNA D stated that he had relieved CNA B in providing care to Resident 1. CNA D stated, I got there at 7 AM on 8/18/24. We have our rooms assigned and we usually round with night shift. [CNA B] never came, I started looking for her. Then I noticed things hadn't been done, residents hadn't been changed. I went into Resident 1 ' s room, saw red on her bed and a big skin tear. I ran to the nurse's station to report it. If I hadn't rounded that morning, it could have fallen on me. She left without telling anyone what happened. There were two other residents on her run, they were wet, two were sitting in feces. It was a horrible job.CNA D stated that Resident 1 ' s skin tear appeared bruised and swollen, more like it had hit a surface like the bed headboard. CNA D stated that he sees a lot of skin tears and they are never bruised like that. The pattern she left looks like [CNA B] grabbed her left hand to change her. [Resident 1] does strike out.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 41715 Based on interview and record review the facility failed to follow physician orders to consistently cover and protect Resident 2 ' s nephrostomy stoma (a hole in a resident ' s back with a tube to drain urine from the kidney into a bag) during showers, and failed to remove the dressings for Resident 2, Resident 3, and Resident 4 following their dialysis treatments as required. This had the potential to contribute to infection, illness, and may have contributed to an interruption to Resident 2, 3 and 4 ' s care. Findings Resident 2 was admitted to the facility for conditions including end stage renal disease (kidney disease worsening), diabetes, history of stroke, dementia, and was dependent on dialysis (using a machine to do the work of the kidney to clean the blood of waste). A review of the facility ' s policy titled, Dialysis Care, dated 10/1/18, indicated that the facility will arrange for dialysis care as ordered by the attending physician. The policy indicated, Facility Staff will educate resident on the importance of complying with the care plan and attending physician orders. Review of the section Arteriovenous Shunt, a graft of a patient ' s own vein and artery to be used for dialysis treatments, Dressing will be changed in accordance with physician ' s order. Resident 2 ' s post-treatment notes were reviewed (post treatment notes are a binder prepared by the dialysis nurse that travels back and forth with the resident to communicate dialysis results and goals with the skilled nursing facility). A review of post treatment notes dated 7/29/24 indicated, Old gauze left on since last treatment! Please remove today ' s gauze after four hours! A review of physicians ' orders for resident 2 indicated that the facility ' s medical director wrote an order dated 8/12/24 indicating, Ensure that compression dressing from dialysis site is removed four hours after dialysis treatment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/19/24 at 10:54 AM, an outside Dialysis Social Services (DSS F) stated that when Resident 2 left dialysis on several occasions, the nurses put a compression dressing on his access site (where needles are inserted to remove and replace dialysis blood) . DSS F stated that these dressings consistently need to be removed after four hours to prevent damage to the access site. DSA stated, Within the past month there have been at least 2 occasions when [Resident 2] returned to us two days later with the bandage still on. This is a compression bandage that is just intended to stop bleeding and can reduce circulation through the graft and cause it to clot if it is left on. We put big notes on his treatment binder that returns with him to the facility to remind staff to take off the bandage after four hours. On August 12 he came in for treatment and the access had clotted and he could not have dialysis that day because we had no access. He went to a vascular surgeon to have it de-clotted. I believe the nurse put a doctor's order in to trigger them to take the bandage off after we kept telling them. DSA stated that the pressure dressing remaining on Resident 2 ' s arm could have been a contributing factor to his clotting. A review of follow-up correspondence from DSS F dated 8/21/24, indicated that The standard of care for AV fistula or graft (the type of dialysis access Resident 2 had), is to remove the dressing four hours after treatment. It is recommended that you twist the bandaging to prevent skin or scab tears. Patients are advised not to leave the bandage on longer, or even to wear tight clothing or jewelry on their access (dialysis vein access). If the patient bleeds during bandage removal, they are advised to place new gauze and hold pressure for 10 minutes and re-check. In an interview on 8/20/24 at 12:35 PM, Licensed Vocational Nurse (LVN E) stated that there are inconsistent compliance with removing Resident 2 ' s dressing before showering or after 4 hours of it being placed on. Patients come back from dialysis with a dressing. I usually assess it in a few hours. If the shunt is dry and clean, I take off the dressing and leave it open to air, he staed. I know sometimes the other nurses don't take it off. I will come back from my day off and find that it's still on after a patient comes back from dialysis. There has been no staff inservice (on-the-job-teaching) that I know of for this particular type of dressing. We get their post-treatment binder back when they return from dialysis. Sometimes there's a yellow sticky note on the chart to removed the dressing, I'm not sure it's standard practice, but it's my practice. In an interview on 8/20/24 at 12:45 PM, LVN C stated that Resident 2 was a dialysis patient who returned from her dialysis appointment today. Resident 2 was observed to have two small folded compression dressings underneath a larger dressing on her left arm. LVN C stated, [Resident 2] came back from dialysis at 10:30. There were no instructions when to take her dressing off. I usually keep it in place for 24 hours then take it off. LVN C stated she doesn't have Resident 1 (above) as a patient, but his dressing is usually taken off the next day. In a concurrent interview and record review on 8/20/24 at 1:00 PM, LVN G stated that she was caring for Resident 3 who received dialysis that day, Resident 3. LVN D stated that Resident 3 had returned from dialysis earlier that morning at 8:20 AM, four hours and forty minutes prior to when dressing was observed to continue to remain on Resident 3 ' s arm. Resident 3 stated that she prefers to take the dressing off herself. LVN D stated that she does not usually remove pressure dressings from residents who receive dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/20/24 at 1:10 PM, CNA E was confused about how long dialysis dressings are to be left on residents or whether they should be covered in the shower. CNA E stated, I believe dialysis residents' dressings stay on for 30 minutes. The nurses leave them on and some ask her to take it off. Resident 4 was admitted to the facility for end stage kidney disease, muscle weakness, and lung disease. In an interview on 8/20/24 at 1:12 PM, Resident 4 stated that she receives dialysis at an outside facility. Resident 4 stated that she unwraps her dressing herself, they don't unwrap it. She stated that sometimes her bandage stays on too long and it gets irritated. In an interview on 8/20/24 at 1:20 PM, LVN F was familiar with the four-hour time frame to unwrap dialysis dressings and stated that it was a commonly known standard of care. In a follow-up interview on 8/23/24 at 10:47 AM, DSSF further stated that she had a conversation with the unit manager at the skilled nursing facility and that she knew exactly what I was talking about that the dressings were not being removed. Some days its fine. Some days not, DSS F sated, it's inconsistent and doesn't seem like all staff know what to do. It seems like the residents who are more alert and oriented and received dialysis either take it off themselves or ask to have it taken off. [Resident 2] doesn ' t know any better, or to ask them to take it off. The Unit Manager said that she would educate staff.