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	02/28/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 46147 Based on interview, and record review, the facility failed to ensure three of 10 sampled residents (Resident 6, 8 and Resident 9) were treated with dignity and respect when Licensed Nurse (LN) D spoke to the residents with a demeaning tone, was rushing with medication administration, and was not gentle with medication administration. This failure had the potential to result in emotional stress, embarrassment, feelings of neglect, increased anxiety, fear, and isolation. Findings: The facility's policy revised 1/2012, titled, Residents' Rights, indicated the purpose of this policy is to promote and protect the rights of all residents at the facility. Employees are to treat residents with kindness, respect and dignity and honor the exercise of residents' rights. The facility's policy revised 3/2017, titled, Quality of Life-Dignity, indicated that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. All residents shall be treated with dignity and respect at all times. Demeaning practices and standards of care that compromise dignity is prohibited. Verbal staff to staff communication is conducted outside the hearing range of residents and the public. During a review of Resident 9's clinical record titled Admission Record, indicated Resident was admitted the facility on 12/20/24 with diagnoses that included diabetes (too much sugar in the blood), end stage renal (kidney) disease, depression (persistent feelings of sadness), suicidal ideations (thinking about or planning suicide), generalized anxiety (uncontrollable worry, persistent feel of dread interfering with daily life), Peripheral Vascular Disease (PVD, poor circulation or reduced blood flow in the legs and arms) and schizoaffective disorder (mental illness in which people experience low motivation, intense sadness, and poor attention). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 9 dated 2/11/25, indicated that Resident 9 was cognitively intact (ability to think, reason and make decisions), with a brief interview for mental status (BIMS) score of 15 out of 15, and was totally dependent for staff with all activities of daily living (ADLs). (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 9's clinical record, titled, MDS, section GG , dated 2/11/25, indicated Resident 9 is totally dependent on facility staff for medication administration. During an interview on 2/13/25 at 11:15 am, Resident 9 stated, I don't trust LN D and I am scared of LN D, she is paranoid. She has an attitude and and mistreats the staff. LN D yells at the staff all the time and I can hear it in my room. My personal example is she is not gentle, she is rough. The other nurses take their time giving me a shot. She has an attitude and is disrespectful. During a review of Resident 8's record titled Admission Record, indicated Resident 8 was admitted the facility on 12/6/24, with diagnoses that included chronic respiratory failure, (lungs cannot exchange oxygen adequately), diabetes, congestive heart failure (long term condition when the heart muscle cannot pump adequately), atrial flutter (irregular heartbeat), and high blood pressure. A review of the most recent MDS, for Resident 8 dated 12/6/24, indicated that Resident 8 was cognitively intact with a BIMS score of 15 out of 15 and was totally dependent for staff with all ADLs. During a review of Resident 8's record titled, MDS, section GG , dated 12/6/24 , indicated Resident 8 is totally dependent on facility staff for medication administration. During an interview on 2/13/25 at 11:20 am, Resident 8 stated, Well, I don't like to talk bad about anyone, but LN D makes my anxiety worse. She is paranoid, as an example she will ask me if I am videoing her. I don't want her as my nurse, but I am afraid to tell anyone. I am scared of her but scared to report her also. LN D is not very kind, you can tell the ones who care about you, I would say she has an attitude. Please ask other residents too, I don't want to be the one to get her into trouble. During a review of Resident 6's record titled Admission Record, indicated Resident 6 was admitted the facility on 3/15/24, with diagnoses that included heart disease, depression, pulmonary edema (fluid buildup in the lungs), atrial fibrillation (irregular heartbeat), lymphedema (selling caused by lymph fluid), history of falling, and kidney stones. A review of the most recent MDS, for Resident 6 dated 11/22/24, indicated that Resident 6 was cognitively intact with a BIMS score of 15 out of 15, and was totally dependent for staff with all ADLs. During a review of Resident 6's record titled, MDS, section GG , dated 11/22/24, indicated Resident 6 is totally dependent on facility staff for medication administration. During an interview on 2/13/25 at 1:50 pm, Resident 6 stated, LN D complains about everything every time she works, always complaining. She is always rude to the other staff which bothers me because the staff is good to me, I don't like to hear her fuss at them. I have heard LN D be rude to everyone, even the patients, I can hear her from my room. She huffs and puffs a lot. LN D doesn't want to work; you know people like that it is obvious they don't like their job. You can tell the only reason she is here is for the money, it is not to help others. It is a sad and bad situation for the rest of us. During an interview on 2/13/25 at 10:38 am. Certified Nursing Assistant (CNA) I stated, LN D is rude to all of us and the residents, please just go ask the residents and they will tell you. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/25 at 10:45 am, CNA G stated, I hope you are here for the nurse LN D, she yells at the staff and the residents. During an interview on 2/13/25 at 10:50 am, LN B stated, LN D is paranoid, talks to herself, and she is rude to all of us. I heard she treats the residents horrible, but I did not hear it firsthand, please go talk with some residents that are alert and oriented. I cannot report verbal abuse if I don't hear it, but I have told the staff to report any type of abuse they see or hear. I will tell you who is alert and oriented so you can investigate LN D's behaviors. During an interview on 2/13/25 at 11:50 am, LN C stated, LN D does not have a good personality. LN D is not approachable or friendly, she is paranoid at times. I have heard LN D is rude with the residents, but I have not personally seen her interact with any residents. During an interview on 2/26/25 at 12:40 pm, the Administrator (Admin) confirmed that the treatment of any resident in a rude and disrespectful way was unacceptable and would not be tolerated. Admin stated, LN D is very curt, but I did not know she is like that with the residents. I do confirm LN D has poor customer service skills. I have never heard she was rough with insulin administration, but I do know she tends to mumble out loud. During a record review titled, Corrective Action Memo, dated 9/2/24, 9/17/24, and 11/7/24, LN D was given a write up including Violation of Safety Rules , Failure to follow instructions, and Other related to pain management, involving residents in the facility. These Corrective Action Memos were signed and dated by LN D and the supervisor. During an interview on 2/26/25 at 1:14 pm, LN D stated, I am not rude, I am just straight forward.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on interview, record review, and the facility's policy, the facility failed to update a change of condition for one of three sampled residents (Resident 1) when: 1.The Licensed Nurse (LN) did not update the physician when Resident 1 needed oxygen for a new onset of shortness of breath. 2. The LN did not notify Resident 1's family or responsible party when there was a major decline in health status. This failure resulted in a poor negative clinical outcome for Resident 1. Findings: 1. During a review of the facility's policy revised [DATE], titled, Change of Condition Notification, indicated A Licensed Nurse will notify the resident's Attending Physician and legal representative or an appropriate family member when there is an: A significant change in the resident's physical, mental or psychosocial status, deterioration in health, mental or psychosocial status, life-threatening conditions or clinical complications. Any untoward response or reaction by a patient to a medication or treatment. A need to alter treatment significantly (e.g. based on lab/x-ray results, a need to discontinue an existing form of treatment due to change of condition). Reporting Information to the Attending Physician: Emergency Situations: In emergency situations, (a resident is experiencing unexpected shortness of breath, intense pain, unexpected bleeding, serious abnormal labs or x-ray) the Licensed Nurse will: Call the Attending Physician stat (Without delay, immediately). During a record review, a document titled, Licensed Vocational Nurse (LN) Job Description, indicated the LN Provides nursing care as prescribed by physician/health care professional in accordance with the legal scope of practice, any Board of Licensing restrictions, and within established standards of care, policies, and procedures. The LN administers professional services and provide care consistent with allowing residents to attain or maintain his or her highest practicable physical, mental, and emotional well-being. Provides clinical data and observations to contribute to the nursing plan of care. Admits, transfers, and discharges residents in accordance with policy and procedure. Collects clinical data and reports significant clinical findings according to policy. Prepares/administers medications as ordered by the physician and within the legal scope of practice. Presents professional image to consumers through dress, behavior, and speech. Treats residents/family members with dignity and respect. Records care information accurately, timely and concisely. Completes all required documentation including resident observations, interventions, and patient response(s) in the medical record in accordance with policy. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's clinical record titled Admission Record, indicated Resident was admitted the facility on [DATE], with diagnoses that included diabetes (too much sugar in the blood), Cerebral Vascular Infarction (CVA, or stroke), congestive heart failure (CHF, (long term condition when the heart muscle cannot pump adequately), severe protein malnutrition (poor nutrition without enough energy or protein), dysphagia (difficulty swallowing), altered mental status (simply confusion), heart disease, high blood pressure, seizures (convulsions, sudden involuntary movements caused by abnormal brain activity), chronic pain (long lasting health condition), and tobacco use. A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 1 dated [DATE], indicated that Resident 1 was cognitively intact (ability to think, reason and make decisions), with a brief interview for mental status (BIMS) score of 13 out of 15, and was totally dependent for staff with all activities of daily living (ADLs, personal hygiene, dressing, toileting, transferring and bathing). During a review of Resident 9's clinical record, titled, MDS, section GG , dated [DATE], indicated Resident 9 is totally dependent on facility staff for all ADLs. During an interview on [DATE] at 10:30 am, LN E stated, I asked about [Resident 1] yesterday why he was not in the dining room, and I was told he went to lay down because he was not feeling good. During an interview on [DATE] at 10:38 am, Certified Nursing Assistant (CNA) I stated, I was told [Resident 1] told LN D he had a headache, which is unusual for him, he is always up and around in activities, he was alert and oriented. During an interview on [DATE] at 11:20 am, Resident 8 stated, Another example related to LN D is I heard a CNA in the hall ask her to call a family and LN D stated, Another nurse can do that, I am not calling the family. During an interview on [DATE] at 11:35 am, Resident 5 stated, My roommate just passed away. He had complained of a headache. He just kept coughing for days, and then he died in his sleep. He was coughing several days, the headache I remember he had a couple of days, I think worse yesterday, then he just died last night, just like that, he just died . 2. During an interview on [DATE] at 1:20 pm, LN D confirmed she did not document any notes about Resident 1's change in condition, and she did not call the the Responsible Party (RP). LN D stated, I did not inform the RP with the change of condition, I think I texted the physician when I put the oxygen on [Resident 1], he was also having diarrhea. Resident 1 said he was having a hard time breathing; I should have called the RP looking back. I did not document any notes on Resident 1's change of condition and I did not place him on alert charting. During an interview on [DATE] at 2:15 pm, the Administrator (Admin) confirmed LN D did not call the physician for Resident 1 when he was short of breath and needed oxygen, there was no alert charting for a new cough, no change of condition was documented, and did not update the RP.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on interview, record review, and the facility's policy, the facility failed to ensure timely, accurate, and complete documentation for one of three residents (Resident 1) when there was a change in condition. This failure resulted in an incomplete, and an inaccurate clinical medical record, for Resident 1. Findings: During a review of the facility's policy revised 4/1/2015, titled, Change of Condition Notification, Documentation: A Licensed Nurse will document the following: Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. The time the family/responsible person was contacted. iv. Update the Care Plan to reflect the resident's current status. The incident and brief details in the 24-Hour Report. If the resident is transferred to an acute care hospital, complete an inter-facility transfer form. Complete an incident report per Facility policy. A Licensed Nurse will communicate any changes in required interventions to the CNAs involved in the resident's care. A Licensed Nurse will document each shift for at least seventy-two (72) hours. Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the Twenty-Four-Hour Report. During a record review, a document titled, Licensed Vocational Nurse (LN) Job Description, indicated the LN Provides nursing care as prescribed by physician/health care professional in accordance with the legal scope of practice, any Board of Licensing restrictions, and within established standards of care, policies, and procedures. The LN administers professional services and provide care consistent with allowing residents to attain or maintain his or her highest practicable physical, mental, and emotional well-being. Collects clinical data and reports significant clinical findings according to policy. Records care information accurately, timely and concisely. Completes all required documentation including resident observations, interventions, and patient response(s) in the medical record in accordance with policy. During a review of Resident1's clinical record titled Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included diabetes (too much sugar in the blood), Cerebral Vascular Accident (CVA, stroke), congestive heart failure (CHF, long term condition when the heart does not pump blood adequately), severe protein malnutrition (poor nutrition without enough energy or protein), dysphagia (difficulty swallowing), altered mental status (AMS, or confusion), heart disease, high blood pressure, seizures (convulsions, sudden involuntary movements caused by abnormal brain activity), chronic pain (long lasting health condition) and tobacco use. During a review of the most recent Minimum Data Set, (MDS, a resident assessment), dated 1/24/25, indicated Resident 1 was cognitively intact (ability to think, reason, and make decisions), with a brief interview for mental status (BIMS) score was 13 out of 15, and was totally dependent for staff with all activities of daily living (ADLs, personal hygiene, dressing, toileting, transferring and bathing). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's clinical record, dated 2/12/25 through 2/13/25, there were no progress notes for nursing documentation that indicated the most recent LN D assessment to reflect Resident 1's new onset of shortness of breath, for oxygen needed, no notification to the physician, and no update to the Responsible Party (RP). Resident 1 was not added to alert charting for communication for all staff per facility policy. During an interview on 2/26/25 at 1:14 pm, LN D stated, I did not document any changes for Resident 1. I did not make any entries in the nurses' notes for Resident 1, or document I had texted the physician, and I did not add Resident 1 to alert charting to continue to monitor. During an interview on 2/26/25 at 2:15 pm, the Administrator (Admin) confirmed there was no documentation for Resident 1, there was nursing notes to identify changes in Resident 1, and Resident 1 was not put on alert charting for communication per their policy. Admin stated, There is nothing here, I cannot find any notes from LN D. There are no notes for administering oxygen to [Resident 1].