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	04/23/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observation, interview and record review, the facility failed to ensure narcotic (controlled drugs, also called opioid pain relievers with potential for abuse) medications for pain control were accurately used and documented in the medical records for one out (Resident 1) of eight sampled residents. This deficient practice had the potential for medication errors and risk of drug diversion. Findings: During a review of the facility policy titled, Medication - Administration , revised 1/1/2012, indicated: The purpose of the policy is to ensure the accurate administrate of medications for residents in the facility. Medication Rights: - Nursing staff will keep in mind the seven rights of medication wen administering medication. - The seven rights of mediation are: The right medication; the right amount; the right resident; the right time; the right route; Resident has right to know what the medication does; Resident has the right to refuse the medication (unless court ordered). During a review of the facility policy titled, Administration of Pain Medication , revised 11/2016, indicated that the Licensed Nurse (LN) will only administer pain medications according to the physician's order. While administrating the pain medication, the LN will review the physician orders and administer the pain medications as ordered. The LN will document the administrator of an around-the-clock (ATC) pain medication on the Medication Administration Record (MAR). During a review of the facility policy titled, Medication - Errors , revised 7/2018, indicated: The purpose of the policy is to ensure the prompt reporting of errors in the administration of medications and treatments to residents. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All errors related to the administration of medications or treatments will be reported to the Director of Nursing Services (DNS), the attending physician, and the Administrator immediately. The DNS will notify the Attending Physician, resident, and responsible party of the medication error. The Licensed Nurse will make an immediate assessment of the resident in relation to the nature of the error and continue to monitor the resident closely for any adverse effects from medication error. Medication Error means the administration of medication: To the wrong resident. ; At the wrong time ; At the wrong dose ; Via the wrong route ; Which is not currently prescribed. A Medication Error Report is completed for all mediation administration errors. The medication given in error is documented in the Medication Administration Record (MAR). Follow-up notes are written if any adverse effects are noted, including the monitoring of residents and therapy given. The Director of Nursing Services or his/her designee will investigate the error to determine the cause. The Administrator will determine if any corrective or disciplinary action is required. The Quality Assessment and Assurance Committee reviews medication errors at their meetings. During a review of Resident 1's admission record, indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses which included chronic pain, non-pressure chronic ulcer (a persistent, open sore or wound that doesn't heal, and isn't caused by prolonged pressure) of right lower leg with fat layer exposed, non-pressure chronic ulcer of left lower leg with unspecified severity, heart failure (when the heart can't pump enough blood to meet the body's need), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body), and end stage of renal disease. Resident 1 was not her health care decision maker. During a review of Resident 1's most recent Minimum Data Set (MDS - an assessment and care screening tool), dated 3/18/25, indicated Resident 1's cognition was intact. Resident 1 suffered constant pain at the level of 9 out of 10 on the pain scale, and the pain had been interfering with her sleep and the therapy activities. During an interview on 3/25/25 at 2:38 pm with Resident 1 and Resident 1's Responsible Party (RP) in Resident 1's room, the RP stated Resident 1 was in pain constantly and needed to take the pain medication right on the schedule. During a review of Resident 1's physician order, indicated doctor's orders for an opioid pain medication as follow: Hydrocodone-Acetaminophen (combination pain and opioid medication) tablet 10-325 MG (a unit of measure); Give ONE tablet by mouth every 6 hours as needed for moderate pain level 5-7 or excruciating pain level 8-10; Start date 3/4/25; Order Status: Active. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record on 3/29/25 at 7:19 am with Licensed Nurse (LN) J, a comparative review of Resident 1's medical record titled, Individual Narcotic Record (INR) and the corresponding Medication Administration Record (MAR) with date range of 3/1/25 to 3/29/25, for the above order, LN J confirmed with the following inconsistencies in administration and narcotic opioid use: - 3/21/25: INR documentation for Hydrocodone-Acetaminophen 10-325 MG, ONE tablet removed at 8 pm by LN C, with a black line marked through the record, with a word written Error . There's no signature of who marked the error line; there's no indication of what Error was made; The corresponding documentation in Resident's MAR indicated one tablet given. - 3/22/25: INR documentation for Hydrocodone-Acetaminophen 10-325 MG, ONE tablet removed at 11 am by LN U, however, there was a black line marked through the record, with a word written Error , with LN U's signature next to the Error , there's no indication of what Error was made; The corresponding documentation in Resident's MAR indicated one tablet given. LN J stated she could not locate any medication error note in Resident 1's record. LN J said, From what I could tell, the medication was not given to Resident 1. I don't know what happened. But if that happened to me, I would call the Director of Nursing (DON) and ask for instructions. Usually, two nurses needed to waste that medication together and signed their names on the INR. It didn't happen here! During a concurrent interview and record review with DON, on 4/8/25 at 12:32 pm, in the survey room, Resident 1's INR was reviewed. The DON stated, The nurse cannot receive the Med Cart (or medication cart, is a wheeled, mobile storage unit used in healthcare facilities to store and transport medications and medical supplies) if there's a discrepancy on the Narcotic count. They would call me, so we would go back to the administration record to find out what had happened. If a pill was found in the Bubble Pack (also known as a Blister Pack - a card that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles), and not given to the resident, they had to pop it, destroy it, and both nurses cosigned it to the resident's INR. The DON confirmed that Resident 1's INR documentation for Hydrocodone-Acetaminophen, on 3/21/25 and 3/22/25, by stating, Those shouldn't mark as an Error , the staff's initial was missing on 3/21/25. They should have called me. The DON confirmed that it appeared that the medication was not given to Resident 1. The DON later identified that Resident 1 had two INR for Hydrocodone-Acetaminophen with different strengths, Page 32 was for Hydrocodone-Acetaminophen with strength of 5-325 mg; Page 33 was for Hydrocodone-Acetaminophen with strength of 10-325 mg. The DON stated, LN C was not paying attention, signed off at the different page. However, the DON could not locate an order for Hydrocodone-Acetaminophen with strength of 5-325 mg in Resident 1's record. The DON stated, I would have to do my own investigation and find out what happened. The DON agreed that if LN C had followed the Seven Medication Rights policy, LN C would have noticed that page 32 was not the right dose, right order for Resident 1. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/17/25 at 9:30 am, with the administrator (ADMIN) and the DON, in the survey room, the ADMIN stated they had completed their investigation and concluded that LN C gave Hydrocodone-Acetaminophen 5-325 mg to Resident 1 on 3/21/25. The [NAME] stated, When the medication was changed or about to run out, we put in the new order, the pharmacy came in and gave it to the nurse. The nurse just locked them into the Med Cart. The cart could still have some old (cancelled) pill packs that had some pills left. And that's what happened to LN C. It was given but under dosage. The order for the 5-325 MG was cancelled. The new order was for 10-325 mg. A review of Resident 1's INR for Hydrocodone-Acetaminophen 5-325 MG, the ADMIN and the DON confirmed that Resident 1 was given this medication one time on 3/21/25, 3/22/25, 3/24/25, and 3/29/25, three times on 3/23/25, and twice on 3/25/25. A total of 9 medication errors by administrating at the wrong dosage in 9 days. During an interview on 4/17/25 at 11:25 am, with Resident 1's RP, in the hallway outside Resident 1's room, the RP stated he was not aware of whether the resident was getting the wrong dosage of the pain medication, RP stated, No one had told me. She just had more pian .