| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056074 | A. Building<br>B. Wing | 05/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Creek Post Acute | 587 Rio Lindo Avenue<br>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.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739<br><br>Based on interview and record review, the facility failed to ensure an infection control program was implemented by Infection Preventionist (IP) to reduce the spread of infection in the facility for three of the three sampled residents (Resident 1, 2, and 3) when:<br><br>1. Resident 1 was tested positive for Multidrug-resistant organisms (MDROs - microorganisms or germs, such as bacteria or fungi, that are resistant to one or more classes of antimicrobial agents) in the urine (on 3/21/25) and wound (on 3/31/25). Resident 1 continued residing in a shared room (ROOM A) with two other residents (Resident 2, 3).<br><br>2. Resident 2 was transferred to ROOM A on 3/25/25, where Resident 1 resided.<br><br>These failures had the potential to contribute to the spread of infection for residents who shared the room with Resident 1.<br><br>Findings:<br><br>During a review of The Centers for Disease Control and Prevention (CDC - the nation's leading science-based, data-driven, service organization that protects the public's health)'s website, the guideline of MDRO Management titled, Management of Multidrug-Resistant Organisms in Healthcare Settings , dated 4/12/24, in the section of Patient placement in hospitals and Long-Term-Care Facilities (LTCFs), indicated:<br><br>- When single-patient rooms are available, assign priority for these rooms to patients with known or suspected MDRO colonization or infection. Give highest priority to those patients who have conditions that may facilitate transmission.<br><br>- When single-patient rooms are not available, cohort (the practice of grouping together patients who are colonized or infected with the same organism to confine their care to one area and prevent contact with other susceptible patients) patients with the same MDRO in the same room or patient-care area.<br><br>- When cohorting patients with the same MDRO is not possible, place MDRO patients in rooms with patients who are at low risk of acquisition of MDROs and associated adverse outcomes from infection and care likely to have short lengths of stay.<br><br>(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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy titled, Infection control - Policies & Procedures , revised 1/1/12, indicated that the policies are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The Objectives are to Prevent, detect, investigate, and control infections in the Facility; Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public; Establish guidelines for implementing isolation precautions, including standard and transmission-based precautions<br><br>During a review of the facility's policy titled, Resident Isolation -Categories of Transmission-Based Precautions , revised 1/1/12, indicated:<br><br>- The purpose of the policy is to ensure that transmission-based precautions are used when caring for residents with communicable diseases or transmittable infections.<br><br>- Transmission-based precautions are used accordingly when caring for residents who are documented or are suspected of having communicable diseases or infections that can be transmitted to others.<br><br>- Contact precautions are implemented for residents known or suspected of being infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Example of infections requiring Contact Precautions include, but are not limited to, Gastrointestinal, respiratory, skin, or wound infections or colonization with multi-drug-resistant organisms (e.g., Methicillin-resistant Staphylococcus aureus (MRSA - a type of bacteria), Vancomycin Intermediate Staphylococcus aureus (VISA - a type of bacteria that has developed a degree of resistance to the antibiotic vancomycin.).<br><br>- Residents who were placed under Contact Precautions - The resident is placed in a private room when it is not feasible to contain drainage, excretions, blood or body flids ; When a private room is not available, the Infection Control Coordinator assesses various risks associated with other resident placement options (e.g., cohorting).<br><br>Resident 1<br><br>During a review of Resident 1's admission record, indicated that Resident 1 was admitted to the facility on [DATE] with diagnosis which included schizophrenia (a mental illness that is characterized by disturbances in thought), depression and low blood pressure. Resident 1 was later diagnosed with pressure-induced deep tissue damage (a damage to the skin and underlying soft tissues due to prolonged or intense pressure) of sacral region (located at the bottom of the spine, above the buttocks) and urinary tract infection (an infection in the urinary system) on 12/10/24. Resident 1 was not his own health care decision maker.<br><br>During a review of Resident 1's progress note, on 3/18/25 at 10:54 pm, the note indicated that Resident 1's Foley catheter (a thin, flexible tube inserted into the bladder to drain urine) drained Cloudy yellow urine with sediment. Urinalysis (UA - a test of the urine. It is often done to check for a urinary tract infection, kidney problems, or diabetes) results pending.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 1's urine lab results report, dated 3/21/25, the report indicated that the urine sample was collected on 3/18/25 at 8 am, and the report was sent to the facility on [DATE] at 12:01 pm, indicating that Resident 1 had urinary infection with MRSA.<br><br>During a review of Resident 1's progress note, on 3/27/25, the note indicated that Resident 1 was sent to Hospital W wound care clinic for wound evaluation. A review of Hospital W's visit summary report which was faxed to the facility on [DATE] at 3:09 pm. The summary report indicated that a wound culture (a test to identify bacteria or other germs causing a wound infection) was collated from his pressure ulcer of sacral region on 3/27/25 at 2:47 pm. The result report, dated 3/31/25 at 7:19 am, indicated that the wound had 1 or 2 colonies MRSAs .<br><br>During a review of Resident 1's census list from 10/23/24 to 4/18/25, indicated Resident 1 had resided in ROOM A from 2/23/25 to 4/9/25. Resident 1 was confirmed to be infected with MRSAs on 3/21/25 and was transferred to ROOM B on 4/9/25.<br><br>Resident 2<br><br>During a review of Resident 2's admission record, indicated that Resident 2 was admitted to the facility on [DATE] with diagnosis which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), difficulty in walking, and localized edema (swelling caused by too much fluid trapped in the body's tissues). Resident 2 was his own health care decision maker.<br><br>During a review of Resident 2's progress note, on 3/2/25 at 12:58 pm, the note indicated that Resident 2 was noted to have multiple skin issues during admission:<br><br>- Blisters on both the ankles and right second toe.<br><br>- Three scabs from an old fall on the right lower leg.<br><br>- An open lesion on the back of the right lower leg, measured, 7.5 centimeter (cm) in length, 5 cm in width, and 0.2 cm in depth.<br><br>During a review of Resident 2's census list, from 2/28/25 to 4/16/25, the list indicated that Resident 2, who had multiple skin issues with open wound, was transferred to ROOM A on 3/25/25 at 4:37 pm, and resided with Resident 1 who was infected with MRSAs on 3/21/25.<br><br>During a review of Resident 2's progress note, on 4/8/25 at 11:19 am, indicated Resident 2 had redness, heat, and tenderness on the left lower leg, and his right lower leg was tender, with mild redness. The physician was notified, Resident 2 was diagnosed with Cellulitis (a bacterial skin infection).<br><br>Resident 3<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review or Resident 3's admission record, indicated that Resident 3 was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnosis which included diabetes (high blood sugar) with foot ulcer (an open sore on the foot), non-pressure chronic ulcer of other part of left foot (a persistent open sore or wound that develops on a specific area of the foot), hypertensive heart (heart conditions caused by high blood pressure) and chronic kidney disease with heart failure (heart can't pump blood effectively to meet the body's needs), dementia (a progressive state of decline in mental abilities).<br><br>During a review of Resident 3's census list from 9/18/20 to current, the list indicated that Resident 3 had resided in ROOM A from 2/14/25 to current. Resident 3 had resided with Resident 1 from 2/23/25 to 4/9/25. Resident 1 was infected with MRSAs n 3/21/25.<br><br>During a concurrent interview and record review on 4/17/25 at 1 pm, with Nursing Unit Manager (NUM) Y, in nursing station 2, Resident 1's urine lab report, dated 3/21/25, was reviewed. NUM Y stated that Resident 1 didn't move to ROOM B until she asked IP to transfer Resident 1 to a private room on 4/9/25. NUM Y confirmed that the room change did not happen until two weeks after Resident 1 was tested positive with MRSAs by stating, I told them when a resident was positive with MRSA, that resident needed to be moved to a private room. They did not know that until I told them! It should have happened much sooner. NUM Y stated, Resident 2 and Resident 3 had lots of comorbidities, they both had open wound, they were vulnerable. They shouldn't be sharing a room with a resident with MRSA. Resident 2 was discharged last week with cellulitis. We did not do a wound culture for him, we did not know whether Resident 2 was infected with MRSA or not.<br><br>During a concurrent interview and record review on 4/23/25 at 1:01 pm, with IP, in the IP's office, Resident 1, 2's medical records were reviewed. IP confirmed that Resident 1 was sharing ROOM A with Resident 2, and 3 while Resident 1 was tested positive with MRSA. IP also confirmed that she was aware that Resident 2 was diagnosed with cellulitis and was prescribed with oral antibiotics before he was discharged . IP stated, If I could go back, I would definitely place Resident 1 in a private room. IP stated she was not sure whether there was a private room available on 3/21/25 and was not made aware of the room changing for Resident 2 on 3/25/25. IP stated Social Service Department (SSD) made the room change decision.<br><br>During a review of the facility census list, from 3/21/25 to 4/8/25, indicated:<br><br>- From 3/21/25 to 3/23/25, there was one empty room available at station 3, and three empty rooms available at station 4.<br><br>- From 3/24/25 to 3/25/25, there was one empty room available at station 3, and two empty rooms available at station 4.<br><br>- On 3/26/25, there were three empty rooms available at station 3, and two empty rooms available at station 4.<br><br>- On 3/27/25, there were three empty rooms available at station 3, and station 4.<br><br>- On 3/28/25, there were three empty rooms available at station 3, and station 4.<br><br>- On 3/29/25, there were three empty rooms available at station 3, and station 4.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - From 3/30/25 to 3/31/25, there were four empty rooms available at station 3, and three empty rooms available at station 4.<br><br>- From 4/1/25 to 4/7/25, census records obtained were incomplete.<br><br>- On 4/8/25, there were five empty rooms available at station 3, and one empty room available at station 4.<br><br>During an interview on 4/23/25 at 4:10 pm, with the Director of Nursing (DON), in the survey room, DON stated, The situation could be avoided if the staff communicated better to each other. The SSD should have communicated with IP before they moved Resident 2 to ROOM A on 3/25/25. |