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	08/25/2025

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 - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This requirement was not met when a staff member reportedly spoke to a resident (Resident 1) using profane language and with a disrespectful tone. This had the potential to cause the resident to feel unsafe or that his environment was not home-like.Review of Resident 1's medical record indicated that he was admitted to the facility for Parkinson's Disease (a gradual worsening of coordination and movement caused by diseased brain cells), cognitive communication deficit (trouble speaking and thinking), depression and dementia (age related decline in brain function).A review of Resident 1's Basic Interview for Mental Status (BIMS) performed on 5/28/25 indicated his cognitive (thinking, memory) function was 12 on a scale of one to 15, or moderate cognitive impairment (lessened ability to think and remember).Review of the facility's policy titled, Residents' Rights -- Quality of Life, dated March 2015 indicated: XI. Demeaning practices and standards of care that compromise dignity are prohibited. Facility Staffpromote dignity and assist residents as needed .A review of the facility's Mission Statement and Code of Conduct (undated) indicated: Every employee must take personal responsibility for his or her own actions and behaviors. We want you to be part of developing and keeping a workplace culture of trust and respect both for your co-workers and the residents we serve, and, We also expect that you will communicate in a manner that is clear so that others will know that they can trust and depend upon what you say and do. If this is a problem for you, again, we want to know about it. Review of a report filed by the facility on 8/12/25 indicated that Certified Nursing Assistant, (CNA B) reported that she overheard CNA A state to a Resident 1, Shut the [expletive] up! Stop screaming, you are disturbing everyone around you!In an interview on 8/18/25 at 2:55 PM, Resident 1 stated that he overheard swearing by a staff member (the prior week), but was confused and could not remember which staff member he overheard or what exactly was said.In an interview on 8/18/25 at 2:58 PM, CNA A, (the CNA who allegedly spoke disrespectfully to Resident 1), stated she had no recollection of the event although she did know the resident.In a concurrent interview and record review on 8/18/25 at 3:10 PM, Administrator (ADM) confirmed that she received report of an Incident that allegedly happened 8/11/25 around 3:30 PM in which Certified Nursing Assistant (CNA A) was overheard by several staff swearing at Resident 1. ADM stated that CNA A was put on suspension for the rest of 8/11/25 until the facility investigated the incident. ADM stated that the facility's internal investigation concluded that there was insufficient evidence of abusive conduct, and that CNA A's comments might have been heard intermixed with swearing from Resident 1.In an interview on 8/19/25 at 10:20 AM, CNA B stated, I was working with the resident in C bed (in room [ROOM NUMBER]), [Resident 1] was in B bed next to me. [Resident 1] started screaming, and I overheard [CNA A say to [Resident 1]t, Shut the [expletive] up, you're disturbing everybody. CNA B indicated she could tell the difference between a male resident swearing and a CNA swearing at them.In a record review on 8/19/25 at 11:30 AM , ADM provided a printed phone text statement from CNA A that indicated: While on morning shift while I was helping another resident in C bed get up for breakfast, I overheard another CNA [CNA A] who was helping a resident in B bed to shut f up, stop screaming you are disturbing everyone around you.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview this requirement was not met when one of three sampled medication carts were left unlocked and unattended. This had the potential for unauthorized access including nearby residents with dementia, and the potential for harm. In an observation on 8/18/25 at 3:15 PM, one of three sampled treatment carts on nursing station 4 was observed to be unattended and unlocked. Drawers were opened and inspected; accessible supplies and medicines included six, 1-ml hypodermic syringes, and a 12-ounce bottle of what was labeled to be povidone iodine whose plastic top was broken off with brown residue visible on the cap. Residents were observed to be sitting in wheelchairs in the hallway directly adjacent to nursing station 4. No staff stopped or intervened as the drawer was inspected.In a concurrent interview and observation on 8/18/25 at 3:20 PM, the closest nurse to the cart, LVN A, stated she wasn't sure where the nurse was who was responsible for the cart. LVNA confirmed that the facility's policy was for all med carts to be locked when unattended.In an interview with Administrator (ADM) on 8/18/25 at 3:30 PM, ADM confirmed that a nurse who was accountable for the treatment cart, LVN C, had left early for the day for a family emergency.In an interview on 8/19/25 at 10:00 AM, Director of Staff Development (DSD B) stated it is absolutely the facility's policy to ensure med carts are locked when not in use.DSD B stated that she recognized that the facility was recently cited for the same med cart being unlocked in the same location, and the plan of correction was daily audits, which she has been doing daily. She stated that the nurse responsible for the cart had left for a family emergency which may have contributed to the situation. She acknowledged that some things in the cart could be a danger to residents, and if there were syringes there, that's definitely dangerous. She acknowledged that iodine in a large amount could also be dangerous around residents.In an interview on 8/19/25 at 10:15 AM, LVN C stated that the treatment cart that was observed to be left open was a shared cart among the various nursing staff providing wound treatments, etc. LVN C confirmed that she had left the previous day due to a family emergency, but denied that was the reason the cart was left unlocked. LVN C stated that the cart was left unlocked because the regular treatment nurse was out on vacation, so the only way to access the medications in the cart was for staff to leave it unlocked. LVN C stated she was aware of the facility's policy for carts to remain locked when not in use. [NAME] stated that she was aware of staff having left the cart unlocked previously.In an interview and concurrent record review, Administrator (ADM) indicated that the facility had recently undergone a plan of correction for an open medicine cart. Review of the facility's Plan of Correction included Rounds of the carts daily until no incidents of carts being found open and unattended occur for 30 days. The Plan of Correction was documented as complete on 7/22/25Review of Medication Management and Storage, (undated) provided by the facility on 8/19/25 as its standard of care for medication storage, indicated, Med cart locked and no unlocked meds in patient rooms.