

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/31/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Creek Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility did not ensure one out of three sampled residents (Resident 1) was provided with Physician ordered medications when Registered Nurse (RN) B did not transcribe (copy from a written order and entered into the electronic medical record, EMR) the Physician's orders. This failure had the potential to cause a decline in health status. Findings: A review of the facility's policy and procedure (P&amp;P) titled, Medication-Administration, revised 6/26/25, indicated, the Licensed Nurse (LN) would administer all medications as prescribed by the Physician. A review of the undated Job Description, titled, RN Staff Nurse, indicated, nursing staff would provide care to residents as prescribed by the physician. The Job Description indicated nursing would Receive and transcribe (copy from paper form into electronic form) orders accurately from attending/alternate Physician. The Job Description indicated that the RN would order medication as prescribed by the Physician. A review of Resident 1's admission Record, dated 9/19/25, indicted admission to the facility on 9/19/25 with the diagnoses of displaced fracture of second cervical vertebra (broken neck bone), fracture of nasal bone (broken nose), fracture of upper end humerus (upper arm broken bone), and a recent fall. Resident 1 was their own decision maker and was discharged from the facility on 11/1/25. A review of Resident 1's admission Minimum Data Set (MDS, an assessment tool), dated 9/22/25, indicated, Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident). Resident 1 scored a 14 out of 15, which indicated Resident 1 had a good memory. During an interview on 12/30/25 at 9:40 am, Resident 1 stated, I went to my doctors for a last-minute appointment [on 10/15/25], and she had orders for me to take medications, two creams. I didn't get them right away and I didn't get the medication until I ended up coming home and was discharged [on 11/1/25] from the facility. During a concurrent interview and record review on 12/30/25 at 2:30 pm, with Assistant Director of Nursing (ADON), Resident 1's handwritten Physician's Orders, dated 10/15/25 was reviewed. ADON confirmed, the Physician's Orders indicated the Urologist (a doctor that specialized in the urinary system for both males and females) ordered two new medications: Clotrimazole cream (an antifungal cream that treated skin infections) twice daily, place on upper thigh, groin (an area of the body that included the vagina) and vulva (the outside area of the vagina) as needed for redness and itching and Esterace (cream that contained female hormones that helped ease symptoms of menopause, such as redness, itching or dryness in the vagina) one gram inserted into the vagina once a week at bedtime for six months. ADON stated, when a resident left the facility for a doctor's appointment, we send them with a blank Physician's Orders note (the Physician writes their orders and recommendations onto the Physician's Orders note for the facility). ADON confirmed, the Physician's Orders were noted (signed and dated by the nurse, indicating it was reviewed, and Physician instructions were understood) by RN B, and stated, the ADON, DON, or Unit Manager Nurse were responsible to enter [transcribe] the new Physician's Orders into the electronic medical record (EMR). During a concurrent interview and record review on 12/30/25 at 2:35 pm, with ADON, Resident 1's Health Status Note (progress note), written by RN B, and dated 10/15/25 was reviewed. ADON confirmed, the progress note indicated that Resident 1 had an appointment with the Urologist and was placed on Clotrimazole cream and Esterace cream. ADON reviewed the Physician's Order section of the EMR. ADON confirmed, the Clotrimazole cream and Esterace cream were not entered as an order into Resident 1's EMR and stated, the cream orders should have been entered. During an interview on 12/31/25 at 8:36 am, Director of Nursing (DON) confirmed, an independent record review had been performed by DON and stated, the two medications were not ordered [for Resident 1].</p>		