

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  12/02/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43739</p> <p>Based on observation, interview, and record review, the facility failed to ensure the nursing staff respond in a timely manner to the resident's requests for assistance for three out of three sampled residents (Resident 3, Resident 4, and Resident 5), when:</p> <ol style="list-style-type: none"> <li>1. Resident 3 was soiled, and the nursing staff was not available to assist Family 1 to change Resident 3.</li> <li>2. Resident 4's call-light was on and was yelling for help for 12 minutes when she was leaning on the bedrail, three staff walked past Resident 4's room, and did not respond to Resident 4's calling for help.</li> <li>3. Resident 5's call-light was not answer in a timely manner for multiple times.</li> </ol> <p>These failures resulted in Resident 3 and Resident 5 soiling their incontinence briefs which had a negative effect on the residents' self-esteem and self-worth and placing Resident 4 at risk of falling from her bed.</p> <p>Findings:</p> <p>During a review of the facility policy titled, Communication - Call System , revised 1/1/2012, indicated, The Facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. The Nursing Staff will answer call bells Promptly, in a courteous manner. In answering to request, Nursing Staff will return to resident with the item or reply promptly, and assistance will be offered before leaving.</p> <p>During a review of the facility policy titled, Resident Rights - Quality of Life , revised 3/2017, the policy indicated, Each resident shall be cared for in a manger that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being.</p> <p>During a review of the facility job description manual titled, Certified Nursing Assistant Job Description , no date provided, indicated,</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A nursing assistant responsible for providing routine nursing care in accordance with established policies and procedures and as may be directed by the Charge Nurse, Registered Nurse Supervisor, Director of Nurse, or Administrator, to assure that the highest degree of quality resident care can be maintained at all times.</p> <p>Answer residents' call lights promptly.</p> <p>Report all complaints to the Charge Nurse.</p> <p>Report any resident abuse immediately (i.e , harsh/abusive language, unnecessary roughness, etc.)</p> <p>Report any bruise, skin tears, incidents, or accidents to the Charge Nurse immediately.</p> <p>1. During a review of Resident 3's clinical record, indicated that she was admitted to the facility on [DATE], with diagnoses which included stroke, affecting left dominant side, muscle weakness, and need for assistance with personal care. Resident 3 was not her own health care decision maker. She had a Responsible Party (RP) to make decisions.</p> <p>During a review of Resident 3's Minimum Data Set (MDS - an assessment and care screening tool), dated 10/8/24, the MDS indicated that her Brief Interview for Mental Status (BIMS) scored an eleven (moderate cognitive impairment). Resident 3 had impairment on one side of her upper and lower extremities, she required supervision or assistance for toileting hygiene, and body dressing.</p> <p>During an observation in Resident 3's care conference meeting on 10/25/24 at 1:15 pm, attendees included Ombudsman X, Family 1, Resident 3, Administrator (ADMIN), Director of Nursing (DON), Business Office Manager (BOM), Assistant Director of Rehab (ADOR), Licensed Nurse (LN) A, Director of Staffing Development (DSD), Social Services (SS). The Family 1 stated Resident 3 needed Cues for everything. The Family 1 said, She won't know that she needed to go to the bathroom, or to be changed . Last Sunday, she was completely soaked. Certified Nursing Assistant (CNA) H said she was changing another resident, and she reminded herself that she would change Resident 3 after. But, by the time CNA H was done with that resident, CNA H had to take her lunch break, CNA H forgot to come back to Resident 3. When CNA H came back from lunch, I had already changed her. The Family 1 stated she then asked CNA H, Don't you have someone to cover your residents for you while you were on break? CNA H said to me, ' you supposed to, but no in this facility. It didn't happen here . The ADMIN apologized to The Family 1 and Resident 3, and stated, That shouldn't be happening, the hall CNAs should cover CNA H. We would reeducate the staff .</p> <p>During an interview on 11/8/24 at 2:04 pm, with CNA H, CNA H stated, I told the RP that I did not know what happened, I told everyone that I was going to lunch. My teams supposed to answer the call-lights for me.</p> <p>2. During a review of Resident 4's clinical record, indicated that she was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included history of falling, low back pain, and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). Resident 4 was not her own health care decision maker. She had a RP to make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated that her BIMS scored an eight (moderate cognitive impairment). Resident 4 was completely dependent on her mobility.</p> <p>During a review of Resident 4's care plan for Risk for falls related to Parkinson's , revised on 10/17/24, the interventions indicated, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.</p> <p>During a concurrent observation and interview on 10/25/24 at 11:28 am, at the nursing station 1, observed Resident 4's room (near the nursing station, two rooms down the hall) call-light was on, Resident 4 was constantly yelling Nurse .Nurse At 11:30 am, observed one male staff walking past Resident 4's room, and did not answer Resident 4's call-light. At 11:33 am, observed two female CNAs walking past Resident 4's room, also did not answer Resident 4's call for help. At 11:40 am, Resident 4 had called out Nurse .Nurse . for over 12 minutes, observed LN B who was previously working on the med-cart walking inside Resident 4's room, and the call-light was turned off. When asked, LN B stated Resident 4 was leaning on her side and required assistance to be gently moved back to a more centered position.</p> <p>During an interview on 10/27/24 at 4 pm, at nursing station 1, with LN B, LN B stated that CNAs were supposed to let the nurse and other CNAs know when they were going to take their break. LN B stated on 10/25/24, Resident 4's assigned CNA I did not tell him where she went, and LN B did not know whether she went for a 15-minutes short break, or the 30-minutes lunch break. LN B said, Resident 4 was calling for help, so I went in and found out Resident 4 was leaning on her side, she could fall out of her bed if I did not help her LN B stated he wasn't aware how long Resident 4's call light was on, and he would expect the CNAs who walked past by Resident 4's room to go in and assist Resident 4.</p> <p>During an interview on 11/8/24 at 12:55 pm with CNA I, CNA I acknowledged that Resident 4 was one of her assigned residents on 10/25/24, she said, that day, I told the nurse and the teams (CNAs) when I went for my break. The CNA I stated the team was supposed to answer the call light for her residents when she was on break.</p> <p>3. During a review of Resident 5's clinical record, indicated that she was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), muscle weakness, and need for assistance with personal care. Resident 5 was not her own health care decision maker. She had a RP to make decisions.</p> <p>During a review of Resident 5's MDS, dated [DATE], the MDS indicated that her BIMS scored an fifteen (Intact cognitive response).</p> <p>During a review of RP's complaining statement, dated 10/28/24, indicated that RP had witnessed many times that the staff did not answer Resident 5's call light timely.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 11/8/24 at 11:53 am, with the DSD, the DSD stated, The CNA team should answer the call light for their team when they were on break! it's something we talked about throughout the year, and upon hiring. We talked about their roles, and how things should work on the floor. Today, we had in-service, we reeducated them on The Hall Partner. The DSD stated she also told the CNAs that if they could not find the nurse when they were going to their break, they should write their break time right next to their names on the assignment board at the nursing station. When reviewed the photo of the assignment board, taken on 10/25/24, the DSD confirmed that there was no CNA's break time written on the assignment board.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43739</p> <p>Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse when Certified Nursing Assistant (CNA) D insisted on changing Resident 2's brief when Resident 2 refused and asked CNA D to leave. This failure caused a 4.5-centimeter (cm) x 5-centimeter (cm) bruise between Resident 2's thumb and the 1st finger, Resident 2 was angry and humiliated.</p> <p>Findings:</p> <p>During a review of the facility policy titled Abuse - Prevention, Screening, &amp; Training Program , revised 7/2018, indicated:</p> <p>The Facility does not condone and form of resident abuse, neglect, misappropriation of resident property, exploitation, and /or mistreatment and develops Facility policies, procedures, training programs, and screening and prevention systems to promote an environment free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment.</p> <p>Abuse is defined as the willful, deliberate infliction of injury</p> <p>Physical abuse is defined as, but not limited to, hitting, slapping, punching, and/or kicking. It also includes corporal punishment which is physical punishment used to correct and/or control behavior.</p> <p>Willful , as related to abuse, is defined as the individual acting deliberately (not inadvertent or accidental) and not that the individual must have intended to inflict injury or harm.</p> <p>During a review of Resident 2's clinical record, indicated that she was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses which included stroke, affecting right dominant side, muscle weakness, and need for assistance with personal care. Resident 2 was her own health care decision maker.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - an assessment and care screening tool), dated 9/24/24, the MDS indicated that Resident 2 had a brief interview for mental status (BIMS) score of 14, at section C Cognitive Patterns indicating that her cognition was intact.</p> <p>During a review of Resident 1's Interdisciplinary Team (IDT, a group of dedicated healthcare professionals who work together to provide the care the residents need) progress note, dated 10/22/24 at 3:02 pm, by the Director of Nursing (DON), indicated that the IDT reviewed a Recent incident with CNA D on 10/21/24 pm shift. The note indicated, .when Resident 2 went to get her bed control, the CNA pulled on it, catching Resident 2's hand in the control causing a bruise about 4.5 cm x 5 cm in size .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's progress note, dated 10/22/2024 at 00:27 am, by Licensed Nurse (LN) C, the note indicated Resident 2 called LN C into her room to report an abuse claim on CNA D. Resident 2 said to LN C that CNA D began pulling on her blankets, she told CNA D she was dry and did not need to be changed. CNA D continued pulling on her blanket, when she went to get her bed control, CNA D pulled on the remote and caught her hand in the control, causing a bruise 4.5 cm x 5 cm is size .</p> <p>During a concurrent observation and interview on 10/31/24 at 12:50 pm, with Resident 2, in Resident 2's room, Resident 2 was in bed, when asked about the incident happened on 10/21/24, Resident 2 showed a bruise on the back of her left thumb. Resident 2 stated the incident happened around 8 pm, CNA D just changed her brief two hours ago, We were good, I was dry and happy. Resident 2 stated the CNA D came in, stood on her right side, and said to her that she wanted to check on her brief, CNA D then proceed to pull off Resident 2's blank on her food. Resident 2 said, I couldn't get the blanket back to cover my foot. I kept telling her No! I didn't need to be changed; I was dry. She did not stop. She kept pushing me, I then started pushing her so she would leave. She did not leave. She came over to my left said. I was lying flat on the bed, I tried to reach my bed remote, so I could sit up and talk to her. When she saw me trying to push my bed remote, she grabbed the remote from my hand, the cord of the remote was around my hand, she pulled the remote and it caused the bruises on my hand. She did it deliberately It was so humiliated to go through that event What made me even more sad was that two hours ago, we were good I did not feel safe around her. I felt CNA D did that purposely to intimidate me. I believe she was angry. Something had gotten to her, and she took it on me Resident 2 stated she reported this incident to LN C.</p> <p>During an interview on 11/8/24 at 1:44 pm with LN C, LN C stated she was called into Resident 2's room on 10/21/24, a CNA reported to her that Resident 2 asked to speak to her. LN C stated Resident 2 told her, Couple CNAs walked in, started pulling her blanket, they told her that she needed to be changed, she kept saying no, but they kept coming LN C confirmed that she saw the bruise on Resident 2's hand, It was deep purple color. LN C stated after taking the report from Resident 2, she went to talk to CNA D, and asked why CNA D did not report the incident to her as she supposed to per the facility's policy. LN C said, I asked her, why didn't you tell me right away that you had the issue with Resident 2, CNA D said, ' I did not know who the nurse was!' I said No! you had been seeing me in and out the rooms, and asked you to do things, CNA D said, ' I didn't know you were the nurse.' I then asked 3 other staffs to go inside Resident 2's room again, they saw the bruise and they interviewed Resident 2, Resident 2 told them the same story. LN C stated that night was the first time she worked with CNA D, and she felt CNA D was not cooperative with the assignments she asked her to do, She was belligerent! I asked her to take all her residents' vital signs and wrote them down on a piece of paper, she asked why, I explained to her, and she appeared not very willingly. She said, ' why, other place I worked at, I just had it on any paper I wanted . ' LN C stated that she felt CNA D was not doing her job completely, I did not feel comfortable working with her. I do believe the incident did happen, but Resident 2 might have exaggerated her. I don't believe Resident 2 was soaking wet. I do believe CNA D was not happy with Resident 2.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/8/24 at 2:38 pm with CNA F, CNA F stated that she was working with CNA D as a team on the night of the incident (10/21/24). CNA F said, When we changed Resident 2 earlier that night, Resident 2 was really nice. At around 9 pm, CNA D asked me to help her change her residents. We went into Resident 2's room together. I was changing Resident 2's roommate, I heard CNA D asked Resident 2, ' Can I change your brief?' I didn't hear Resident 2 said No at first, but, when I was done changing Resident 2's roommate, I heard Resident 2 said No, then CNA D asked me to help her change Resident 2 When I was taking care of Resident 2, if she said no, I would walk away and try to come back to ask her later. CNA F stated that CNA D was very demanded, It was her personality. When CNA D wanted it done, she had to get it done. CNA D usually super nice, until the resident said No, then she would become a little bit rough.</p> <p>During an interview on 11/8/24 at 2:54 pm with CNA D, CNA D stated the incident with Resident 2 happened around 8:30 pm to 9 pm on 10/21/24. CNA D stated, I asked if she was soiled, she said ' I don't know, go ahead and check.' I checked and she was soiled, when I started to change her, she called me b****. I asked CNA F to help me. CNA D denied that she ever heard Resident 2 said no/refused to be changed. However, CNA D stated she heard Resident 2 calling her, You are a b****, get out of my room! CNA D said Resident 2 told her to get out. However, CNA D did not leave the room, as CNA D stated that was what she would do when a resident refuse to be changed and thus caused the incident. CNA stated, If they said no, I would come back and reapproach them again CNA D stated she had abuse and resident right training.</p>		