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	01/03/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49934 Based on interview, and record review, the facility failed to protect 1 out 3 residents (Resident 1) from abuse when, Licensed Vocational Nurse 1 (LVN 1) on duty told Resident 1 to mind his own f***ing business. Resident 1 stated he backed off and that the response from LVN 1 surprised him because they had got along prior to this. Resident 1 stated he asked LVN 1 how his Resident 2 was doing after her fall. He had his phone in his hand and asked if she wanted him to call 911. LVN 1 said, If you ' re calling 911, I will f***ing kill you. This had the potential to result in psychosocial harm. Findings: A review of a facility document titled, Abuse- Prevention, Screening, and Training Program, revised July 2018, defined abuse as the willful, deliberate infliction of injury .it includes verbal abuse, sexual abuse, physical abuse, mental abuse . A review of a facility document titled, Abuse Prevention and Management, copyright 2022, stated, The facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and /or mistreatment. During an interview, on 11/15/24 at 3:58 pm, Resident 1 stated that a fell ow resident, Resident 2, had fallen out of her bed. He went to check on the resident and the Licensed Vocational Nurse 1 (LVN 1) on duty told Resident 1 to mind his own f***ing business. Resident 1 stated he backed off and that the response from LVN 1 surprised him because they had got along prior to this. Resident 1 stated he asked LVN 1 how his Resident 2 was doing after her fall. He had his phone in his hand and asked if she wanted him to call 911. LVN 1 said, If you ' re calling 911, I will f***ing kill you. He stated that she has talked about residents in a mean way, and that LVN 1 has stated that residents are playing with her, to annoy her. During a record review of Resident 1 ' s Medicare/5 Day Assessment (required assessment of a resident), dated 09/11/24, the Brief Interview for Mental Status (BIMS- mental assessment of resident) score was 14/15, which indicated Resident 1 ' s mental capabilities were intact. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/24 at 4:04 pm, Certified Nursing Assistant 1 (CNA 1) stated that LVN 1 asked her, How much is he getting paid to act like this? CNA 1 stated that LVN 1 ' s words were negative towards the residents, and she had often stated that nurses were sabotaging her. CNA 1 stated she does not know why LVN 1 would say this about her fell ow nurses or the negativity towards the residents. CNA 1 also stated that after Resident 2 ' s fall, Resident 2 was trying to get-up and out of her wheelchair, and LVN 1 was trying to settle her. CNA 1 then heard LVN 1 say to Resident 2, I wish you would fall, crack your head open so I can send you to the hospital. CNA 1 stated that Resident 2 has dementia. During a record review of Resident 2 ' s Quarterly Assessment (required assessment of a resident), dated 09/03/24, the BIMS score was 99, which indicated Resident 2 ' s mental capabilities were not intact. Resident 2 ' s diagnoses include dementia, mild, with generalized anxiety, and generalized Anxiety Disorder. Observed Resident 2 with a one-on-one and she was exhibiting behaviors. During an interview, on 11/15/24 at 4:24 pm, CNA 2 stated that LVN 1 has always been rude and does not have a filter with residents. CNA 2 was assigned to Resident 2 ' s hall when she fell and heard LVN 1 tell Resident 1 to mind your own g** d*** business, when Resident 1 went to check on Resident 2. CNA 2 also heard LVN 1 state to Resident 2 that she hoped she would fall and crack her head open so she could transfer her to the hospital. Resident 2 was being a bit challenging with her behaviors but did not deserve to be spoken to in that manner, stated CNA 2, even if she did not understand. During an interview on, 11/15/24 at 4:34 pm, CNA 3 stated that LVN 1 has said on occasions, that residents act out on purpose to get at her, to agitate her, and only act out when she is around, and that other staff members were out to get her. CNA 3 does not understand why LVN 1 has stated such things. During an interview, on 11/15/24 at 4:48 pm, CNA 4 was assigned a one-on-one (CNA is assigned one particular resident for their shift to keep them safe and help them with daily activities) with a resident. CNA 4 ' s resident had fallen asleep, so she got up to stretch and to find someone to cover her while she took a break. LVN 1 was at his door with the med cart and talking to a different resident. As CNA 4 walked towards the door, LVN 1 stated that CNA 4 had taken a picture of her so that CNA 4 could turn her in. CNA 4 stated LVN 1 continued to state that if she was turned in, she would know, and if CNA 4 turned her in, LVN 1 would sue her. CNA 4 stated this made the rest of her shift uncomfortable. During an interview, on 11/15/24 at 5:11 pm, LVN 2 stated that LVN 1 was a nightmare, that she was dangerous because residents are not safe with her. LVN 2 stated residents on his assigned hall were scared of her, and have said, Oh god, she ' s here, when they have noticed her in the building. He has never heard a kind word from her, she has not treated the residents well, and he would not trust her if she was his nurse. During an interview, on 11/15/24 at 5:27pm, the Administrator stated that LVN 1 was suspended until further notice. LVN 3 called the Administrator regarding the incident at 10:49 pm, and LVN 1 at 10:57 pm, via text, was to count out her cart with RN 1 and RN 1 would take over the cart. LVN 1 clocked out at 1:10 am after charting for her shift was completed, per the Administrator. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 11/27/24 at 10:07 am, RN 1 stated that LVN 1 was very assertive and had her own way of nursing. RN 1 has worked with LVN 1 prior at a different facility and there were no issues with her there. She just had a strong personality and was always professional. Resident 1 informed RN 1 of the incident he had with LVN 1. RN 1 was also notified by two other nurses. The situation was chaotic because too many people were involved. RN 1 stated that sides were being chosen, and other staff were coaching everyone up to get LVN 1 in trouble. RN 1 also stated that Resident 1 was escalating the situation; it was a high school situation that he did not want to be involved in. RN 1 counted LVN 1 out around 11:00 pm and took over her cart. During an interview, on 11/27/24 at 10:37 am, Resident 3 stated that LVN 1 started cussing at Resident 1 when he came to check on Resident 2 after she fell . Resident 1 offered to call 911, and LVN 1 stated she would kill him if he did. Resident 3 stated that LVN 1 is unprofessional and that she does not feel safe when LVN 1 is assigned to her hall. During a record review of Resident 3 ' s Quarterly Assessment, dated 11/18/24, the BIMS score was 15/15, which indicated Resident 3 ' s mental capabilities were intact. During an interview, on 11/27/24 at 4:59 pm, LVN 3 stated that Resident 1 came to her to discuss the incident with LVN 1. LVN 3 stated that Resident 1 was very upset and stated that LVN 1 told him to mind his own business when he went to check on Resident 2 after her fall, and if he called 911, she would f***ing kill him. LVN 3 stated she notified the Administrator and the Director of Nursing (DON) of the incident around 10:30 pm or 11:00 pm. LVN 3 also stated she was on the floor at 1:40 am and LVN 1 was still in the facility, charting. During an interview, on 11/27/24 at 5:19 pm, RN 2 stated that Resident 1 spoke to her about the fall of Resident 2 and the incident with LVN 1. Resident 1 stated to RN 2 that that when he went to check on Resident 2 after her fall, LVN 1 told him she would f***ing kill him if he went into the room of Resident 2, and for him to mind his own business. RN 2 stated she had no reason to doubt Resident 1 ' s concerns. Administration was notified. RN 2 said she saw RN 1 counting out LVN 1 around 11:00 pm and saw LVN 1 charting afterwards.