

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  06/03/2025
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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record and facility policy review, the facility failed to ensure that call lights (an electronic sound and light communication device in the residents room that allows a resident to alert staff when they need help), was available for use and within the residents' reach for three of five residents sampled for call lights being within their reach. (Residents 1, 2, and 12)</p> <p>This failure had the potential for the residents not to be able to alert staff that they needed help which could lead to unmet needs, falls, and emotional frustration for the residents.</p> <p>Findings:</p> <p>A review of the facility's policy titled, Communication-Call System revised 8/24/24, indicated that, 2.The Call alert device will be placed within the resident's reach. 3. Facility Staff will answer call alerts promptly and in a courteous manner.</p> <p>A review of Resident 1's admission record indicated Resident 1 was admitted on [DATE] with diagnoses that include heart failure, dysphagia (difficulty swallowing foods or liquids), and major depressive disorder. Resident 1 was unable to make his own health care decisions.</p> <p>A review of Resident 1's Quarterly Minimum Data Set (MDS, a data driven clinical assessment) dated 3/4/25, reflected that Resident 1's cognition (ability to solve problems, remember, and think clearly) was moderately impaired. Resident 1 was dependent (resident cannot perform the task on their own and fully relies on staff help) for toileting, dressing, personal hygiene, and transfers.</p> <p>A review of Resident 1's, At Risk for Falls Care Plan indicated an intervention to, Be sure the resident's call light is within reach. The resident needs prompt response to all requests for assistance.</p> <p>A review of Resident 2's admission record indicated Resident 2 was admitted on [DATE] with diagnoses that include parkinsonism (body tremors and stiffness), chronic pain, and anxiety. Resident 2 was unable to make his own health care decisions.</p> <p>A review of Resident 2's MDS, dated [DATE], reflected that Resident 2's cognition was moderately impaired. Resident 2 was dependent on staff for transferring in and out of bed, personal hygiene, and toileting hygiene.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 2's, At Risk for Falls Care Plan indicated an intervention to, 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 an observation and interview with roommates Resident 1, Resident 2, and Certified Nursing Assistant (CNA) A on 6/2/25 at 3:35 pm, Resident 1 and Resident 2 were observed lying in their beds. Resident 2 was yelling for help and asking for water. Resident 1 and Resident 2 both indicated they could not find their call lights. Resident 1 and 2's call lights were observed sitting on a nightstand located behind and at the side of their beds, where they were not able to see or reach their call light devices. CNA A confirmed that Resident 1 and Resident 2 could not see or reach their call lights and stated, I should have put them [the call lights] back, but I forgot.</p> <p>A review of Resident 12's admission record indicated that Resident 12 was admitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a serious lung disease), need for assistance with personal care, difficulty in walking, and a history of falling. Resident 12 was unable to make his own health care decisions.</p> <p>A review of Resident 12's MDS, dated [DATE], reflected that Resident 12's cognition was intact. Resident 12 required supervision and physical assistance with transfers in and out of bed, walking, and going to the bathroom.</p> <p>A review of Resident 12's, At Risk for Falls Care Plan indicated an intervention to, 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 phone interview with Resident 12's Family Member (FM) on 6/3/25 at 1:41 pm, FM indicated that she visited Resident 12 many times and had observed his call light on the floor in his room. FM said, He will try and get up by himself. He falls quite a bit.</p> <p>During an interview with the Administrator (Admin) on 6/3/25 at 4:36 pm, Admin confirmed that call lights should be within all residents' reach and it was not their practice for call lights to be out of the reach of the resident.</p>		