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	10/27/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to notify the Responsible Party (RP- the person who is responsible for making health care decisions for a resident) of falls and a change of condition for one of two residents (Resident 1) sampled for falls, when Resident 1 had four unwitnessed falls, her indwelling catheter (a soft tube that is inserted into the bladder and allows urine to drain into a collection bag) fell out and was not replaced, a change in condition due to a head injury, was transferred to an emergency department (ED) and the RP was not notified.Refer to F689.This failure prevented the family from knowing about Resident 1's falls, condition changes, and transfer to the emergency department, hindering their ability to make informed decisions and participate in Resident 1's care.Findings.A review of the facility's policy titled Change in Condition dated 8/25/22 indicated A Licensed nurse will notify the resident's Physician/APP (advanced practice providers) and legal representative or an appropriate family member when there is an: a. Incident/accident involving the resident: b. An accident involving the resident which results in injury and has the potential for requiring physician intervention; c. A significant change in the resident's physical, mental or psychosocial status. g. A decision to transfer or discharge the resident from the facility. The Licensed Nurse will notify the family/surrogate (an RP) decision-maker of any changes in the resident's condition as soon as possible.A review of Resident 1's admission Record dated 8/13/25, indicated Resident 1 was admitted to the facility from a local hospital on 8/13/25 with the diagnoses that included Urinary Tract Infections (UTI, and infection in the bladder, causing pain and increased urination), Covid-19 (a respiratory disease that easily spreads to other people), difficulty in walking, muscle weakness, cognitive communication deficit, dysphagia (difficulty with swallowing), need for assistance with personal care, chronic pain syndrome, atrial fibrillation (irregular heart beat that can cause dizziness, tiredness, lightheadedness, reduced ability to exercise, and weakness), overactive bladder (the sudden urge to urinate that may be hard to control), retention of urine (difficulty in urination), osteoarthritis (bone inflammation) of the right and left knee. Resident 1's RP and Emergency contact #1 was Daughter A.A review of Resident 1's admission Minimum Data Set (MDS, a data driven clinical assessment) with an Assessment Reference Date (ARD) (the last day of the observation period for a MDS assessment) of 8/20/25, Section C (review of mental status) indicated a Brief Interview for Mental Status (BIMS, a review of mental status with scoring from 0 to 15, where 0=resident is severely mentally impaired to 15=resident is mentally intact.) was conducted and Resident 1 scored a 10 indicating moderate mental impairment. Section GG (functional abilities) indicated Resident 1 used a walker when walking, required moderate assistance from staff with standing, transferring to chair or bed, walking, and toilet transfers. Section H (Bowel and Bladder) indicated Resident 1 was admitted with an indwelling catheter and continent with her bowel movements.A review of Resident 1's August 2025's Physician Orders indicated an order dated 8/13/25 which included: Resident is unable to make healthcare decisions.A review of Resident 1's Durable Power of Attorney for Health Care (legal document that allows you to name a person to make medical treatment decisions for you if you cannot, an RP) dated and signed by Resident 1 on January 25, 2001, indicated that Resident 1's husband was designated and appointed to make health care decision for Resident 1. If Resident 1's husband was unable to act as her agent, then Resident 1's two daughters (Daughter A and Daughter B) are to serve as her decision maker for health care.A review of Resident 1's Progress Note titled N Adv - Post Fall Evaluation dated 8/13/25 at 10:30 pm, Licensed Vocational Nurse (LVN) B documented Time of Fall 8/13/25 9:45 pm. Fall was not witnessed. Fall occurred in the Resident's room. Activity at the time of fall: Attempting to brush her teeth. Resident 1's post fall risk score was 7 (at risk for falls). Resident's responsible party notified: Yes. Person contacted: Resident is her own RP. A review of Resident 1's Progress Note titled Alert Note dated 8/14/25 at 11:28 am, Registered Nurse (RN) A indicated Resident 1's indwelling catheter had fallen out. The indwelling catheter was not replaced. There was no documentation indicating the RP was notified.A review of Resident 1's Progress Note titled Social Service on 8/15/25 at 3:57 pm, Social Service (SS) documented Resident (1) request daughter, (name, Daughter A), to be her RP since her daughter is taking care of everything for herA review of Resident 1's Progress Note titled N Adv-post Fall Evaluation dated 8/19/25 at 01:05 am, concerning fall at 8/19/25 at 0:55 am, LVN B documented Unwitnessed fall responsible party notified: Yes, Person Contacted: Resident is her own RP.A review of Resident 1's Progress Note titled N Adv-post Fall Evaluation dated 8/19/25 at 9:10 pm, concerning fall at 8/19/25 at 9:00 pm, LVN B documented Unwitnessed fall responsible party notified: Yes, Person Contacted: Resident is her own RP.A review of a Progress Note titled eINTERACT (Interventions to Reduce

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an injury of unknown origin and major accident for one of two residents (Resident 1) sampled for falls, was reported to the California Department of Health (CDPH) when Resident 1 had a bruise and bump on her head of unknown origin, unwitnessed falls, and a change in condition which sent Resident 1 to the hospital and eventually die due to a brain bleed.This failure to report had the potential for delaying investigations into injuries of unknown origin by facility and required reporting agencies to be able to rule out abuse.FindingsA review of the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting dated [DATE], indicated The Facility reports the following events by phone and in writing to the appropriate State or Federal agencies (California Department of Health, CDPH) c. Other Occurrences. ii. Major accidents. iv. Other occurrences that. affect the welfare, safety, or health of residents. Unusual occurrences are reported to the appropriate agency withing 24 hours by telephone and confirmed in writing.A review of Resident 1's admission record dated [DATE], indicated Resident 1 was admitted to the facility from a local hospital on [DATE] with the diagnoses that included Urinary Tract Infections (UTI, and infection in the bladder, causing pain and increased urination), Covid-19 (infectious respiratory disease caused by a virus), difficulty in walking, muscle weakness, cognitive (relating to the mental process involved in knowing, learning, and understanding things) communication deficit, dysphagia (difficulty with swallowing), need for assistance with personal care, chronic pain syndrome, atrial fibrillation (irregular heart beat that can cause dizziness, tiredness, lightheadedness, reduced ability to exercise, and weakness), overactive bladder (the sudden urge to urinate that may be hard to control), retention of urine (difficulty in urination), osteoarthritis (bone inflammation) of the right and left knee.A review of Resident 1's admission Minimum Data Set (MDS, a data driven clinical assessment) with an Assessment Reference Date (ARD) (the last day of the observation period for a MDS assessment) of [DATE], Section C (review of mental status) indicated a Brief Interview for Mental Status (BIMS, a review of mental status with scoring from 0 to 15, where 0=resident is severely mentally impaired to 15=resident is mentally intact.) was conducted and Resident 1 scored a 10 indicating moderate mental impairment. Section GG (functional abilities) indicated Resident 1 used a walker when walking, required moderate assistance from staff with standing, transferring to chair or bed, walking, and toilet transfers. Section H (Bowel and Bladder) indicated Resident 1 was admitted with an indwelling catheter and continent with her bowel movements.A review of Resident 1's Progress Notes titled IDT (Interdisciplinary Team, a group of professionals to address complex problems) Progress Notes- Falls dated [DATE] at 7:23 am, IDT clinical team documented a review of Resident 1's unwitnessed. fall on [DATE] at 5:10 am. Per resident input, I fell and hit my head on the door'. 'I don't know what happened, I just fell.'A review of Resident 1's Progress Notes titled Alert Note by Licensed Vocational Nurse (LVN) B on [DATE] at 00:55 am, the note indicated that Resident 1 had another unwitnessed fall.A review of Resident 1's Progress Note titled Alert Note by LVN B on [DATE] at 9:10 pm, the note indicated that Resident 1 had another unwitnessed fall.A review of a Progress Note titled eINTERACT (Interventions to Reduce Acute Care Transfers, a clinical decision support tool) SBAR (Situation, Background, Assessment, Recommendation, a communication framework used to exchange information between healthcare professional) for a change in condition, dated [DATE] at 1:30 pm, Registered Nurse (RN) A indicated that Resident 1 had a change in condition which was due to abnormal vital signs, BP=174/122 (normal is less than 120/80) altered level of consciousness and increased confusion potential signs of a head injury and/or brain bleed. Primary provider was notified and ordered to send Resident 1 to the acute care setting (local hospital) for further evaluation and treatment.A review of the Ambulance report dated [DATE] at 2:30 pm, Paramedic (PM) documented female sitting in her wheelchair complaining of a headache secondary to a fall 5 days ago. Staff report patient has fallen 4 times in the last 5 days. Pt experienced a head strike with the first fall 5 days ago. Staff report patient has become more altered today and began complaining of a splitting headache. Small contusion (bruise) to forehead .A review of the local hospitals report dated [DATE] by Medical Doctor (MD), MD documented Over the last few days has had multiple falls with one known head strike. Is normally oriented x 4 but today was found to be oriented x 1 only and is confused. She is complaining of a headache. Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: CNS (central nervous system, brain and spinal cord, which act as the body's main control center) failure or compromise A review of the local hospital's CT (computerized

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of two residents (Resident 1) sampled for falls. Resident 1 had four unwitnessed falls in seven days, three occurring after an indwelling catheter (a soft tube that is inserted into the bladder and allows urine to drain into a collection bag) was not replaced and contributed to Resident 1's falls by her attempting to toilet herself. Key failures included:Care Plan was not updated with new interventions to prevent further falls, despite the facility's fall policy requiring increased observation and structured routine for residents with two or more falls in a week.Nurses had not completed the required assessments, the Neurological (refers to brain, nerves and spinal cord function) Flow Sheet (a standardized document used by healthcare professionals to record and monitor a patient's neurological status over time. This tool is crucial for detecting subtle changes or a sudden deterioration in a patient's condition, especially in cases of head trauma that results in a brain bleed), for 72 hours after an unwitnessed fall, and the alert charting (nursing documentation once a shift concerning the status of a resident after a fall) for 72 hours, to determine if Resident 1 had a head injury and had not recognized when she showed signs of a brain bleed (signs of a brain bleed include: headache, confusion, difficulty in thinking, weakness of one side of the body and loss of balance and coordination.No bladder assessment or individualized toileting program (staff track the resident's bathroom habits over several days to identify patterns in urination) was done after the catheter came out.This resulted in repeated falls for Resident 1 and subsequently, a head injury that developed into a brain bleed that required hospitalization and resulted in the death of Resident 1.Findings:A review of the facility's policy and procedure (P&P) titled Fall Management Program revised [DATE], indicated it is the facility's purpose to provide a safe environment that minimizes complications associated with falls. The P&P indicated that the Licensed nurse and/or IDT (Interdisciplinary Team, a group of professionals to address complex problems) will develop a Plan of Care according to the identified risk factors and root cause. Following each resident fall, the Licensed Nurse will perform a Post-Fall Assessment and update, initiate or revise a Plan of Care. The Licensed Nurse will complete the Neurological Flow Sheet for an un-witnessed fall. for seventy-two hours following the fall incident. Within 15-20 minutes after a fall the Licensed Nurse will initiate a post fall huddle utilizing the Post fall Huddle form. Once the post fall huddle is completed the Licensed Nurse will update the care plan with immediate recommendations. A resident who sustains multiple falls as defined as more than one fall in a day, week. will be considered a high risk to fall and as a result may sustain a major injury. These residents may: require more frequent observation of activities and whereabouts, may require a structured environment or routine, and may require special equipment to promote independence. These interventions will be documented on the resident's plan of care and in the resident's clinical record.A review of the facility's Fall Incident Checklist (undated), indicated that after a resident has a fall the staff is to place resident on alert charting for 72 hours, initiate frequent safety checks and implement a new intervention in the long-term care plan.A review of the facility's policy and procedure (P&P) titled Bowel and Bladder Indwelling Catheter -Insertion, Maintenance and Discontinuation of revised [DATE], indicated Discontinuation of an Indwelling Catheter. D. Bladder training (a therapy that aims to improve bladder control and uses scheduled urination timetable to help gain control of urination) will be provided as indicated per the Bowel and Bladder Training/Toileting Program. F. The residents' care plan will be updated as necessary.A review of the facility's P&P titled Bowel and Bladder Training/toileting Program revised [DATE], indicated, The licensed nurse will assess a Resident's bowel and bladder status.upon the removal of an indwelling catheter. Interventions identified by the licensed nurse and or the IDT will be care planned and communicated to the corresponding professional and to the facility staff for implementation. Following review and determination for the residents voiding (urinating)/bowel evacuation pattern, the licensed nurse will develop an individualized Bowel and Bladder Training Program to meet the Resident's needs. The established pattern and individualize bowel and bladder training intervention (s) will be documented in the care plan. A review of Resident 1's admission record dated [DATE], indicated Resident 1 was admitted to the facility from a local hospital on [DATE] with the diagnoses that included Urinary Tract Infections (UTI, and infection in the bladder, causing pain and increased urination), Covid-19 (infectious respiratory disease caused by a virus), difficulty in walking, muscle weakness, cognitive (relating to the mental process involved in knowing, learning, and understanding things) communication deficit, dysphagia

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure one of two sampled residents (Resident 1), who was admitted with an indwelling catheter (a soft tube that is inserted into the bladder and allows urine to drain into a collection bag), had care and services to maintain normal bladder function when Resident 1(‘s): Did not have an assessment for the need of an indwelling catheter. Indwelling catheter was discontinued without a physician's order. Was not provided bladder training to restore normal bladder function after the indwelling catheter was removed. Did not have a care plan created with interventions concerning her bowel and bladder function.These failures caused Resident 1 to get up and down to the bathroom many times without assistance and have multiple falls.Findings:A review of the facility's policy titled Nursing Policy and Procedure (P&P)- Bowel and Bladder, Indwelling Catheter - insertion, maintenance and Discontinuation of. revision date of 7/22/25, indicated, A Licensed Nurse will assess the need for continued use of a catheter. The Licensed Nurse will notify the physician if the assessment indicates the need to discontinue catheter use and obtain orders. Bladder training (a therapy that aims to improve bladder control and uses scheduled urination timetable to help gain control of urination) will be provided as indicated per the Bowel and Bladder training/Toileting Program. The licensed nurse will monitor for any signs or symptoms of urinary burning, frequency, urgency, or suprapubic pain after the removal of the indwelling catheter and inform the physician for orders if noted or reported. The resident's care plan will be updated as necessary. A review of the facility's policy and procedure (P&P) titled Bowel and Bladder Training/Toileting Program revised August 21, 2020, the P&P indicated After the removal of a urinary catheter (indwelling catheter), services are provided to restore or improve bladder function to the furthest extent possible. The P&P continue to indicate: The licensed nurse will assess a Resident's bowel and bladder status. upon the removal of an indwelling catheter. Interventions identified by the licensed nurses and/or the Interdisciplinary Team (IDT, Interdisciplinary Team, a group of professionals to address complex problems) will be care planned and communicated to the corresponding professional and to the facility staff for implementation. The Certified Nursing Assistant (CNA). will observe and document the Resident's current voiding (urination)/bowel evacuation pattern for a minimum of three days. Following review and determination of the Resident's voiding/bowel evacuation pattern the licensed nurse will develop an individualized Bowel and Bladder Training Program to meet the Resident's needs. The established pattern and individualized bowel and bladder training interventions will be documented in the plan of care.A review of Resident 1's admission record dated 8/13/25, indicated Resident 1 was admitted to the facility from a local hospital on 8/13/25 with the diagnoses that included Urinary Tract Infections (UTI, and infection in the bladder, causing pain and increased urination), Covid-19 (infectious respiratory disease caused by a virus), difficulty in walking, muscle weakness, cognitive (relating to the mental process involved in knowing, learning, and understanding things) communication deficit, dysphagia (difficulty with swallowing), need for assistance with personal care, chronic pain syndrome, atrial fibrillation (irregular heart beat that can cause dizziness, tiredness, lightheadedness, reduced ability to exercise, and weakness), overactive bladder (the sudden urge to urinate that may be hard to control), retention of urine (difficulty in urination), osteoarthritis (bone inflammation) of the right and left knee. A review of Resident 1's admission Minimum Data Set (MDS, a data driven clinical assessment) with an Assessment Reference Date (ARD) (the last day of the seven day observation period for a MDS assessment) of 8/20/25, Section C (review of mental status) indicated a Brief Interview for Mental Status (BIMS, a review of mental status with scoring from 0 to 15, where 0=resident is severely mentally impaired to 15=resident is mentally intact.) was conducted and Resident 1 scored a 10 indicating moderate mental impairment. Section GG (functional abilities) indicated Resident 1 used a walker when walking, required moderate assistance from staff with standing, transferring to chair or bed, walking, and toilet transfers. Section H (Bowel and Bladder) indicated Resident 1 was admitted with an indwelling catheter and was continent (able to control) with her bowel movements. A review of Resident 1's Progress Notes titled Alert Note dated 8/14/25 at 11:28 am, Registered Nurse (RN) A indicated Resident 1's indwelling catheter had fallen out. A review of Resident 1's Progress Notes titled IDT Progress Notes- Falls dated 8/15/25 at 7:23 am, IDT indicated Resident 1's indwelling catheter had been discontinued. A review of Resident 1's August 2025 Progress Notes indicated there was no documentation in Resident 1's progress notes to indicate why the indwelling catheter was not replaced. And there was no Alert Charting concerning Resident 1's status after the indwelling catheter was removed. A review of Resident 1's August 2025 Physician Orders indicated