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 03/06/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient competent staffing to meet the needs for three of four sampled residents (Residents 1, 2 and 3) when dependent residents required assistance with toileting waited a long time when call light initiated.This failure resulted in residents having unrelieved discomfort, emotional distress, and feelings of and neglect.Findings:A review of undated facility document titled,Certified Nursing Assistant (CNA) job description, indicated, a CNA's General Duties and Responsibilities including keep incontinent residents always clean and dry as possible and answer call lights promptly; A CNA's Clinical skill includes, Assist residents to/from bathroom promptly.A review of Resident 1's record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included encounter for orthopedic aftercare following surgical amputation, difficulty in walking and need for assistance with personal care. Resident 1 was able to make his own health care decisions.A review of Resident 1's most recent Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 1/30/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, cognitive screening tool) and scored 14 (cognitively intact). Resident 1 used a walker and or a wheelchair for her mobility. MDS indicated the need for partial/moderate assistance (helper does less than half the effort) for transfers.A review of Resident 1's fall care plan dated 2/2/26, indicated Resident 1 was at risk for falls due to gait/balance problems. Resident 1 needs prompt response to all requests for assistance.During interview on 2/13/26 at 1:02 pm, with Resident 1, Resident 1 stated, a few nights ago after dinner and medications I asked staff to take me to the restroom. Resident 1 stated a male staff member took him to the restroom. Resident 1 stated after he finished, he pushed the call light button and waited. Resident 1 stated after waiting a for a little while a female Certified Nursing Assistant (CNA) came by and turned off the call light, and did not help him out of the bathroom, just walked out of the room. Resident 1 stated he transferred himself to his wheelchair and sat in the doorway to the restroom, for a little bit then backed the wheelchair out and waited for approximately 45 minutes for staff to assist him back to bed. Resident 1 explained he then wheeled himself back to the bed and waited for staff, no one came so he self-transferred himself into the bed. Resident 1 stated he felt frustrated and kept his cool then went to bed.A review of Resident 2's record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included spinal stenosis, difficulty in walking, not elsewhere classified and need for assistance with personal care. Resident 2 was able to make her own health care decisions.A review of Resident 2's most recent MDS dated [DATE], indicated Resident 2 had a BIMS score of 13 (cognitively intact). Resident 2 used a wheelchair for her mobility. MDS indicated the need for partial/moderate assistance (helper does more than half the effort) for toileting.A review of Resident 2's bowel and bladder care plan dated 12/9/25, indicated Resident 2 was at risk for urinary tract infection related to insufficient fluid intake and urine retention secondary to avoidance of voiding in brief. Offer privacy, dignity and prompt assistance when toiletingDuring Interview on 2/13/26 at 1:35 pm, with Resident 2, Resident 2 stated, care at the facility depends on the day and staff. Resident 2 stated there are not enough staff to care for her needs. Resident 2 stated facility (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

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 03/06/2026
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	was always short staffed mostly on day shift. Resident 2 stated she complained before to the nurse and was reported to social services. Resident 2 stated after the complaint things only seemed to change for a day or so. Resident 2 stated that when needing to use the restroom she has to wait 30 minutes to an hour. Resident 2 stated this caused incontinent accidents and did not want this to ruin her progress of controlling her bowel and bladder. Resident 2 stated an agency staff member once told to void in her brief. Resident 2 explained a couple months ago, and another CNA told her to have fun when trying to go to the bathroom on her own. Resident 2 stated that a female CNA was removed from her care. Resident 2 stated, it makes me feel like the facility doesn't give a shit like they are only in it for the money. Resident 2 stated almost every day she has an incontinent episode due to having to wait to be taken to the restroom. Resident 2 stated yesterday she fell asleep in the bathroom waiting 30 minutes for a staff member to assist her. A review of Resident 3's most recent MDS dated [DATE], indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis that included spinal surgery and arthritis. Resident 3 had a BIMS score of 15 (cognitively intact). Resident 3 used a wheelchair for her mobility. MDS indicated Resident 3 was dependent on staff for all transfers.During an interview on 2/13/26 at 2:13 pm, CNA A stated the day shift currently was short staffed. CNA A stated she was frequently asked to stay late if they can't get registry coverage due to staff call outs. CNA A stated she was able to give basic care and sometimes she had to skip giving resident showers due to short staffing. During an interview on 2/19/26 at 9:45 am, Resident 3 stated she needs assistance when transferring out of bed to wheelchair. Resident 3 stated it takes a while for staff to answer call lights. Resident 3 stated it seemed like facility was short staffed. Resident 3 stated she has had incontinence episodes due to staff delayed response to call light request. Resident 3 stated by the time they arrive she has already voided before they can get the bed pan which is embarrassing.A review of the facility staff schedule for February 11, 2026, indicated CNA B was asked to cover station 3 resulting from two employees calling out for their shift. Station 3 is the station where Residents 1, 2 and 3 reside.During an interview on 2/19/26 at 11:32 am, with CNA B who stated the Director of Staff Development spoke CNA B about the scheduler who asked CNA B to go to station three for 30 minutes. CNA B stated she was originally assigned to be on station one. CNA B stated she was unaware of the other CNAs on shift when she came to Station 3, she saw a bunch of call lights on, so she started checking call lights. CNA B stated she was asked about a Resident and if she turned off a call light. CNA B stated the resident she believed was in question needed help getting out of the bathroom but was already in the wheelchair so CNA B helped resident get into bed. CNA B stated there was a lot of miscommunications between staff. CNA B stated she was re-educated, but it was more like a short conversation than CNA B signed the paperwork. CNA B stated there is not enough staff on pm shift to meet the needs of Residents. CNA B stated a lot of call outs. CNA stated she has informed the nurse and also when attending staff meetings, she brings it up staffing, but she feels like falls on deaf ears.During an interview on 2/29/26 at 11:58 am, CNA C who stated Resident 1's niece informed CNA C that Resident 1 and herself were very frustrated due to Resident 1 having to get into a wheelchair and out of bathroom on his own. CNA C stated she was told Resident 1 waited a long time and had to get in bed by himself. CNA C stated CNA B hit the call light off but left Resident in the restroom who waited from nine to eleven pm in the restroom. CNA stated she knew who the other CNA was due to having to give her a report the day before when she took over the shift.During an interview on 02/24/26 at 2:15 pm, with the Director of staff Development (DSD), DSD determined it was CNA B in charge of the care of Resident 1, 2 and 3 who all reported waiting a long time for assistance. DSD stated CNA B was re-educated on answering call lights timely when residents request assistance with toileting.