

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  04/23/2026
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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to develop and implement safe discharge plan for one sampled resident (Resident 1) when the Interdisciplinary Team (IDT, a team composed of nursing, social work, and therapy who develop resident plan of care) did not ensure Caregiver (CG) had training and services were arranged before returning home. This resulted in Resident 1 falling in the facility parking lot on 3/6/26 at 2 pm, when the resident was dropped by the CG during a transfer from the wheelchair to the car. Findings: A review of a facility policy titled Discharge and Transfer of Residents, revised 3/21/25, indicated the facility may transfer or discharge a resident with an order from the resident's physician if the resident's health has improved significantly and services provided by the facility are no longer required. A review of an undated facility policy titled Discharge Against Medical Advice Operational Manual Policy, indicated the facility will make reasonable attempts to ensure the safety of residents wishing to leave the facility against medical advice. A review of Resident 1's admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included heart disease, difficulty in walking and need for assistance with personal care. Resident 1 was able to make her own health care decisions. A review of Resident 1's Minimum Data Set (MDS) dated [DATE], in the section of Mobility, indicated the following mobility performance levels: Sit to lying required partial to moderate assistance; Lying to sitting on the side of the bed required substantial to maximum assistance; Sit to stand was dependent; and Chair to bed and toilet transfers required substantial to maximum assistance. Walking 10 feet, 50 feet, or 150 feet was not attempted due to medical condition or safety concerns. A review of Resident 1's physical therapy notes, dated 2/19/26, 2/20/26, 2/24/26, and 2/26/26, indicated that on 2/19/26 the Interdisciplinary Team coordinated to clarify Resident 1's weight bearing orders with the physician, with Resident 1 tolerating strengthening activities but unable to complete planned car transfer training due to the physician not being reached; on 2/20/26 Resident 1 demonstrated fear of falling during transfer training, reported episodes of excruciating right lower extremity knee pain, was intermittently unable to bear weight, required varying levels of assistance for transfers, and was unable to ambulate; on 2/24/26 Resident 1 reported concern about the right lower extremity collapsing during transfers, required assistance to safely complete turning to sit in the wheelchair, demonstrated anxiety and fear of falling, and had car transfer training canceled by the caregiver; and on 2/26/26 Resident 1 again demonstrated fear of falling during transfer training and required some assistance. A review of Resident 1's IDT meeting note, dated 2/27/26 at 2:02 pm, indicated that on 2/26/26 at approximately 10:00 am, Resident 1 reported fear that the CG was taking financial advantage of the resident, stating the CG had not provided bank statements and had pressured the resident to assign power of attorney (POA) after the resident received a substantial inheritance in mid-2025; Resident 1 reported signing the POA in September 2025 due to this pressure. The note also reflected that Resident 1 had made multiple prior reports of fear, distrust, and concerns regarding the CG, which the facility had reported to California Department of Public Health (CDPH) and the Ombudsman. During an Ombudsman meeting on 2/26/26, Resident 1 expressed a desire to revoke the financial POA and planned to consult with an (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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>attorney. It was further documented that the CG continued calling Resident 1 on the resident's personal phone, and Resident 1 continued answering the calls. Resident 1 was encouraged to report concerns to staff as they arise. A review of Resident 1's nursing notes, dated 2/27/26 at 7:30 am, indicated that at approximately 6:40 am, Resident 1's cell phone rang multiple times, prompting the Licensed Nurse (LN) to inform the resident that the CG was calling. Resident 1 requested that the LN answer the call and notify the CG that the resident wished to continue sleeping. The LN honored the resident's request and intercepted the call, during which the CG stated, It is a quarter to seven, why the hell are you still sleeping?! The LN advised the CG that Resident 1 had the right to rest, but the CG demanded that the LN wake the resident to speak with the CG. The LN reiterated that Resident 1's wishes would be followed, after which the CG stated, You are such an asshole! and abruptly ended the call. During an interview on 3/5/26 at 2:06 pm with the Director of Rehabilitation (DOR), the DOR stated that the CG had come into the facility and made demands. The DOR reported that on 2/28/26, the DOR asked Resident 1 whether the resident felt safe with the CG, and Resident 1 stated the CG had mental health issues and had thrown the resident's pain medications away. The DOR stated that these concerns were reported to the Administrator, who discussed the possibility of discharge. The DOR further stated concern regarding Resident 1's potential discharge and reported that the DOR would be completing an assessment that day and observing the caregiver's transfer of the resident prior to signing off for discharge. During an interview on 3/5/26 at 3:11 pm, with Social Services Assistant (SSA), the SSA stated that CG had demanded a meeting to assert that Resident 1 should not receive pain medication because the CG believed the resident was a drug addict, which the SSA stated was not clinically justified. The SSA reported that the meeting was ended because Resident 1 was present and became upset. The SSA further stated that there had been several prior meetings in which Resident 1 expressed fear due to the CG threatening to take the resident's dog and yelling at the resident, and that the CG frequently called Resident 1 in the middle of the night, waking the resident to talk. The SSA stated Resident 1 continued to express a desire to return home with the CG, although car transfer competency had not been signed off for discharge. The SSA reported concerns regarding the safety of discharging Resident 1 to the CG's care and stated that discharge against medical advice (AMA) had not been discussed with the resident. A review of Resident 1's IDT meeting note, dated 3/6/26 at 6:31 pm, indicated that Resident 1 was scheduled for discharge that day at the CG request; however, a licensed nurse reported that the CG did not wait for staff assistance during the car transfer, resulting in a witnessed fall in the facility parking lot. The IDT note documented that the CG had been offered education and hands-on car transfer training multiple times by therapy but refused, including again on the day of discharge, stating the CG needed to leave. Multiple training attempts had been scheduled, but the CG repeatedly provided reasons for not attending. After Resident 1 returned to the facility following the fall, the resident expressed concern about safely transferring home and requested to remain in the facility. The IDT recommended scheduling a care conference with the Ombudsman and increasing staff presence during CG visits to ensure Resident 1's comfort and safety. A review of Resident 1's social services progress note, dated 3/9/2026 at 11:28 am, indicated that staff met with Resident 1 to assess the resident's psychosocial functioning following the attempted discharge with the caregiver, during which the resident was instructed to get into the SUV independently and subsequently dropped to the ground. The note documented that Resident 1 stated she was doing okay, but reported that the caregiver called earlier that day and told the resident, If you are not discharged by the 17th your world is going to be fire. A review of Resident 1's IDT note, dated 3/9/26 at 2:11 pm, Resident 1 reported that earlier that morning, the CG contacted the resident by personal phone and stated that if the resident did not discharge by 3/17/26, her life would go up in flames. Rehabilitation staff documented that Resident 1 appeared distressed and fearful following the call. During a subsequent interview with the Director of Nursing (DON), Resident 1 stated the CG told her that failure to discharge home by 3/17/26 would result in her life being permanently altered. The IDT note further indicated that Resident 1 has made multiple prior reports of (continued on next page)</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>fear, distrust, and concerns regarding the CG, and the facility has submitted multiple reports to CDPH and the Ombudsman. During an interview on 3/13/26 at 10:45 am, with the DOR, the DOR stated that on the day of discharge, CG appeared to be rushing to take Resident 1 outside. After Resident 1 fell, the resident stated that she wished to remain at the facility and reported that CG did not assist her and just let her fall. The DOR stated that Resident 1 also expressed, I can't believe she would let me fall. The DOR reported multiple attempts to arrange car transfer training but was unclear whether the training was intended for CG, Home Health agency, or the resident. The DOR stated that the discharge plan should have specified if the CG would be the mode of transport. During an interview on 3/13/26 at 11:26 am, with Resident 1, Resident 1 stated that during the 3/6/26 car transfer incident, CG dropped her while attempting to transfer her into the car and threatened that she would not pick up the resident's dog or provide her medications. Resident 1 reported she did not feel safe and was fearful of what the CG would or would not do for her. Resident 1 recalled that Home Health agency would not be available until Monday (3/9/26) and that the CG would be with her continuously over the weekend. Resident 1 stated the CG is forceful and yells at her when she does not comply with the CG's demands. Resident 1 confirmed that the DOR explained the need for all caregivers to be trained in transfer techniques and in the use of the new soft brace for her right knee. During an interview on 3/13/26 at 11:45 am, with DON, the DON confirmed she participated in the care plan meeting regarding Resident 1's potential discharge. The DON reported that the CG stated Resident 1 needed to leave the facility by March 7 to attend an appointment with the resident's primary care provider. The DON stated she informed the CG that Resident 1 must first meet discharge goals before leaving the facility. The DON reported she had multiple notes documenting the CG canceling scheduled training sessions. The DON stated the facility did not have evidence of a complete or coordinated discharge plan for Resident 1. During an interview on 3/13/26 at 1:18 pm, with Licensed Vocational Nurse (LVN A), the LVN A stated that on 3/6/26 the CG appeared to be in a rush. LVN A reported that he informed the CG he needed to prepare the paperwork and secure Resident 1's medications before providing discharge instructions and assisting with the transfer. LVN A stated that when he returned with the medications, Resident 1 and the CG were already outside, and Resident 1 was back in her wheelchair after the fall, visibly upset and telling the CG, You were rushing me. LVN A further reported that as Resident 1 returned inside the facility, the CG stated, You're on your own. During a review of a social services note, dated 3/19/26 at 12:25 pm, it indicated that Resident 1 left the facility AMA on that date.</p>		