

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 05/21/2026
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an alleged violation involving a resident fall resulting in a head injury and right hip fracture to the required state agency for one of four sampled residents (Resident 1). This failure had the potential to delay investigation and corrective actions, placing all residents at risk for ongoing safety hazards and preventable injury. Findings: During a review of the facility's policy titled Unusual Occurrence Reporting, effective 6/12/24, indicated that unusual occurrences must be reported to the appropriate agency within 24 hours by telephone and subsequently confirmed in writing. During a review of Resident 1's admission record, indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), muscle weakness, difficulty in walking, and need for assistance with personal care. Resident 1 was not her own health care decision maker. During a review of Resident 1's progress note, dated 3/21/26 at 4:07 pm, indicated that Resident 1 sustained an unwitnessed fall and reported lower back pain rated as 4 on a 0-10 pain scale (described as mild discomfort). The note documented that Resident 1 was confused and unable to recall the circumstances of the fall. Staff found Resident 1 lying on the floor in a prone position. During a review of Resident 1's progress note, dated 3/22/26 at 8:22 pm, indicated that Resident 1 had an unwitnessed fall on 3/21/26 at 2:45 pm. The note documented that Resident 1 had complained of hip pain since the fall and had shown mental decline. An in-house x-ray was obtained earlier on 3/22/26, and radiology later reported a right femoral neck fracture. Resident 1 was transported to the hospital at 4:30 pm. During a review of Resident 1's local hospital's emergency department records, dated 3/22/26 at 4:54 pm, indicated that Resident 1 was transferred from the facility following an unwitnessed fall with a probable right hip fracture and a closed head injury. The final impressions were, Closed fracture of the proximal end of the right femur (the thigh bone) and closed head injury. During interview on 5/21/26 at 12:26 pm, with the Administrator (Admin), the Admin acknowledged that Resident 1's fall was not reported to the state agency as required. When asked about the facility's expectation of reporting unusual occurrences, the Admin stated that a resident with dementia who experiences a fall resulting in a hip fracture must be reported.		

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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