

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

Printed: 10/09/2026
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 07/14/2026
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that care plans were updated and individualized for three of three sampled residents (Resident 1, Resident 2, and Resident 3) when interventions were not specific to the care needs of the resident. This had the potential for residents to not receive the interventions that were consistent with their care needs and have a negative impact on their physical and emotional well-being. Findings: A review of the facility's policy titled, Person Centered Care Planning, revised 4/24/2025 indicated, The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident-specific health and safety concerns to prevent decline or injury . The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practical . well being. All goals, objectives, interventions . from the . baseline care plan will be included in the resident's comprehensive care plan. A review of the facility's policy titled, Pressure Injury Prevention, revised 6/27/2024 indicated, Implement interventions identified in the plan of care which may include, but are not limited to, the following: a. Pressure redistributing devices for bed and chairb. Repositioning and turningc. Heel and elbow protectorsd. Increasing mobility (when appropriate) through a Restorative Nursing Program or therapyprograme. Off-loading pressure from heelsf. Use of (wedge) pillows for positioning and pressure reliefg. Moisturizers and barrier creams to protect the skinh. Bowel and bladder training, scheduled toileting, or incontinence management programs.i. Devices (bed trapeze bar, draw sheets, mechanical lifts, positioning aides, etc.) to reducefriction and shearing when repositioning.j. Contracture management programsk. Monitoring food and fluid intakek. Confirming that the Resident has properly fitting shoes.m. Monitoring splints, casts, and site of medical tubes and catheters. The National Pressure Injury Advisory Panel (https://www.internationalguideline.com/the-international-guideline) provides the following guidance for pressure injury classification: Stage 1: Observable, pressure-related alteration of intact skin with non-blanchable [redness that does not go away when touched] redness of a localized area . it may appear. blue or purple.Stage 2: Partial thickness loss of (skin) presenting as a shallow open ulcer with a red or pink wound bed, without slough (soft yellow or white substance that forms over a wound) or bruising. May also present as an intact or open/ruptured blister.Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling [severe tissue destruction of skin beneath the surface of a pressure injury where the skin separates and creates passages].Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar (thick, hard, or rubbery patch of dead tissue that forms over wounds). Often includes undermining and tunnelingUnstageable Pressure Ulcer: Pressure ulcer/ injury known but unstageable due to slough (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056074 If continuation sheet Page 1 of 4

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and/or Eschar: Pressure ulcer known but not stageable due to coverage of wound bed by slough and/or eschar.1.The record for Resident 1 was reviewed. Resident 1 was admitted on [DATE] with diagnoses that included metabolic encephalopathy (a malfunction of the brain caused by a chemical imbalance,) aphasia (difficulty speaking,) and need for assistance with personal care.A physician's order, dated 6/11/26 indicated, TX (treat) blanchable redness to sacral coccygeal (base of spine between buttock folds) area, cleanse with NS (normal saline) and pat dry. Apply foam dressing for pressure relief. A physician's order dated 6/11/26 indicated, wound consult (a physician who specializes in wounds) with follow up treatments as indicated. A physician's order dated 6/11/26 indicated, CCHO [controlled carbohydrate] standard portion diet. A physician's order dated 6/18/26 indicated, 4 oz [ounces] house supplement/milk shake two times daily with lunch and dinner. A physician's order dated 6/25/26 indicated, TX open discoloration to sacral coccygeal area. Cleanse with NS and pat dry. Apply Triad (an ointment used in wound treatments) to wound and cover with foam dressing every day shift every other day for 30 days. The physician's order dated 6/25/26, further indicated, LAL (low air loss) mattress related to impaired mobility and current wounds. A physician's order dated 6/27/26 indicated, Send [Resident 1] to. hospital for evaluation and treatment.A review of Resident 1's care plans was conducted. A care plan with the focus, Unstageable pressure to coccyx r/t (related to) immobility was reviewed. Under the section titled , Interventions the following were included, Follow facility policies/protocols for the prevention/treatment of skin break down, Administer medications as ordered, Monitor nutritional status. Serve diet as ordered. Monitor intake and record.Resident 1's care plan had not included any resident specific interventions such as her wound care treatments, nutritional supplements, the specialized mattress ordered by the physician, or specify the actions staff should take to prevent further skin breakdown based on her risk factors. The care plan did not specify any interventions or treatments that had been attempted and modified or discontinued. During an interview and current record review on 7/10/16 at 3:32 pm, with the Director of Nursing (DON) she reviewed the care plans for Resident 1. DON confirmed that the physician ordered interventions including wound treatments, nutritional supplementation, and a specialized mattress were not identified in Resident 1's care plan. DON stated that specific orders or treatments are never included in the care plan or kept updated because staff should review the physician's orders. DON confirmed the care plan directed staff to follow policies for skin breakdown, but stated staff should know their resident's specific needs, and again indicated staff could review the physician's orders or the policy. DON acknowledged that the LAL mattress ordered by the physician should have been included in the care plan and was not.2.The record for resident 2 was reviewed. Resident 2 was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis (left sided paralysis after a stroke,) pressure ulcer, malignant neoplasm (cancer) of the pancreas, and gastrostomy tube (a tube through which nutrition is delivered directly to the stomach.)A physician's order ,dated 6/7/26 indicated, Wound consultation with follow up treatment as needed.A physician's order, dated 6/17/26, indicated, LAL mattress for wound management r/t pressure injury. Use continuously until reassessment indicates no longer needed. Ensure mattress is functioning properly and setting matches current weight twice daily.A physician's order, dated 7/2/26, indicated, Tx coccyx stage 2 pressure, cleanse with NS and pat dry, apply Triad for preventive LOA (leave open to air- no dressing), every day shift for 14 days.A review of Resident 2's care plan with the focus, Resident has stage 2 pressure ulcer to coccyx r/t (related to) immobility was reviewed. Under the section titled, Interventions the following were included in the care plan, Follow facility policies/protocols for the prevention/treatment of skin break down, and Administer treatments as ordered. The care plan had not included or specified which interventions staff should (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that changes in residents health status were reported for one of five sampled residents when Resident 1's Responsible Party (person designated to make healthcare decisions when the resident is unable to) was not notified of changes in her wound. This resulted in the resident's representative being unaware of changes and unable to fully participate in advocating for and making choice's on Resident 1's behalf. Findings: A review of the facility's policy titled, Pressure Injury Prevention, revised 6/27/24 indicated, The physician and responsible party will be notified when there is a change in the condition of the pressure injury or skin integrity condition. The record for Resident 1 was reviewed. Resident 1 was admitted on [DATE] with diagnoses that included metabolic encephalopathy (a malfunction of the brain caused by a chemical imbalance,) aphasia (difficulty speaking,) and need for assistance with personal care. A physician's order reviewed, dated 6/11/26, indicated, TX [treat] blanchable redness to sacral coccygeal area [lower part of back], cleanse with NS [normal saline] and pat dry. Apply foam dressing for pressure relief. A physician's order reviewed, dated 6/25/26, indicated, TX open discoloration to sacral coccygeal area. Cleanse with NS and pat dry. Apply Triad (an ointment used in wound treatments) to wound and cover with foam dressing every day shift every other day for 30 days. The physician's order, dated 6/25/26, also indicated, LAL (low air loss) mattress related to impaired mobility and current wounds. A physician's order reviewed, dated 6/26/26 indicated, Resident is incapable of making health care decisions due to cognitive decline. and designated the resident's husband as her Responsible Party. A physician's order reviewed, dated 6/27/26, indicated, Send to. hospital for evaluation and treatment. During an interview and concurrent record review on 7/14/26 at 4 pm, with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), both reviewed the record for Resident 1. DON confirmed that Resident 1 had been admitted with blanchable redness to her coccyx area and that there had been a change in Resident 1's skin condition when the wound worsened. DON confirmed that Resident 1's husband was her Responsible Party. When asked if the facility had notified Resident 1's husband of the change in her condition, DON stated the doctor had been notified. When asked again if the resident's husband had been notified ADON stated that the facility was unable to provide documentation that this notification had occurred. Both acknowledged that Resident 1's husband should have been notified by the facility when there was a change in her skin condition.		