

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 07/28/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement resident-specific fall prevention interventions recommended by the Interdisciplinary Team (IDT) after a fall for two of three sampled residents (Resident 1 and 2). This failure has the potential to place all residents at risk of falls and injuries. Findings: A review of the facility's policy titled Fall Management Program, revised August 2025, indicated that fall risk evaluation and care planning require the IDT and/or a licensed nurse to develop a care plan based on identified risk factors. The licensed nurse must evaluate the resident's response to interventions weekly and update the care plan as needed. The policy further states that, for post-fall assessment, evaluation, and documentation, the licensed nurse is responsible for confirming the resident's safety and stability before proceeding with post-fall protocols, interviewing staff regarding the incident, completing a post-fall evaluation, and updating the resident's care plan with recommended interventions. The Interdisciplinary Team (IDT) is responsible for investigating the fall, reviewing the resident's medical record and the Post-Fall Evaluation, assessing the circumstances surrounding the fall, summarizing its conclusions in an IDT note, and revising the resident's care plan as necessary. A review of Resident 1's admission record indicated that Resident 1 was admitted to the facility on [DATE], with diagnoses which included aftercare following joint replacement surgery, difficulty in walking, and dementia. Upon admission, Resident 1 was identified as a high fall risk. A review of Resident 1's IDT note, dated 6/22/26 at 3:18 pm, indicated that Resident 1 lost her balance and stumbled on a mirror on 6/19/26, and discoloration on her face was observed on 6/20/26. The IDT recommended a medication regimen review (MRR), an interim pharmacy review of medication to verify interactions that increase risk for falls), and a therapy evaluation. A review of Resident 1's IDT note, dated 7/7/26 at 10:48 am, indicated that Resident 1 was observed by a CAN slowly lowering herself from a standing position to the floor on 7/6/26 at 5:05 pm. The IDT recommended keeping Resident 1 in high-visibility areas and continue frequent safety checks. A review of Resident 1's record titled Pharmacist Report to Nursing, dated 7/7/26 -completed two weeks after Resident 1's first fall on 6/19/26-indicated that no changes were recommended to the current medication regimen. This was the only medication regimen review (MRR) provided. A review of Resident 1's Therapy Post-Fall Screen (for the fall on 7/6/26), dated 7/6/26, indicated, Patient with increased behaviors requiring one on one supervision (close monitoring one patient to one staff member) at times. Patient with increased confusion and attempting to stand unassisted. The recommendations made by therapy on 7/6/26, including the need for one-to-one supervision at times as part of the IDT guidance, were not implemented. A review of Resident 2's admission record indicated that Resident 2 was admitted to the facility on [DATE], with diagnoses which included cancer of the liver, hospice, muscle weakness, and difficulty in walking. Resident 1 (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 07/28/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was a high fall risk.A review of Resident 2's IDT note, dated 6/29/26 at 12:37 pm, indicated that Resident 2 had an unwitnessed fall on 6/26/26 at 2:25 pm. Resident 2 was found on the floor in her room, positioned facing the window. According to Resident 2, she was attempting an independent transfer from her wheelchair to the bed when she lost her balance and fell. The IDT reviewed the incident and recommended completion of a MRR, assessment for the use of a bed cane (a bedside assistive device-a short, single-sided grab bar that slips between the mattress and box spring and secures to the bed frame with a safety strap. It is designed to provide support, stability, and balance for a resident when getting in or out of bed or repositioning at the bedside), and evaluation for orthostatic hypotension (a sudden drop in blood pressure when a person stands after sitting or lying down.)A review of Resident 2's Bed Rail Evaluation, dated 7/22/26, completed four and a half weeks after IDT's recommendation for a bed rail assessment, indicated that Resident 2 needs grab bars on both sides of the bed; however, the facility did not ensure timely completion or implementation of the recommended intervention. A review of Resident 2's record titled Pharmacist Report to Nursing, signed by the pharmacist on 7/23/26 -completed four and a half weeks after the IDT's recommendation for an MMR on 6/29/26-indicated that the facility did not ensure the timely completion of the required MRR.During an interview on 7/22/26 at 2:00 pm, with Licensed Vocational Nurse (LVN) who served as the fall prevention manager, he LVN stated that Resident 1 wanders and exhibits behaviors.During an observation on 7/23/26 at 10:15 am, in Resident 2's room, Resident 2 was observed asleep in bed with no bed cane or grab bar attached to the side of the bed.During a concurrent interview and record review on 7/23/26 at 11:25 am, with the Director of Nursing (DON), the DON acknowledged that the facility failed to timely implement the therapy recommendations for Resident 1 and stated that the pharmacy evaluation was completed two weeks after Resident 1's fall. The DON confirmed that Resident 1 was not tried on one-to-one supervision. The DON also stated that Resident 2 did not have the IDT recommendations implemented and that Resident 2's pharmacy evaluation was completed four and a half weeks post fall. The DON further confirmed that Resident 2's bed cane evaluation was conducted on 7/22/26, four weeks after the IDT meeting, and stated that the evaluation should have been completed at the time of the recommendation and implemented to prevent further falls.		