STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056231	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lassen Nursing & Rehabilitation Center	2005 River Street Susanville, CA 96130

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review, the facility failed to adhere to professional standards of practice for one out of three sampled residents (Resident 4) when: 1. The facility did not implement the Urologist's (a physician that specialized in the urinary system) order for daily suprapubic catheter (a catheter tube inserted through the lower abdomen into the bladder to drain urine) flushes (sterile water was inserted through the catheter tube into the bladder to remove debris or blockage). 2. Treatment nurse did not document a provided treatment or an assessment following a reported suprapubic catheter complication. These failures had the potential to cause a decline in health status. Findings: 1. A review of the facility's policies and procedure (P&P) titled, Physician's Orders, dated 11/1/23, indicated, A current list of orders must be maintained in the clinical record of each resident. A review of the Admission Record, dated 7/1/22, indicated Resident 4 was admitted to the facility on [DATE] with the diagnoses of urinary tract infection (an infection in the urinary system) and obstructive and reflux uropathy, unspecified (a disorder of the urinary tract that occurred due to a blockage of urine flow). Resident 4 was not his own responsible party (decision maker). During an interview on 4/17/25 at 7:59 am, Social Services Director stated, when orders come in [from outside sources] it is given to the nurse and the nurse enters the order. (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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/17/25 at 11:34 am, with Director of Staff Development (DSD) and Administrator (Admin), Resident 4's Doctor's Appointment Form, dated 9/6/24 was reviewed. DSD and Admin confirmed, Resident 4 had seen the Urologist, and the Doctor's Appointment Form indicated, Licensed Nurses (LN) were to flush Resident 4's suprapubic catheter two times a week with Renacidin (a medication that was flushed into the bladder to break down matter that clogged the catheter tube) and to perform sterile water flushes every day that Renacidin was not used. Admin reviewed all active and discontinued orders and confirmed, there was no order present in the electronic medical record regarding daily sterile water flushes. Admin stated, nursing should have followed up with that. 2. A review of the facility's P&P titled, Suprapubic Catheter Care, dated, 10/1/10, indicated, the date, time, procedure, and assessment would be documented in the resident medical record. During a concurrent interview and record review on 4/16/25 at 11:48 am, with LN A, Resident 4's Health Status Note (progress notes), dated 3/29/25 was reviewed. LN A stated, the progress notes indicated, [Resident 4] had no urine output all night and the Treatment Nurse [TN] would flush the catheter. LN A reviewed all progress notes dated 3/29/24 and stated, [TN] did not document the care that was provided. A review of Resident 4's Active Orders, dated 9/7/24, indicated, Renacidin Irrigation Solution, use 30 milliliters (ml) via irrigation as needed for maintenance of catheter patency, irrigate catheter, clam catheter for 30-60 minutes then drain, repeat until urine is clear. During a concurrent interview and record review on 4/17/25 at 10:51 am, with DSD, Resident 4's progress notes, dated 3/29/25 was reviewed. DSD confirmed, there was no documentation present that indicated, TN had provided care to Resident 4's suprapubic catheter. During a concurrent interview and record review on 11/17/25 at 11:34 am, with TN, Resident 4's progress notes, dated, 3/29/25 was reviewed. TN stated, I flushed the catheter, the catheter was fine, there was sediment [debris] in the tube, I flushed with the ordered flush, and I'm unsure how much urine output there was. TN confirmed, TN did not document the procedure and stated, I should have. TN reviewed the Medication Administration Record (MAR), dated 3/1/25 through 3/31/25, and confirmed, the MAR section labeled Renacidin PRN (as needed) was blank. TN confirmed, TN had not documented the Renacidin PRN flush on 3/29/25 and stated, I should have documented it.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to provide palatable (tasted good) meals to five out of five sampled residents (Residents 1, 2, 5, 6, and 7) when they stated, the food was bad, had a weird flavored spice that could be tasted on all the food, and the food was cold. This caused residents to have feelings of anger and had the potential to cause unintended weight loss. Findings: A review of the facility ' s policy and procedure titled, Food and Nutrition Services, revised 10/1/24, indicated, Each resident is provided with a nourishing, palatable, well-balanced diet . and it was the responsibility of the food and nutrition department to ensure meals were .palatable and attractive, and it is served at a safe and appetizing temperature. A review of Resident 1 ' s Admission Record, dated 10/29/23, indicated, admission to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, a lung disease that caused difficulty with breathing), major depressive disorder (a sad mood), and adult failure to thrive (a decline in health status). Resident 1 was her own responsible party (RP, made own decisions). A review of Resident 1 ' s significant change of status Minimum Data Set (MDS, a resident assessment tool), dated 4/14/25, indicated, Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen cognition, that included memory, orientation, and judgement status of the resident) score of 13 out of 15, which indicated, good cognition. A review of Resident 2 ' s Admission Record, dated 2/7/24, indicated, admission to the facility on [DATE] with the diagnoses of major depressive disorder, hypomagnesemia (magnesium was a nutrient in the body, low magnesium could affect the muscles and could increase the risk of heart attacks) and hypokalemia (potassium was a nutrient in the body, low potassium could affect the muscles and cause weakness) Resident 2 was her own RP. A review of Resident 2 ' s annual MDS, dated [DATE], indicated, a BIMs of 15 out of 15, which indicated, good cognition. During a concurrent observation and interview, on 4/16/25 at 11:23 am, Resident 1 stated, the food is nasty, inedible, vegetables are mushy and overcooked, the fried potatoes are hard, the fruit is sometimes hard, and had a weird tasting spice all over it. Resident 1 stated, the pork chops are so hard you can ' t stick a fork in it. Assistant Director of Nurses (ADON) was present and confirmed, there were food concerns and stated, sometimes the meat is tough. Resident 2 (Resident 1 ' s roommate) stated, they serve meat I can ' t eat; I have no teeth, and it ' s tough. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/16/25 at 12:45 pm, Residents 1 and 2 were served lunch. The lid was removed from the plate, and both residents were observed to grimace and frown after seeing what was on the plate and Resident 2 stated loudly, rice again! The plate of food consisted of cauliflower, rice that looked like Mexican style rice, and a finely chopped up mixture of light-colored meat. Both residents declined to eat most of what was served, and facility staff was observed discussing alternates that could be provided. A review of the menu, indicated, lunch was Mandarin chicken, fried rice, roasted cauliflower, diced pears and water. A review of the Resident Council meeting notes, dated 1/17/25, the section titled, New Business (new concerns that were discussed during Resident Council meeting), indicated, residents had concerns regarding food being served cold. The Resident Council Suggestion/Issues/Questions/Concern form, dated 1/17/25, indicated, the pellet warmer was being fixed (a pellet warmer was used to warm ceramic disks [pellets] that were placed under the meal plate to keep food warm), time logs would be placed on the meal carts to ensure timely deliver of meal trays, and hot food would be held at 135 degrees until served. A review of the Resident Council meeting notes, dated March 2025, the section titled, Old Business, indicated, meal temps were ongoing, extra help with meal assistance was resolved. The Resident/Family Response Form, dated 3/28/25, indicated, on 4/2/25, the Dietary Department had responded to resident food concerns. Five residents were individually interviewed, and concerns regarding cold food, had not been completely resolved. The section indicating that resident food issues had been resolved to reasonable satisfaction was selected as yes. A review of Resident 5 ' s Admission Record, dated 10/11/22, indicated, admission to the facility on [DATE] with the diagnoses of hypertension, and generalized muscle weakness. A review of Resident 5 ' s Quarterly MDS, dated [DATE], indicated, a BIMs of 15 out of 15, which indicated good cognition. During an interview on 4/17/25 at 9:22 am, Resident 5 confirmed, Resident Council had voiced concerns regarding food issues. Resident 5 stated, food concerns were getting better but there were still complaints. Resident 5 stated, we don ' t get fried eggs anymore because they are overcooked and hard, sometimes the meat is tough and overcooked, and sometimes hot food is not hot and cold foods are not cold. Resident 5 stated, they were served rice often, and I don ' t like rice, I don ' t tell anyone, and I just don ' t eat it. A review if Resident 6 ' s Admission Record, dated 1/13/23, indicated, admission to the facility on [DATE] with the diagnoses of COPD, malignant neoplasm of lower lobe, right bronchus, or lung (lung cancer), and major depressive disorder. A review of Resident 6 ' s Quarterly MDS, dated [DATE], indicated, a BIMs of 13 out of 15, which indicated good cognition. During an interview on 4/17/25 at 9:36 am, Resident 6 was asked how he like the food. Resident 6 began cussing and loudly stated, I can ' t eat it! They always serve rice, I don ' t like it, sometimes it ' s cold, the meat is tough, and it tasted bad. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 7 ' s Admission Record, dated 6/3/24, indicated admission to the facility on [DATE] with the diagnoses of COPD and major depressive disorder. Resident 7 was his own RP. A review of Resident 6 ' s Quarterly MDS, dated [DATE], indicated, a BIMs of 13 out of 15, which indicated good cognition. During an interview on 4/17/25 at 9:50 am, Resident 7 stated, the food is overcooked, meat was tough, and there was a weird tasting spice on all of the food, including food there should not be spice on. During a concurrent interview and record review on 4/17/25 at 10:00 am, with Dietary Manager (DM), four untitled documents dated 4/7/25 were reviewed. DM confirmed there were complaints regarding cold food, and stated, the Dietary Department developed a cart audit log. DM stated, the cart audit log indicated the time the cart was called to be picked up, what time staff picked up the cart, and the time the last meal from the cart was served. Dm stated, the cart audit logs were developed to determine if the cold food was a dietary department issue or caused by facility staff not passing the meal trays in a timely manner. DM reviewed Hall #1 cart audit log, and stated, breakfast took 10 minutes [for facility staff] to pick up and 24 minutes to pass the trays, and if there ' s no warming pellet under the plate, the food would most likely be cold and confirmed, the lunch section was not filled out by facility staff. DM confirmed, the cart audit log labeled Hall #2 was not completed by facility staff and the breakfast and lunch sections were blank. DM confirmed the cart audit log labeled, Social, indicated, facility staff did not enter the time the last tray was served for breakfast and dinner. DM confirmed, the cart audit log labeled Assisted, did not include the time the last tray was served for breakfast, lunch, and dinner. DM stated, there was an order placed for more warming pellets, the facility did not have enough for every plate. DM was asked about the weird spice that residents had noticed on the food. DM stated, I ' ve noticed the cooks are using a garlic and herb seasoning, maybe they are overusing it. DM reviewed, Food Temperature Log, dated 4/1/25 through 4/17/25. DM stated, the Food Temperature Log indicated, no food temperatures had been recorded for dinner from 4/1/25 through 4/3/25, no food temperatures had been recorded for breakfast and lunch from 4/4/25 through 4/6/25, no food temperatures had been recorded for breakfast, lunch, and dinner from 4/7/25 through 4/16/25. During an interview on 4/17/25, at 10:29 am, [NAME] was asked who was responsible for completing the Food Temperature Log. [NAME] stated unawareness, and DM stated, It was my responsibility to train [NAME] on Food Temperature Logs and I did not. DM confirmed, when the cooks did not monitor tray line temps, and facility staff did not complete the cart audit forms, there was no way to ensure if cold food was caused by the dietary department or facility staff not passing meal trays timely.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to follow safe infection control practices for three out of four sampled residents (Residents 1, 2, and 3) when: 1. Facility staff did not wear personal protective equipment (PPE, gloves, gowns, or masks that were worn to reduce the spread of infection) while performing resident care with Resident 1 and did not perform hand hygiene (washing hands with soap and water or use alcohol-based hand sanitizer) after providing care for Resident 1 or before touching Resident 2; and 2. Enhanced barrier precaution (EBP, use of PPE to reduce the spread of infection for residents who have wounds or foley catheters, a tube inserted into the bladder and was attached to a bag) signage and PPE was not present outside of Resident 3's room and facility staff touched Resident 3's foley catheter tube without use of PPE. These failures had the potential for the spread of infection. Findings: 1. A review of the facility's policy and procedure (P&P) titled Enhanced Barrier Precautions, dated 4/1/24, indicated, EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. The P&P indicated, transferring (moving from bed to chair) and changing linen were considered high contact resident care activities. A review of Resident 1's Admission Record, dated 10/29/23, indicated, admission to the facility on [DATE] with diagnoses of urinary tract infection (UTI, an infection in the bladder/urinary tract), klebsiella pneumoniae (bacteria in the urinary tract that caused UTI), Escherichia coli (E. coli, natural bacteria found in the gut and some strains could cause UTI), Proteus (Mirablis) (Morganii) (most often a pathogen of the urinary tract), bacteremia (an infection in the blood that can lead to a life threatening complication known as sepsis), and artificial opening of urinary tract status (urostomy, an opening in the belly that redirected urine from the bladder to a bag that was attached to the belly). Resident 1 was her own responsible party (RP, made own decisions). A review of Resident 2's Admission Record, dated 2/7/24, indicated, admission to the facility on [DATE] with the diagnoses of UTI and hypertension (high blood pressure). Resident 2 was her own RP. During an observation on 4/16/24 at 10:22 am, Student Nurse Aide (SNA) B was observed climbing onto Resident 1's mattress. There was no linen on the mattress and SNA B was not wearing any PPE. Both hands and both knees were in full contact of the mattress. SNA B was observed readjusting her own clothing and walking over to Resident 2 without performing any hand hygiene. SNA B placed both hands on top of Resident 2's blanket and rubbed Resident 2's legs (Residents 1 and 2 were roommates). SNA B was observed leaving the room without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/16/25 at 10:25 am, with SNA B, the EBP signage outside of Resident 1 and 2's room was observed. SNA B confirmed observations made and stated, [Resident 1] was on EBP for urinary [urostomy] and colostomy [a surgical procedure that allowed waste to leave the body and into a bag]. SNA B stated, the EBP signage indicated, use of gowns and gloves during linen changes and transfers. SNA B stated, I only wore gloves when I assisted with [Resident 1's] transfer and linen change. During an interview on 4/16/25 at 11:42 am, the Assistant Director of Nursing (ADON) confirmed the observations made of SNA B. ADON stated, I was in the room with [SNA B], I didn't tell her to get PPE, and I should have. 2. A review of the facility's P&P titled Enhanced Barrier Precautions, dated 4/1/24, indicated, residents with wounds would be placed on EBP and Signs are posted at the door or wall outside the residents room indicating the type of precautions and PPE required. The P&P indicated PPE supplies will be made available near or outside of the resident rooms, placement is at the discretion of the facility. A review of Resident 3's Admission Record, dated 2/19/19, indicated admission to the facility on [DATE] with the diagnoses of personal history of UTI and dementia (memory loss). Resident 3 was conserved (a public guardian made decisions). During a concurrent observation, interview, and record review, on 4/16/25, at 3:27 pm, with Infection Preventionist (IP), Resident 3 was observed with her legs hanging off the bed and moaning loudly. IP called for assistance and two unnamed Licensed Nurses and Certified Nurse Assistant (CNA) C assisted Resident 3 back into bed, CNA C was observed adjusting the foley catheter tube (a tube that was inserted into the bladder that connected to a bag that urine drained into) with her bare hands and tried to reattach the foley catheter tube to a device that was attached to Resident 3's left thigh. (The device was used to secure the foley catheter tube and protect it from dislodgement). IP was observed providing PPE to the unnamed LNs and CNA C. IP observed the wall and door outside of Resident 3's room and confirmed, there was no PPE or sign that indicated Resident 3 was on EBP. IP confirmed, Resident 3 required EBP due to having a foley catheter and a wound. IP reviewed maps of the facility that were titled, February EBP, March 2025 EBP, and April 2025 EBP. IP stated, the maps indicated, [Resident 3] was not on IP's EBP list and should have been. During an interview on 4/17/25 at 9:53 am, CNA C confirmed, touching Resident 3's foley catheter tube with bare hands and stated, I should have worn gloves.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to answer call lights in a timely manner when five out of five sampled residents (Residents 1, 2, 5, 6, and 7) stated experiencing long call light wait times. This failure caused residents to have feelings of anger, worthlessness, and had the potential to negatively impact resident health status. Findings: A review of the facility ' s policy and procedure titled, Answering the Call Light, revised 9/1/23, indicated, The purpose of this procedure is to ensure timely responses to the resident ' s requests and needs and that call lights would be answered as soon as practicable (able to be done). A review of Resident 1 ' s Admission Record, dated 10/29/23, indicated, admission to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, a lung disease that caused difficulty with breathing), major depressive disorder (a sad mood), and was dependent upon supplemental oxygen (additional oxygen that was needed for people with breathing problems). Resident 1 was her own responsible party (RP, made own decisions). A review of Resident 1 ' s significant change of status Minimum Data Set (MDS, a resident assessment tool), dated 4/14/25, indicated, Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen cognition, that included memory, orientation, and judgement status of the resident) score of 13 out of 15, which indicated, good cognition. A review of Resident 2 ' s Admission Record, dated 2/7/24, indicated, admission to the facility on [DATE] with the diagnoses of major depressive disorder and hypertension (high blood pressure). Resident 2 was her own RP. A review of Resident 2 ' s annual MDS, dated [DATE], indicated, a BIMs of 15 out of 15, which indicated, good cognition. During an interview on 4/11/25 at 2:29 pm, Family Member (FM) stated, [Resident 1] called me on the morning of 3/30/25 and stated no one answered the call light. FM stated, [Resident 1] told me she had gone out into the hallway to find help. FM stated, calling the facility and no one answered. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 4/16/25 at 12:21 pm, Resident 1 stated, one Sunday, on 3/30/25, I waited two hours in the morning for my call light to be answered and I think it was between 10:00 am and 12:00 pm. Resident 2 confirmed being present during the long call light wait time. Resident 2 pointed to the hall outside of their door and stated, [Resident 1] had to go out there to get help. Resident 2 stated, a long time ago, I used to time the call lights, and stopped because it didn ' t change anything. Resident 2 stated, my call light will be on and they [facility staff] are laughing and joking outside the room and ignore the light. Resident 1 stated, I use my call light went my urostomy [an opening in the belly that redirected urine from the bladder to a bag that was attached to the belly] or ostomy [colostomy, an opening in the belly that redirected stool to a bag that was attached to the belly] is leaking or detaches from the wafer [the bag attached to a device called a wafer, the wafer was attached to the skin]. Resident 1 stated, by the time they get here, I ' m so upset. Resident 1 maintained good eye contact, her voice became shaky, and tears were observed in her eyes. Resident 1 stated, I ' m just tired, I do the best I can on my own, and I have no motivation, I don ' t want to eat, and I just feel like I ' m giving up. Resident 1 stated, I was told someone fell on the other side of the building, everyone was over there helping, and that ' s why it took so long to answer my light. Resident 1 asked, Does everyone have to go over there? What if someone needed help? Resident 2 frowned and stated, I turn my light on for [Resident 1], sometimes I call the front desk for help, and sometimes I go in the hallway to find someone. During a concurrent interview and record review on 4/17/25 at 8:51 am, Administrator (Admin) stated, the facility department heads performed daily call light audits and confirmed, this was in response to Resident Council concerns regarding long call light wait times. Assistant Director of Nursing (ADON) joined the interview at 9:01 am and stated, on the morning of 3/30/25, I found [Resident 1] in the hallway and recall [Resident 1] stated, she came into the hallway to get help because she had a long call light wait time. ADON stated, ADON had been in the room [ROOM NUMBER] minutes prior, and after talking to other staff members, the CNA and nurses stated, they had been in the room several times. ADON stated, I requested a note be made regarding the frequency of Resident 1 ' s call light usage and staff entering the room on the morning of 3/30/25. ADON reviewed Progress Notes, dated 3/30/25, and stated, there was no progress note in the chart. Admin reviewed the fall log and stated there was a resident fall at 10:30 am on 3/30/25. A review of Resident 5 ' s Admission Record, dated 10/11/22, indicated, admission to the facility on [DATE] with the diagnoses of hypertension, and generalized muscle weakness. A review of Resident 5 ' s Quarterly MDS, dated [DATE], indicated, a BIMs of 15 out of 15, which indicated good cognition. During an interview on 4/17/25 at 9:22 am, Resident 5 confirmed, call light wait times were an ongoing issue and were brought up during many Resident Council meetings. Resident 5 stated, I don ' t use my call light often, so I don ' t have an issue, but there are other residents who do. A review of the Resident Council meeting notes, dated 1/17/25, the section titled, Old Business (concerns that were discussed at the previous Resident Council meeting), indicated, residents had concerns regarding the call lights not being answered in a timely manner, and the concern had been ongoing. (continued on next page)

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	056231	A. Building B. Wing	04/17/2025

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Resident Council meeting notes, dated March 2025, the section titled, Old Business, indicated, residents had concerns regarding the call lights not being answered in a timely manner, and the concern had been ongoing. A review if Resident 6 ' s Admission Record, dated 1/13/23, indicated, admission to the facility on [DATE] with the diagnoses of COPD, malignant neoplasm of lower lobe, right bronchus, or lung (lung cancer), and major depressive disorder. A review of Resident 6 ' s Quarterly MDS, dated [DATE], indicated, a BIMs of 13 out of 15, which indicated good cognition. During an interview on 4/17/25 at 9:36 am, Resident 6 stated, one time during the day, I waited two hours for my call light to be answered. Resident 6 ' s voice grew louder during the interview and Resident 6 raised his arms, shaking his hands above his head, and stated loudly, no one should have to wait forever for help! Resident 6 stated, it didn ' t happen all the time, but it happens. A review of Resident 7 ' s Admission Record, dated 6/3/24, indicated admission to the facility on [DATE] with the diagnoses of COPD and major depressive disorder. Resident 7 was his own RP. A review of Resident 6 ' s Quarterly MDS, dated [DATE], indicated, a BIMs of 13 out of 15, which indicated good cognition. During an interview on 4/17/25 at 9:50 am, Resident 7 confirmed, Resident 6 ' s statement for long call light wait times and stated, we are roommates, we see it all. Resident 7 stated, during long call light wait times, we use the bathroom emergency light sometimes to get our lights answered, because they answer the bathroom light faster.