

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056231	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  Lassen Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0602  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money.  (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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to protect one out of three resident's (Resident 2) from misappropriation (taken without permission) of resident property when Resident 2's wedding ring was stolen. This violated Resident 2's rights and had the potential to cause psychosocial harm. Findings: A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/1/21, indicated, residents had the right to be free from misappropriation of resident property. A review of the admission Record, dated, 5/1/24, indicated, Resident 2 was admitted to the facility on [DATE] with the diagnoses of unspecified dementia (memory loss) with behavioral disturbance and major depression (a sad mood). Resident 2 was not his own responsible party (RP, decision maker). A review of the Annual Minimum Data Set (MDS, a resident assessment tool), dated 4/24/25, indicated, Resident 2 had scored 6 out of 15 during a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), which indicated severe cognitive (thinking or remembering) impairment. The MDS indicated, Resident 2 required partial to moderate assistance from facility staff to perform personal hygiene (washing face, hands, combing hair) and to get dressed. The MDS indicated, Resident 2 required substantial (a large amount) to maximum assistance from facility staff to shower. During an interview on 7/15/25 at 11:11 am, Certified Nursing Assistant (CNA) F stated, CNA D was arrested for stealing from residents. CNA E was present during the interview and confirmed, CNA D was arrested for stealing resident property and stated, the police department came to the facility to arrest CNA D. During an interview on 7/16/25, at 12:36 pm, Administrator (ADMIN) stated, on 7/7/25, Family Member (FM) J noticed the wedding ring worn by Resident 2 was missing. We looked through everything and could not find it. ADMIN stated, on the evening of 7/7/25, ADMIN noticed an online post from CNA D with jewelry for sale. ADMIN stated, on 7/8/25 there was suspicion that Resident 2's wedding ring had been stolen by CNA D and the police department was contacted. ADMIN confirmed, CNA D had been arrested and stated, the police notified FM J and I think FM J confirmed the wedding ring belonged to Resident 2. ADMIN stated, the police department's investigation was ongoing and ADMIN had not been provided with an update regarding the case. A review of the document titled, Resident's Clothing and Possessions, dated 5/12/25, indicated, Resident 2 had a ring that was yellow in color with clear stones that wrapped around the ring. A review of the document titled, Nursing Daily Assignments and Sign-In Sheet, dated 7/6/25, indicated, CNA D worked the NOC shift, that started on the evening of 7/6/25 and ended on 7/7/25, and was assigned as Resident 2's CNA. A review of the document titled, Grievance Complaint Form, dated 7/7/25, indicated, FM J, reported to the facility that Resident 2's wedding ring was missing. During an interview on 7/16/25 at 2:18 pm, FM J stated, on 7/7/25, my husband called me and told me his wedding ring was missing and hadn't seen it for the last two days. I know the police department was involved in the investigation. I was shown a photo of the ring, I guess it was purchased through a sting operation. FM J confirmed, the ring that FM J identified through the photograph belonged to Resident 2 and described the ring as being yellow in color with clear stones that wrapped around it.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to report a reasonable suspicion of a crime to the California Department of Public Health (CDPH, responsible for protecting the public's health) for two out of three sampled residents (Residents 2 and 3) when the facility suspected Certified Nurse Assistant (CNA) D had stolen two wedding rings. This failure had the potential for further abuse and could negatively affect residents' mental and psychosocial well-being. Findings: A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation-Reporting and Investigating, revised 9/1/22, indicated, all allegations of suspected or actual abuse, including misappropriation (taken without permission) of resident property, would be reported to the local police department, the Ombudsman's (outside person who advocated for resident rights) office, and CDPH within two hours. A review of the admission Record, dated, 5/1/24, indicated, Resident 2 was admitted to the facility on [DATE] with the diagnoses of unspecified dementia (memory loss) with behavioral disturbance and major depression (a sad mood). Resident 2 was not his own responsible party (RP, decision maker). A review of the Annual Minimum Data Set (MDS, a resident assessment tool), dated 4/24/25, indicated, Resident 2 had scored 6 out of 15 during a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), which indicated severe cognitive (thinking or remembering) impairment. The MDS indicated, Resident 2 required partial to moderate assistance from facility staff to perform personal hygiene (washing face, hands, combing hair) and to get dressed. The MDS indicated, Resident 2 required substantial (a large amount) to maximum assistance from facility staff to shower. A review of the Admissions Record, dated 4/18/25, indicated, Resident 3 was admitted to the facility on [DATE] with the diagnoses of depression, anxiety, and difficulty with walking. Resident 2 was not her own RP. A review of the admission MDS, dated [DATE], indicated Resident 3 had severe hearing and vision loss. The MDS indicated Resident 3 had a BIMS score of 15 out of 15, which indicated intact cognition. A review of the Discharge-return anticipated MDS, dated [DATE], indicated Resident 3 required substantial to maximum assistance from facility staff to use the bathroom, shower, and get dressed. During an interview on 7/15/25 at 11:11 am, CNA F stated, CNA D was arrested for stealing from residents. CNA E was present during the interview and confirmed, CNA D was arrested for stealing resident property and stated, the police department came to the facility to arrest CNA D. A review of the document titled, Grievance Complaint Form, dated 6/23/25, indicated, FM H, reported to the facility that Resident 3's wedding ring was missing. A review of the document titled, Grievance Complaint Form, dated 7/7/25, indicated, FM J, reported to the facility that Resident 2's wedding ring was missing. During an interview on 7/16/25, at 1:30 pm, Administrator (ADMIN) stated, a few weeks ago, I got a call from Resident 3's FM, stating Resident 3's wedding ring was missing. Admin stated, we followed the facility's protocols for lost and missing items and was not able to find the ring. ADMIN stated, on the evening of 7/7/25, ADMIN noticed an online post from CNA D with jewelry for sale and on 7/8/25, I was informed Resident 2's wife alleged Resident 2's ring was missing. ADMIN stated, CNA D was assigned to Resident 2 and 3 when the missing rings were reported and confirmed, on 7/8/25, there were suspicions that CNA D had stolen Resident 2 and 3's wedding rings. ADMIN stated, the police department was notified immediately and confirmed, that suspicions of a crime were not reported to CDPH or the Ombudsman's office.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure medical records were accurate and complete for three out of five residents (Residents 1, 2, and 3) when: 1. Resident 1's code status (the residents' wishes regarding life-sustaining treatment, specifically if the resident stopped breathing or the heart stopped beating) was inaccurately documented throughout Resident 1's medical records. 2. The Resident's Clothing and Possessions form, (inventory sheet, described personal belongings brought into the facility) was not signed by Residents 2, 3, or the resident's responsible party (RP, decision maker). 3. Resident 3's wedding ring and wristwatch were not added to the inventory sheet. These failures had the potential to cause a delay in life sustaining care and personal belongings to not be identified if lost or stolen. Findings: 1. A review of the facility's policies and procedures (P&amp;P) titled, Advance Directives (written instruction on care to be provided when someone was not able to make own decisions and included the code status), revised [DATE], indicated Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. A review of the facility's P&amp;P titled, Attending Physician Responsibilities, revised [DATE], indicated, the attending physician was responsible to ensure orders were appropriate. The P&amp;P indicated, The Physician will provide orders to ensure that individuals have appropriate comfort and supportive measures needed. The P&amp;P indicated, The Physician will keep the well-being of residents as the principal consideration in his/her decisions. A review of the admission Record, dated [DATE], indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of lobar pneumonia (infection in more than one lobe of the lungs) and encounter for palliative care (a specialized approach to medical care that focused on providing comfort and support to residents with serious or life-limiting illnesses). The admission Record indicated, Resident 1 was a DNR (Do Not Resuscitate, if the heart stopped beating, CPR [rescue chest compressions or rescue breathing] would not be provided). Resident 1 was her own RP. During a concurrent interview and record review on [DATE] at 11:38 am, with Licensed Nurse (LN) C, Resident 1's Physician Order, dated [DATE] and POLST (Physician Order for Life-Sustaining Treatment), dated [DATE], was reviewed. LN C stated, Resident 1's Physician's Order indicated, Resident 1 was a DNR (no CPR to be provided) and the POLST indicated CPR with selective treatment. LN C confirmed, the Physician's Order and POLST did not match and stated, Whoever reviewed the POLST with the resident was responsible for entering the Physician's Order. During a concurrent interview and record review on [DATE] at 12:13 pm, with LN B, Resident 1's Health Status Note (progress note), dated [DATE], was reviewed. LN B confirmed, the progress note, indicated, a Certified Nurse Assistant (CNA) requested LN B to assess Resident 1, who was found in bed, not breathing, had no pulse, and was cold to the touch. LN B stated, Resident 1's electronic medical records indicated, Resident 1 was a DNR, and the POLST indicated, Resident 1 wanted CPR. LN B confirmed, the Physician's order and the POLST did not match and stated, it caused confusion. During a concurrent interview and record review on [DATE] at 2:13 pm, with Family Nurse Practitioner (FNP), Resident 1's POLST, dated [DATE] and signed by FNP on [DATE] was reviewed. FNP stated, When Resident 1 came to the facility, at first, she wanted to be comfort care [also known as palliative care]. At a care conference meeting, she wanted CPR. FNP confirmed, Resident 1 signed the POLST, requesting CPR, on [DATE] and confirmed, FNP signed the POLST on [DATE]. FNP stated unawareness if the code status change occurred after the physician orders were reviewed and approved by the Attending Physician (AP). Nurses fill out the POLST and I just review it with the resident and sign it. I did not sign the Physician's Orders. During a concurrent interview and record review on [DATE] at 2:17 pm, with Social Services Director (SSD), Resident 1's Care Conference, dated [DATE] was reviewed. SSD stated, during Care Conferences, we review a bit of everything, including a resident's code status. SSD confirmed, during Care Conference, the Physician's Order and POLST should be reviewed for accuracy. SSD confirmed, the Care Conference note indicated, Resident 1's POLST had been reviewed and confirmed, the Physician Orders and POLST inaccuracies were missed during the Care Conference meeting. During a concurrent interview and record review on [DATE] at 9:33 am, with LN A, Resident 1's Physician's Orders and admission Summary progress note was reviewed. LN A confirmed, LN A performed Resident 1's admission to the facility and stated, paperwork from the hospital indicated Resident 1 wanted to be on Hospice (end of life care with a focus on comfort). During the admission process, Resident 1 wanted to change from a DNR to CPR. LN A reviewed Physician's Order, dated [DATE] and</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to maintain an effective training program when facility staff did not attend mandatory in-services (training classes), and the facility failed to provide additional opportunities to make-up the missed in-services. This had the potential for residents not to attain or maintain their physical, mental, and psychosocial well-being. Findings: A review of the facility's policies and procedures (P&amp;P) titled, Attendance at Training Classes, revised [DATE], indicated, All personnel are required to attend their scheduled training classes. The P&amp;P indicated, facility staff would attend make-up classes for any training class (in-service) that was missed. During a concurrent interview and record review on [DATE], at 10:10 am, with Director of Staff Development (DSD), attendance sheets for facility provided in-services were reviewed. DSD confirmed, the attendance record titled, Theft and Loss-Residents Personal Property, dated [DATE], indicated, three facility staff members attended the in-service. DSD stated, the theft and loss in-service was not done this year, should have been done on [DATE]th and [DATE]th, and had not been rescheduled. DSD confirmed, the attendance record titled, Dementia (inability to remember) Module #2, dated [DATE], indicated, three facility staff members attended the in-service. DSD confirmed, the attendance record titled, Abuse and Neglect, dated [DATE], indicated, at 6:30 am and at 2:30 pm, two facility staff members attended each in-service. DSD confirmed, the attendance record titled, Advanced Directives (a legal document that outlined medical care wishes) and POLST (Physician Orders for Life-Sustaining Treatment, a legal document that indicated whether a person wanted CPR), dated [DATE], indicated, two staff members attended the in-service. DSD stated, when in-services were scheduled, they were provided two times a week so they could attend the second one if they missed it. DSD stated, when facility staff did not attend the in-services, it was made up by providing one-on-one education or during team huddles (when staff gathered for a short meeting). DSD confirmed, there were no attempts to provide the facility staff with in-service make-up classes.</p>		