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	09/12/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat one out of three sampled residents (Resident 1) with dignity and respect when Resident 1 wanted to return to her room during lunch and the Licensed Nurse (LN) assessed (examined) Resident 1 at the lunch table in front of three other residents. This violated Resident 1's right to maintain the privacy of her medical conditions by allowing other residents to watch and listen as the LN examined her.Findings: A review of the facility's policy and procedure (P&P) titled, Resident Rights, revised 2/1/23, indicated, facility staff would treat residents with respect and dignity. The P&P indicated, residents had the right to a dignified existence (treated with self-respect), would be provided privacy and confidentiality, and the facility would support residents in exercising (using or acting on) their rights. A review of the admission Record, dated 3/29/22, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of major depression (a sad mood), anemia (a condition where there was a lower-than-normal number of red blood cells in the blood, red blood cells carried oxygen throughout the body), and fatigue (extreme feeling of tiredness or a complete lack of energy that made it difficult to do everyday tasks). Resident 1 was not her own responsible party (RP, decision maker). A review of the Neuropsychological Assessment (a detailed evaluation that measured how the brain functioned and how it affected behavior and thinking), dated 12/1/23, indicated, Resident 1 had a major neurocognitive (how the brain processed information) disorder due to possible Alzheimer's Disease (memory loss, problems with thinking, and reasoning). During an interview on 9/3/25 at 10:58 am, LN E stated, She [Resident 1] refuses RNA dining [RNAs are Restorative Certified Nursing Assistants who help residents in a designated area in the dining room for residents who need additional help and attention with eating and the RNA provides encouragement for those who have lost weight] a lot, she doesn't like to be around people and be watched while eating. During an observation on 9/3/25 at 11:54 am, Resident 1 was observed in bed, lying on her right side, with her eyes closed. RNA A was observed walking into the room with a wheelchair and stated, I have to get you up for lunch and take you to the dining room. Resident 1 replied I don't want to go, then asked why? RNA A stated, they said you have to go just today. Resident 1 agreed, and was taken to the RNA dining room. During an observation on 9/3/25, from 12:10 pm to 12:31 pm, Resident 1 was observed in the RNA dining room with three other residents at the dining table. Resident 1 appeared dissatisfied with her lunch, displaying signs of unhappiness such as frowning, a wrinkled forehead, and closer together eyebrows. Resident 1 verbally expressed a desire to leave by stating, I want out of here, six times, I want to go back to my room two times, and I don't want any of it two times. While RNA B made attempts to verbally encourage or physically feed Resident 1, she non-verbally indicated refusal by shaking her head side-to-side three times. Additionally, twice when RNA B offered food, Resident 1 physically moved away by placing her right arm on her chest and curling in her right shoulder. During the observation period, Resident 1 also stated, I'm not hungry, it's hard to eat just because I'm supposed to eat. I feel pressure down here, I don't know what it is, while pointing to her lower abdomen [lower belly/gut area]. During an observation on 9/3/25 at 12:31 pm, LN E entered the RNA dining room and squatted next to Resident 1's wheelchair to assess Resident 1's lower abdomen while three other residents were eating lunch at the same table. Resident 1 stated, I just don't want to eat. RNA B responded, We're just going to drink some more of this and be here for a few more minutes. LN E told RNA B, I don't want her to drink it if she's having pressure. LN E then informed Resident 1, After you're done eating, we can go to the bathroom to see if that pressure goes away. LN E then left the RNA dining room, and RNA B asked Resident 1, How about some hot chocolate? Resident 1 replied, I don't know what's happening, I don't want it, I have to go to the bathroom. Facility staff arrived and took Resident 1 to her room and then to the bathroom. During an interview on 9/3/25 at 12:35 pm, RNA B confirmed the observations made in the RNA dining room and stated Resident 1's, family member said she has to be in here. Sometimes I sit in her room and help her eat.During an interview on 9/3/25 at 1:56 pm, RNA B stated, I know she [Resident 1] is more comfortable eating in her room, she should have been taken out of the dining room long before she was, and should have been allowed to drink her Boost [nutritional, milkshake like drink] in her room.During an interview on 9/3/25 at 1:40 pm, Resident 1 confirmed the observations made in the RNA dining room and stated, I don't like eating in front of other people, I don't like going [to RNA dining]. Resident 1 stated, I would expect the conversation about using the bathroom to be private and confidential, I didn't like being asked in front of others During an interview on 9/3/25 at 1:47 pm, LN E confirmed the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to perform a Minimum Data Set (MDS, a resident assessment tool), assessment for one out of three sampled residents (Resident 1) when a significant change of condition was identified. This had the potential for a delay in the review and revision of the care plan (documented resident goals that included instructions for care). Findings: A review of the facility's policies and procedures (P&P) titled, Comprehensive Assessments, revised 10/1/23, indicated, a significant change in status assessment would be performed when the IDT (interdisciplinary team, healthcare professionals who care for the resident work together to coordinate care) determined the resident met the significant change in condition requirements. The P&P defined a significant change in condition as a decline that would not resolve on its own, required staff intervention, impacted more than one area of the resident's health status, and required IDT review and/or revision of the care plan. A review of the admission Record, dated 3/29/22, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of major depression (a sad mood), anemia (a condition where there was a lower-than-normal number of red blood cells in the blood, red blood cells carried oxygen throughout the body), and fatigue (extreme feeling of tiredness or a complete lack of energy that made it difficult to do everyday tasks). Resident 1 was not her own responsible party (decision maker). A review of the Neuropsychological Assessment (a detailed evaluation that measured how the brain functioned and how it affected behavior and thinking), dated 12/1/23, indicated, Resident 1 had a major neurocognitive (how the brain processed information) disorder due to possible Alzheimer's Disease (memory loss, problems with thinking, and reasoning). A review of the Quarterly MDS, GG-Functional Abilities, dated 7/17/25, indicated, Resident 1 was independent with care in the following areas: dressing the upper and lower body, changing position for sitting to standing, transferring from the bed to a chair or toilet, and walking 50 feet that included two turns. The MDS indicated Resident 1 required assistance for setting up and cleaning up during mealtimes. During an interview on 9/3/25 at 10:05 am, Certified Nurse Assistant (CNA) D stated, Resident 1 had experienced a functional decline recently and [Resident 1] required much more assistance with transfers, she has been having weakness and balance problems, uses her cane more and needs help getting out of bed. A review of the Multidisciplinary Care Conference (care conference), dated 8/20/25, indicated that on 8/21/25, a care conference (staff, resident and or resident's RP met to discuss care) meeting was conducted. The document indicated Resident 1 had a gradual decline in physical ability, previously was able to walk around facility, and now required a wheelchair. The care conference indicated, on 8/12/25, Resident 1 had triggered for a change of condition on 8/12/25 for weight loss. During an interview on 9/4/25 at 1:01 pm, MDS Nurse stated, functional decline and weight loss would require a change of condition MDS assessment to be done. Unless it was communicated to me, I wouldn't know to do it. MDS Nurse confirmed, there had been no MDS change of condition assessment completed and it should have been completed within 14 days of Resident 1's significant change of condition. MDS Nurse stated, the purpose of the change of condition MDS was to trigger care plans and ensure we are providing appropriate care. During an interview on 9/5/25 at 1:07 pm, the Administrator confirmed there was no change of condition MDS assessment completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility did not monitor and evaluate the effectiveness of an intervention (instruction for obtaining goals) for one out of three sampled residents (Resident 1) when the staff did not document the amount of Boost (a nutritional drink/supplement) that was consumed. This failure prevented the facility from monitoring and evaluating the intervention's effectiveness, potentially leading to weight loss. Findings: A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/1/23, indicated, assessments of residents are ongoing, and care plans are revised as information about residents and the residents' conditions change. The P&P indicated, care plans would be reviewed and revised when desired outcomes were not met. A review of the facility's P&P titled, Weight Assessment and Interventions, revised 3/1/22, indicated, care plans would include parameters for monitoring and reassessment. A review of the admission Record, dated 3/29/22, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of major depression (a sad mood), anemia (a condition where there was a lower-than-normal number of red blood cells in the blood, red blood cells carried oxygen throughout the body), and fatigue (extreme feeling of tiredness or a complete lack of energy that made it difficult to do everyday tasks). Resident 1 was not her own responsible party (RP, decision maker). A review of the Neuropsychological Assessment (a detailed evaluation that measured how the brain functioned and how it affected behavior and thinking), dated 12/1/23, indicated, Resident 1 had a major neurocognitive (how the brain processed information) disorder due to possible Alzheimer's Disease (memory loss, problems with thinking, and reasoning). A review of the care plan (documented health concerns and goals) titled, Nutritional Problem, revised on 7/14/25, indicated, Resident 1 was underweight. The care plan included an intervention, dated 8/19/25, to provide Resident 1 with Boost as ordered. A review of the Physician's Order, dated 7/2/24, indicated Boost would be provided with breakfast and lunch. During an interview on 9/3/25 at 10:05 am, Certified Nurse Assistant (CNA) D was asked if there was documentation regarding the amount of Boost that Resident 1 consumed. CNA D stated, Resident 1 was not on any I/O's (monitoring and documenting the amount of fluid intake and output) to monitor how much fluid she is drinking in a day. During an interview on 9/3/25 at 10:58 am, Licensed Nurse (LN) E was asked where facility staff documented Resident 1's Boost intake. LN E stated, I'm not sure, I don't think it's documented. During an interview on 9/4/25 at 9:07 am, Registered Dietician (RD) was asked if Resident 1's Boost intake should be documented. RD stated, ya, it would be nice, that's not how the system is set up, unable to know if the boost intervention is working. Without documentation you would need verbal feedback to know how much she is drinking. During a concurrent interview and record review on 9/4/25 at 4:55 pm, with Director of Staff Development (DSD), Resident 1's Medication Administration Record (MAR), dated 9/1/25 through 9/4/25 was reviewed. DSD confirmed, Boost intake was not on the MAR and there was no specific place to document the amount of Boost that was consumed. A review of Resident 1's MAR dated 6/1/25 through 8/31/25, indicated that LN provided Resident 1 with a different type of liquid nutritional supplement during medication administration and documented the amount Resident 1 consumed. There was no documentation in the MAR that indicated how much Boost was consumed. During a concurrent interview and record review on 9/5/25 at 7:29 am with Restorative Nurse Assistant (RNA) A, Resident 1's untitled fluid intake reports dated 8/1/25 through 8/30/25 were reviewed. One report asked staff to document if the resident drank less than 240 milliliters/cubic centimeter (ml/cc, both measurement terms are the same) of fluid with their meal (this was a yes or no question) and the other report indicated facility staff would document the measured amount of fluid consumed in the form of cc's. RNA E confirmed, there was nowhere to enter the Boost intake and stated, the documentation included all fluid combined. During an interview on 9/5/25 at 1:05 pm, Director of Nursing (DON) confirmed, there was no documentation present in Resident 1's medical record that supported how much Boost Resident 1 consumed and stated, without the documentation you couldn't monitor the intervention.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility did not notify the Pharmacy Consultant (PC) to complete medication reviews for three out of three sampled residents (Resident 1, 2, and 3) who experienced weight loss. This resulted in unmet pharmacy service needs and had the potential to contribute to further weight loss. Findings: A review of the facility's policies and procedures (P&P), titled, Weight Assessment and Interventions, revised 3/1/22, indicated, the facility would evaluate medication for possible side-effects that could cause weight loss. A review of the facility's (P&P) titled, Nutritional Assessment, revised 10/1/23, indicated, the PC would review the resident's current medication list and ensure the medication did not interfere with nutrition absorption or appetite. A review of the facility's P&P titled, Consultant Pharmacist Reports, dated 6/1/21, indicated, the consultant pharmacist performed a comprehensive medication regimen review (MRR) at least monthly. The P&P indicated the MRR included a resident evaluation to determine if the resident maintained their highest practicable level of functioning and prevent or minimize adverse consequences related to medication. The P&P indicated, an immediate MRR may be performed if there was a change in condition that medication might have contributed to. The P&P indicted, the Director of Nursing (DON) was responsible to notify the PC when an immediate MRR was required. A review of the admission Record, dated 3/29/22, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of major depression (a sad mood) and fatigue (extreme feeling of tiredness or a complete lack of energy that made it difficult to do everyday tasks). Resident 1 was not her own responsible party (RP, decision maker). A review of the Neuropsychological Assessment (a detailed evaluation that measured how the brain functioned and how it affected behavior and thinking), dated 12/1/23, indicated, Resident 1 had a major neurocognitive (how the brain processed information) disorder due to possible Alzheimer's Disease (memory loss, problems with thinking, and reasoning). A review of the Weight Summary, dated 8/10/25, indicated, Resident 1 weighed 76.4 pounds and triggered for an 11.6 percent (%) loss of body weight, over 180 days, which indicated severe weight loss. A review of the admission Record, dated 12/1/22, indicated, Resident 2 was admitted to the facility on [DATE] with the diagnoses of unspecified dementia (memory loss, doctors were unable to determine the type), unspecified severity (unknown if it is mild, moderate, or severe) and adult failure to thrive (a decline in health that included a slow loss of energy and appetite). Resident 2 was not his own RP. A review of the Weight Summary, dated 7/21/25, indicated, Resident 2 weighed 89 pounds and triggered for a 10.1 (%) loss of body weight, over 180 days, which indicated severe weight loss. A review of the admission Record, dated 10/28/24, indicated, Resident 3 was admitted to the facility on [DATE] with the diagnoses of Alzheimer's, dementia, and type 2 diabetes (body was unable to regulate blood sugar levels) with diabetic neuropathy (high blood sugar levels over time caused nerve damage). Resident 3 was not his own RP. A review of the Weight Summary, dated 5/5/25, indicated, Resident 3 weighed 152 pounds and triggered for a 23.6 (%) loss of body weight, over 180 days, which indicated severe weight loss. During an interview on 9/5/25 at 11:35 am, PC stated, I perform the monthly medication review. The facility requests a change of condition for these special reports, we have a separate department with a different PC for residents with weight loss, and I look at the immediate MRR form also during my monthly MRR if one was completed. There is a fax record the facility should have, the protocol is for the facility to alert us [that] there is a change of condition for weight loss, then we will do a thorough medication review to assess medications and talk with facility. The PC was at a different facility and did not have access to the medical records. PC stated, I can look at the records in the office for these three residents later today and call back. During an interview on 9/5/25 at 12:02 pm, Director of Nursing (DON) stated, change of condition to PC was not done, I didn't know I needed to. DON confirmed, there was no documentation that supported the PC had performed an immediate MRR for Resident 1, 2, and 3's weight loss. During an interview on 9/5/25 at 7:21 pm, PC confirmed, there had been no pharmacy review regarding weight loss for Residents 1, 2, or 3 and there was no documentation that supported the facility notified the PC.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and reviews, the facility failed to consistently provide three out of three sampled residents (Residents 1, 2, and 3) with Physician ordered therapeutic (customized meal plan to manage a medical condition) diets when: 1. Residents 1 and 2 were not consistently provided with a meal that was fortified (added calories); and 2. Resident 3 was not consistently served a fortified meal that included double portions of protein (examples of protein are meats, eggs, and dairy). These failures had the potential to contribute to weight loss.Findings: 1. A review of the facility's policy and procedure (P&P) titled, Therapeutic Diets, revised 10/1/17, indicated, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. A review of the admission Record, dated 3/29/22, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of major depression (a sad mood), anemia (a condition where there was a lower-than-normal number of red blood cells in the blood, red blood cells carried oxygen throughout the body), and fatigue (extreme feeling of tiredness or a complete lack of energy that made it difficult to do everyday tasks). Resident 1 was not her own responsible party (RP, decision maker). A review of the Neuropsychological Assessment (a detailed evaluation that measured how the brain functioned and how it affected behavior and thinking), dated 12/1/23, indicated, Resident 1 had a major neurocognitive (how the brain processed information) disorder due to possible Alzheimer's Disease (memory loss, problems with thinking, and reasoning). A review of the admission Record, dated 12/1/22, indicated, Resident 2 was admitted to the facility on [DATE] with the diagnoses of unspecified dementia (memory loss, doctors were unable to determine the type), unspecified severity (unknown if it is mild, moderate, or severe) and adult failure to thrive (a decline in health that included a slow loss of energy and appetite). Resident 2 was not his own RP. During a concurrent observation and record review, on 9/3/25 at 12:10 pm, Resident 1 was observed in the RNA dining room (RNA, Restorative Nurse Assistants provided residents with additional verbal encouragement or physically fed the resident. The dining room utilized for meals was a small area and the common phrase for that setting was called RNA dining). On Resident 1's lunch tray was a cup of hot chocolate, a cup of grape juice, a cup of water, a bottle of chocolate Boost (a nutritional supplement drink), and a bowl of diced pears. The plate contained [NAME], mandarin chicken, and fried rice. The meal tray ticket indicated Resident 1's meal was fortified. During an observation on 9/3/25 at 4:29 pm, Resident 1's dinner tray was observed. There was a large baked potato covered with chili and cheese, and a bowl of coleslaw was present. A partially empty bowl that contained diced fruit was present. A cup of water, a cup of hot chocolate, and a bottle of chocolate Boost were observed along with a cup of red in color liquid. The meal tray ticket indicated that the meal was fortified. During a concurrent observation, interview, and record review on 9/4/25 at 7:16 am, with Certified Dietary Manager (CDM), Resident 1's Physician's Order (diet order), dated 7/2/24 was reviewed. CDM confirmed the diet order indicated, Resident 1 was on a fortified diet. CDM stated, we don't fortify every meal. For breakfast we fortify the cereal with butter and dry evaporated milk and for dinner we fortify the soup. CDM looked at the photograph taken on 9/3/25, of Resident 1's lunch tray and confirmed, the lunch was not fortified and restated, lunch wouldn't be fortified. CDM reviewed the photograph taken on 9/3/25 of Resident 1's dinner tray. The dinner consisted of a baked potato covered with chili and cheese, coleslaw, and a bowl of diced fruit. CDM stated, it did not appear fortified, there was no soup. CDM walked to the RNA dining room to observe Resident 1's breakfast. There was an uneaten bowl of oatmeal (hot cereal) on Resident 1's tray and CDM stated, the hot cereal was fortified. During a concurrent record review and interview on 9/4/25 at 9:07 am, with Registered Dietician (RD), Resident 1's Nutrition Assessment-V1.5 dated 7/14/25 was reviewed. RD confirmed the Nutrition Assessment, indicated that Resident 1 was on a fortified diet. RD reviewed the care plan (a detailed plan that outlined resident goals and interventions in place for staff to utilize to assist resident with achieving their goals) titled, Nutritional Problem, dated 4/12/22, and confirmed the care plan indicated, an intervention was in place for Resident 1's fortified diet. RD stated, you would fortify every meal and every meal is different. During a concurrent interview and record review on 9/5/25 at 9:40 am with CDM, Resident 2's Physician's Order, dated 5/28/25, was reviewed. CDM stated, the Physician's Order, indicated, Resident 2's diet was fortified. CDM confirmed that lunches were not fortified. 2. A review of the admission Record, dated 10/28/24, indicated, Resident 3 was admitted to the facility on [DATE] with the diagnoses of Alzheimer's, dementia

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility and the Registered Dietician (RD) did not maintain an adequate food and nutrition department for three out of three sampled residents (Resident 1, 2, and 3) with weight loss when: 1. A timely nutrition assessment was not performed for Residents 1, 2, and 3 after a weight loss triggered a change of condition. 2. The RD did not attend weight variance interdisciplinary team (IDT, a group of department heads and staff that provided resident care, to discuss resident care goals and identified concerns) meetings and did not document a progress note that indicated the IDT meeting notes had been reviewed. 3. RD did not communicate to the facility the recommendations made for residents with weight loss or collaborate with the dietary department. 4. The facility and RD were not familiar with the Agreement to Provide Dietetic Consultation Services contract that outlined the facility and RD responsibilities. This had the potential to contribute to further weight loss.Findings: 1. A review of the facility's P&P titled, Nutritional Assessment, revised 10/1/23, indicated, The dietician in conjunction [together] with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change of condition that places the resident at risk for impaired nutrition. A review of the admission Record, dated 3/29/22, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of major depression (a sad mood) and fatigue (extreme feeling of tiredness or a complete lack of energy that made it difficult to do everyday tasks). Resident 1 was not her own responsible party (RP, decision maker). A review of the Neuropsychological Assessment (a detailed evaluation that measured how the brain functioned and how it affected behavior and thinking), dated 12/1/23, indicated, Resident 1 had a major neurocognitive (how the brain processed information) disorder due to possible Alzheimer's Disease (memory loss, problems with thinking, and reasoning). A review of the admission Record, dated 12/1/22, indicated, Resident 2 was admitted to the facility on [DATE] with the diagnoses of unspecified dementia (memory loss, doctors were unable to determine the type), unspecified severity (unknown if it is mild, moderate, or severe) and adult failure to thrive (a decline in health that included a slow loss of energy and appetite). Resident 2 was not his own RP. A review of the admission Record, dated 10/28/24, indicated, Resident 3 was admitted to the facility on [DATE] with the diagnoses of Alzheimer's, dementia, and type 2 diabetes (body was unable to regulate blood sugar levels) with diabetic neuropathy (high blood sugar levels over time caused nerve damage). Resident 3 was not his own RP. During a concurrent interview and record review on 9/4/25 at 9:07 am, with RD, Resident 1s Quarterly Nutrition Assessment-V1.5 (nutrition assessment), dated 7/14/25 was reviewed. RD stated, I started working [at this facility] remotely (worked in a different location that was not in the facility) mid-July, and the nutrition assessment was performed by a different RD. The last assessment [nutrition assessment dated [DATE]] indicated [Resident 1's] PO (by mouth) intake was not great. If she had severe weight loss, she would get another assessment. RD reviewed the Weight Summary, dated 8/10/25 and confirmed, Resident 1 weighed 76.4 pounds and triggered for an 11.6 percent (%) loss of body weight, over 180 days, which indicated severe weight loss. RD stated, I would be happy to assess her and take a harder look at this. A review of the Monthly Weight Report, dated 9/1/25, that included the monthly weights taken throughout the month of August, completed by RD, indicated, Resident 1 triggered an 11.4 % weight loss. A review of the nutrition assessment dated [DATE], indicated that RD performed a nutritional assessment that included recommendations, 26 days after Resident 1 triggered a severe weight loss. During an interview on 9/4/25 at 10:14 am, the facility's Administrator (ADMIN) stated, our regular RD was currently on a leave of absence and the remote RD started working at the facility 7/25/25. During an interview on 9/4/25 at 10:28 am, RD confirmed, the Monthly Weight Reports were performed by RD and the data collected regarding residents with weight loss was emailed to the facility. RD confirmed, the Monthly Weight Report, dated 9/1/25, was a review of weights from 8/1/25 through 8/31/25. During a concurrent interview and record review on 9/5/25 at 10:37 am, Resident 2's reentry nutritional assessment (a reentry assessment was performed when a resident was out of the facility for an inpatient stay at a different facility such as a hospital), dated 5/7/25 was reviewed. RD confirmed, the nutrition assessment was completed by a different RD. RD reviewed the Weight Summary, dated 7/21/25 and confirmed, Resident 1 triggered a severe weight loss. RD reviewed and confirmed, the Weight Summary, dated 7/21/25, indicated, Resident 2 weighed 89 pounds and triggered for a 10.1 (%) loss of body weight, over 180 days, which indicated severe weight loss. RD stated, I started the

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	09/12/2025

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.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to honor food preferences for one out of three sampled residents (Resident 1) when food portions were too large, and Resident 1 stated she was tired of chocolate. This had the potential to contribute to weight loss.Findings: A review of the facility's policies and procedures (P&P) titled, Resident Food Preferences, revised 7/1/23, indicated, resident food preferences would be assessed upon or after admission, food preferences would be based on resident history and life patterns, and communicated to the dietary department. The P&P indicated, If the resident refuses or is unhappy with his or her diet, the staff would confer [talk to] the physician in order to offer a diet the resident is deemed safe to consume in order to satisfy the resident. A review of the admission Record, dated 3/29/22, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of major depression (a sad mood) and fatigue (extreme feeling of tiredness or a complete lack of energy that made it difficult to do everyday tasks). Resident 1 was not her own responsible party (RP, decision maker). A review of the Neuropsychological Assessment (a detailed evaluation that measured how the brain functioned and how it affected behavior and thinking), dated 12/1/23, indicated, Resident 1 had a major neurocognitive (how the brain processed information) disorder due to possible Alzheimer's Disease (memory loss, problems with thinking, and reasoning). A review of the meal tray tickets (a description of the diet order, food preferences and dislikes), dated 9/3/25 and 9/4/25, indicated Resident 1 preferred chocolate drinks. A review of the Weight Note, dated 8/13/24 and 8/14/25, indicated that Resident 1 states, I'm tired of chocolate. The notes did not indicate that the Licensed Nurse (LN) had notified the dietary department of Resident 1's preferences. During an observation on 9/3/25 at 9:34 am, a partially drank chocolate Boost (a supplement drink for residents that needed extra calories and protein) was observed sitting on Resident 1's bedside table. During an interview on 9/3/25 at 10:05 am, Certified Nurse Assistant (CNA) D stated, if she [Resident 1] refuses to eat or drink the Boost, I offer her hot chocolate because she likes that. During a concurrent interview and record review on 9/3/25 at 10:58 am, with LN E, Physician's Orders, dated 1/29/25 was reviewed. LN E stated the order indicated Resident 1 received Ready Care (a supplement drink for residents that needed extra calories and protein) 2.0 chocolate, 120 cc (cubic centimeters also called milliliters, ml) four times a day for supplement to promote weight gain. LN E stated, it was given as a medication, and she drinks it all. LN E reviewed Physician's Order, dated 7/2/24, and stated the order indicated Resident 1 received Boost with breakfast and lunch. During an observation on 9/3/25, at 12:02 pm and ending at 12:34 pm, Resident 1 was observed being served lunch. The amount of food covered more than 75% of the plate and to the side of the plate was a bowl full of diced pears. Resident 1 ate very little of the lunch provided, declined an alternative meal, and the hot chocolate and Boost were partially consumed. During an interview on 9/3/25 1:40 pm, Resident 1 stated, That was a lot of food. When they put that much on my plate it makes me not want to eat. It would be better if they gave me less food. It bothers me, I don't want to waste food, and I'm tired of chocolate. During an observation on 9/3/25 at 4:29 pm, Resident 1's dinner tray was observed. There was a large baked potato covered with chili and cheese, a bowl of coleslaw and a bowl of diced fruit. There was a chocolate Boost, hot chocolate, water, and juice that was red in color. Resident 1 stared at the meal with a dissatisfied look on her face. There were 9 chocolate flavored drinks provided to Resident 1 on 9/3/25. During a concurrent observation, interview, and record review on 9/4/25 at 7:16 am, with Certified Dietary Manager (CDM), Resident 1's Dietary Profile/Preferences (food preferences), dated 6/6/22 was reviewed. CDM stated the food preferences indicated, portions are bigger than resident liking. CDM confirmed the food preferences, dated 6/28/22, and indicated Resident 1 received small portions. CDM stated, during the intake process, at admission, she was overwhelmed. If she was presented to much food she would refuse [to eat] and at one point she was small portions. CDM reviewed past diet orders and stated, the order on 7/1/22 indicated, small portions. CDM stated, the past diet orders indicated, on 7/28/22, there was a new diet order, it indicated weight loss, and small portions were removed (a request for all past diet orders was requested. All past diet orders were provided except the order dated 7/28/25). CDM observed Resident 1's breakfast tray and confirmed, there was an undrunk chocolate boost on the tray and stated, I was unaware she was tired of chocolate; it's listed as a liked preference, we have vanilla and can get strawberry. The food on the plate had been partially eaten and there was a large amount of food left on the plate and the bowl of hot cereal was uneaten. During an interview on 9/5/25 at 8:46 am, Restorative