

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 02/04/2026
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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure that one of three residents sampled (Resident 1) received care consistent with professional standards when the physician's order to change her urostomy bag (a waterproof pouch worn on the outside of the abdomen to collect urine) was not followed. This failure had the potential to cause infection. Findings: Review of a facility policy titled Administering Medications revised December 2012, indicated .must be administered in accordance with the orders, including any required time frames. Review of Resident 1's medical record indicated that she was admitted to the facility on [DATE] and had diagnoses which included history of urinary tract infections (infection of any part of the urinary tract such as the kidneys, ureters, and/or bladder), and artificial opening of urinary tract (urostomy - a surgical opening in the abdomen to create a way for urine to exit the body when the bladder is damaged or removed). During an interview on 2/4/26 at 12:22 pm with Licensed Nurse (LN A), LN A indicated that in the past the urostomy bags were stored in the medication room (a locked room in a healthcare facility used to store, organize, and prepare medications), then an unknown staff person took them out of the medication room and put them in Resident 1's drawer in her room, and then they were moved to central supply (the department in a healthcare facility responsible for ordering, and storing medical equipment and supplies) and that central supply was where they were currently stored. LN A indicated that when the urostomy supplies were stored in Resident 1's drawer nursing staff thought they were out of urostomy bags but later they found them in Resident 1's drawer. During an interview on 2/4/26 at 12:50 pm with the Central Supply Lead (CSL), the CSL indicated that if they are out of urostomy bags one of the nurses can go to the local hospital and get them there. The CSL indicated that the urostomy bags were stored in central supply. During an interview on 2/4/26 at 1:09 pm with the Director of Nursing (DON), the DON indicated that the urostomy bags were kept in central supply or on the treatment cart (a locked cart used to store, transport, and organize supplies needed to perform resident care such as wound care or urostomy care) and that there was a time in the past when they kept them in the medication room. During a concurrent interview and record review on 2/4/26 at 2:20 pm with the DON, the DON confirmed that Resident 1's Treatment Administration Record (TAR) dated January 2026 indicated that Resident 1 had a physician's order (written instructions from a doctor detailing specific treatments, medications, or tests for a patient) for her urostomy bag to be changed every Wednesday and Saturday and that the January 2026 TAR showed no documentation that Resident 1's urostomy bag was changed on Saturday 1/3/26. The DON indicated that Resident 1's urostomy bag should have been changed and that her expectation is that if nursing staff do not have supplies to change a urostomy bag they should have reached out to let her know and that they could have gotten supplies from the local hospital. The DON indicated that they could also have asked any nursing staff and they would be able to tell them where to find the supplies or what to do if the supplies were not available at the facility.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056231	Facility ID: If continuation sheet Page 1 of 1