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	04/08/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that significant medication error was avoided for one of three sampled residents (Resident 1) when, an order written by the Family Nurse Practitioner (FNP) to restart Resident 1's Eliquis (a blood thinner) was not carried out and went unrecognized by the FNP and Licensed Nurses (LN), for 42 days.This failure contributed to Resident 1 developing a Deep Vein Thrombosis (DVT, blood clot) in his right leg which required a surgical procedure and hospitalization to remove the blood clot and had the potential to cause serious pain, emotional distress, prolonged health declines, and life-threatening conditions.Findings:During a review of the facility's policy and procedure (P&P) titled, Attending Physician Responsibilities, dated Revised August 2014,indicated, Each Attending Physician will be responsible for.initial and subsequent resident care.The physician's documentation should indicate review and acknowledgement of a resident's program of care. The review should be extensive enough to ensure that the current approach overall is consistent with the individual's medical condition.The attending physician will perform accurate, timely, and relevant medical assessments.The physician will periodically review all medications prescribed for his/her patients and will monitor both for continuing indications and for possible adverse drug reactions. During a review of the facility's P&P titled, Medication Orders, dated Revision January 2025, indicated, Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. (including) nurse practitioners if they comply with the requirements.The prescriber is contacted to verify or clarify an order (.(if) the directions are confusing).During a review of the facility's P&P titled, Reconciliation of Medications on Admission, dated Revised July 2017, indicated, Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes.During review of Resident 1's medical record, Resident 1 was admitted [DATE] with diagnoses that included Atrial Fibrillation (heart rhythm disorder), Peripheral Vascular Disease (PVD, circulatory blood vessel disorder causing narrowing, blockage, or spasming of vessels which results in clotting of blood), and Chronic Respiratory Failure with Hypoxia (Lungs can no longer transfer oxygen into the blood stream, resulting in low blood oxygen levels).During an interview on 2/26/26 at 10:30 am, with FNP 1 via telephone, FNP 1 stated Resident 1 was sent to the hospital for respiratory complications and hemoptysis (coughing with blood in the sputum) on 12/17/2025, and FNP 1 put Resident 1's Eliquis (a blood thinner) 5 milligrams (mg, unit of measurement) by mouth (PO) that he had been taking twice a day on hold. Resident 1 was then discharged from the hospital back to the facility on [DATE]. On 12/28/25, FNP 1 wrote orders to restart Resident 1's Eliquis 5 mg PO two times daily. FNP 1 stated LN 1 had discontinued (stopped) Resident 1's Eliquis instead of restarting it on 12/28/25, but this was not realized until Resident 1 complained of right leg pain on 2/8/26. FNP 1 confirmed she had made two monthly visits to assess Resident 1 and review his medical record at the facility on 1/1/26 and 2/1/26, but had not realized Resident 1 had not been taking his Eliquis. During an interview on 3/11/26 at 2:00 pm, with Resident 1 in the hallway, Resident 1 stated he had experienced a very painful blood clot in his right lower leg, and he had been sent to the hospital for surgery to remove it. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 confirmed he was doing much better since returning to the facility.During a record review of Resident 1's medical record documents titled, MARs for December 2025, January 2026, and February 2026 were reviewed. Eliquis 5 mg PO two times daily was administered until 12/17/25, when Resident 1 was sent to the hospital. Eliquis was then not administered for the remainder of December 2025 and all of January 2026. Resident 1's Eliquis was not restarted until 2/17/26.During a record review of Resident 1's medical record document titled, Discharge Summary from the hospital, dated 12/22/25, indicated the anticoagulant (Eliquis) was discontinued and would be restarted at the discretion of Resident 1's primary care provider (Physician or FNP 1).During a record review of Resident 1's medical record document titled, Order Details, dated 12/28/25, Order Details indicated that an order was written by FNP 1 to restart Eliquis 5 mg PO two times daily.During a record review of Resident 1's medical record document titled, Order Audit Report, dated 12/28/25, indicated the order placed for Eliquis 5 mg PO two times daily was discontinued by LN 1.During a record review of Resident 1's medical record document titled, Monthly Visit - Progress Notes by FNP 1, dated 1/1/2026 and 2/1/26, indicated Resident 1's medications currently being administered included Eliquis 5 mg BID (two times daily), and the plan of care indicated restart Eliquis 12/28/25. These monthly visit progress notes written by FNP 1 indicated Resident 1 was currently taking Eliquis in January and February 2026. FNP 1 had not recognized that Resident 1's Eliquis had been discontinued by LN 1, in December 2025. During a record review of Resident 1's hospital medical record document titled, Internal Medicine Discharge summary, dated [DATE], indicated Resident 1 presented with right leg pain, diagnostic testing was performed, Computed Tomography Angiography (CTA, non-invasive specialized x-ray diagnostic), results diagnosed Resident 1 with a right distal superficial femoral artery and popliteal artery occlusion (DVT, blood clot in vascular system) requiring vascular surgery of thrombectomy/embolectomy.During a concurrent interview and record review on 2/26/26 at 1:30 pm, with Administrator (Admin) and Director of Nursing (DON) in the administrator's office, Resident 1's Medication Administration Records (MAR, record or medications prescribed to resident with administration indications) dated December 2025, January 2026, and February 2026, as well as Discharge Summary from the local hospital dated 12/22/25, Physician Order Details for 12/28/25, and Hospital Medicine and History and Physical Note (H & P, documentation regarding patient information and plan for care) dated 2/8/26, and Internal Medicine Discharge summary dated [DATE], from the acute regional medical center were reviewed. Admin and DON confirmed that Resident 1 was transferred to the local acute hospital on [DATE] for respiratory problems and hemoptysis. The local acute hospital discharged Resident 1 back to the facility on [DATE] and had discontinued Resident 1's Eliquis 5 mg, PO two times a day. FNP 1 wrote an order to restart Resident 1's Eliquis on 12/28/25, but LN 1 had incorrectly transcribed FNP 1's order as discontinued. This medication error was not identified or recognized by nursing staff or FNP 1, until 2/8/26 when Resident 1 began complaining of right leg pain. Resident 1 was then transferred to the hospital which diagnosed Resident 1 with a Deep Vein Thrombosis (DVT, blood clot in his leg vessel) and then the hospital transferred Resident 1 to a larger medical center for surgery to remove the blood clot (Thrombectomy). Admin and DON confirmed a significant medication error was made by the facility and confirmed the medication error went unrecognized 42 days.