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	05/21/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record reviews, the facility failed to report to the California Department of Public Health (CDPH), the Ombudsman (State advocacy program for residents), and to local Law Enforcement a verbal and physical abuse allegation for two of three sampled residents when Resident 3 told the facility Administrator (FA) that Certified Nursing Assistant (CNA) A was harsh, brutal and mean to her roommates (Residents 1 and 2). This failure to report an abuse allegation prevented local and state agencies from providing prompt oversight to ensure the residents in the facility were safe and protected from abuse.Findings: A review of the facility's policy and procedure titled, Abuse Investigating and Reporting revised July 2017, indicated that, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: 2. a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse . During a record review of Resident 1's, admission Record dated 3/23/26, Resident 1 had diagnoses that included dementia (loss of memory) and bipolar disorder (a type of depression mixed with anxiety). Resident 1 had a Brief Interview for Mental Status (BIMS-a standardized cognitive screening tool scored on a scale from 0 to 15 where higher numbers indicate better cognitive function) score of 10 out of 15, indicating moderate cognitive (ability to understand and make decisions) impairment. During a record review of Resident 2's, admission Record dated 3/23/26, Resident 2 had diagnoses that included mild dementia and bipolar disorder. Resident 2 had a BIMS score of 0 out of 10, indicating severe cognitive impairment. During a record review of Resident 3's BIMS Assessment dated 5/12/26, Resident 3 had a BIMS score of 15, indicating no cognitive impairments. During an interview on 5/20/26 at 12:05 pm, the Director of Nursing (DON) confirmed Resident 3 had reported that CNA A was abusive to Residents 1 and 2. The DON stated, There was [an abuse allegation] and we did investigate it. When asked whether the allegation was reported to CDPH, Ombudsman and Law Enforcement as indicated in the facility's Abuse Policy, the DON stated, I didn't think it rose to that kind of an event. During a concurrent interview and facility Abuse Policy review on 5/20/26 at 12:10 pm, the FA confirmed that there was an allegation made by Resident 3 that CNA A was verbally and physically abusive toward Residents 1 and 2, approximately around 5/5/26. FA stated, The concern was not physical and believed [CNA A] was sounding burned out. FA confirmed CNA A was suspended on 5/10/26. When asked whether the allegation was reported to CDPH, Ombudsman and Law Enforcement FA stated, No. I didn't report 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

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	05/21/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/26 at 12:50 pm, in Resident 1's room, Resident 1 was not able to respond to interview questions. During an interview on 5/20/26 at 12:55 pm, in Resident 2's room, Resident 2 was not able to respond to interview questions. During an interview on 5/20/26 at 1:05 pm, in Resident 3's room, Resident 3 stated, I have a problem with a CNA [CNA A] here. He [CNA A] is harsh and brutal to my room mates. He [CNA A] ripped [Resident 1's] shirt off of her and when I looked over at her she was crying. [Resident 2] is scared of him [CNA A] and he is mean and disrespectful to her and says things like 'In your dreams.' I told [FA] about this and he [CNA A] was off for a few days and now he is back.he is so brutal and mean.