

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 10/24/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755</p> <p>Based on observation, interview, and record review, the facility failed to ensure dignity and respect were maintained for two of 22 sampled residents (Resident 39 and 285) when:</p> <ol style="list-style-type: none"> 1. Certified Nursing Assistant (CNA) A sat behind Resident 39 while assisting her with the lunch meal. 2. Resident 285 received breakfast sixteen minutes after the other resident at her table. <p>These failures resulted in Resident 285 feeling forgotten, and had the potential to result in loss of self-esteem and self-worth for both Resident 39 and 285.</p> <p>Findings:</p> <p>A review of the facility's policy titled, Dignity revised February 2023, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: e. provided with a dignified dining experience.</p> <p>A review of facility's policy titled, Assistance with Meals revised March 2023, indicated, 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity.</p> <ol style="list-style-type: none"> 1. A review of Resident 39's Admission Record (undated), indicated Resident 39 was admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dysphagia (difficulty swallowing), and a cognitive communication deficit (difficulty communicating). <p>A review of Resident 39's Quarterly Minimum Data Set (MDS, a standardized assessment), dated 10/3/24, indicated Resident 39 was severely cognitively impaired (was unable to reason or make decisions), and required full assistance from staff with eating and all other activities of daily living. Resident 39 was severely impaired with the use of her of arms, hands, and legs for both sides of her body.</p> <p>(continued on next page)</p>

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 39's, Nutritional Care Plan revised 7/16/24, showed a documented intervention to, Encourage the resident's socialization and interaction with table mates during meals.</p> <p>During an observation in the dining room on 10/21/24 at 1:43 P.M., CNA A was observed sitting at a round dining room table. Resident 39 was on CNA A's right side and another resident was on CNA A's left side. CNA A was assisting both residents with their lunch meal. Resident 39 was sitting in a wheelchair which was turned to the right and facing the wall (away from CNA A and the other resident). Resident 39's head and neck were supported by the high back on the wheelchair. Resident 39 was unable to turn her head from left to right. Resident 39 was observed following this surveyor with her eyes when spoken to. CNA A was observed lifting Resident 39's spoon containing food, and coming from behind Resident 39's head, CNA A brought the spoon to Resident 39's mouth and fed her some food. CNA A continued this process as she assisted Resident 39 with her meal. Resident 39 was facing the wall and was unable to see CNA A or the other resident.</p> <p>During an interview with CNA A on 10/21/24 at 1:47 P.M., CNA A confirmed Resident 39 was unable to see who was assisting her with her meal and stated, It is best if she could see me. CNA A turned Resident 39 around, to face her and continued to assist with the meal.</p> <p>During an interview on 10/24/24 at 8:19 A.M., the Director of Nursing (DON) indicated that Resident 39 should be facing the staff member that was assisting her with the meal.</p> <p>2. A review of Resident 285's Admission Record (undated), indicated Resident 285 was admitted on [DATE] with the diagnoses including anxiety disorder, adult failure to thrive (the feeling of wanting to give up on life), weakness, and mild cognitive impairment.</p> <p>A review of Resident 285's Admission MDS, dated [DATE], indicated her cognition was moderately impaired (she had difficulty making decisions, reasoning, and thinking), and she required moderate assistance with dressing and transferring in and out of bed. Resident required the help of staff to be pushed in her wheelchair to meals. Resident 285 required the assistance from staff for the setting up of her meals before she was able to eat.</p> <p>A review of Resident 284's meal card (the card that identifies the residents needs and wants for diet), dated 10/4/24, indicated Resident 285 was to eat in the assisted dining room (the dining room where residents require assistance with eating), at table number 4.</p> <p>During an observation on 10/22/24 at 7:44 A.M., breakfast trays were delivered to the hallway of Resident 285's room.</p> <p>During an observation on 10/22/24 at 8:36 A.M., Resident 285's was lying in bed and her untouched tray was sitting on her night stand out of her reach.</p> <p>During an observation on 10/22/23 at 9:00 A.M., Resident 285 was dressed and wheeled to the assisted dining room. The untouched breakfast tray remained on the nightstand in her room.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation in the dining room on 10/22/24 from 9:00 A.M. through 9:16 A.M., Resident 285 was observed sitting at a table with another resident who was eating her breakfast. Resident 285 was watching the other resident eat and looking up at staff as they walked by. All the trays had been passed and some residents were leaving the dining room because they had finished their meal. At 9:08 A.M., Resident 285 looked at a CNA that was helping another resident and said, Can I eat? When can I eat? No staff was observed responding to her. At 9:09 A.M., Resident 285 again said in a louder voice, Can I eat? The Assistant Director of Nursing (ADON) came up to Resident 285 and said, You have already eaten. At 9:16 A.M., the Infection Preventionist (IP) indicated she found Resident 285's tray in her room and since it had been sitting out too long, they would replace it with a fresh tray.</p> <p>During an interview on 10/22/24 at 9:17 A.M., CNA C indicated Resident 285's breakfast tray was taken to her room by mistake, and it should have come out on the assisted dining room tray cart and been delivered to her when she got to the dining room, but it was not.</p> <p>An interview on 10/22/24 at 10:09 A.M., Resident 285 indicated that her food was brought to her room earlier, but she could not reach it. Resident 285 continued to say, They brought me to the dining room but did not bring my tray. The tray should have been in the dining room. I basically felt forgotten about.</p> <p>During an interview on 10/24/24 at 8:53 A.M., the ADON stated it was a dignity issue that she had to sit there a wait for food.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755</p> <p>Based on observation, interview, and record review, the facility failed to ensure a homelike environment when:</p> <ol style="list-style-type: none"> 1. The walls in two of 22 sampled resident's (Resident 285 and 76) rooms were unpainted and scratched up. 2. A Hoyer lift (a mobile assistive device that allows residents to be transferred between bed and a chair, by the use of electrical or hydraulic power using a sling to hold the resident), that was used by residents was soiled with dried thick brown and white matter. <p>This deficient practice had the potential to create a poor quality of life that may lead to depression due to the unkept living conditions.</p> <p>Findings:</p> <p>A review of the facility's policy titled, Homelike Environment revised February 2021, indicated Residents are provided with a safe, clean, comfortable, and homelike environment</p> <p>1. A review of Resident 285's Admission Record (undated), indicated Resident 285 was admitted on [DATE] with the diagnoses including anxiety disorder, adult failure to thrive (the feeling of wanting to give up on life), weakness, and mild cognitive impairment.</p> <p>A review of Resident 76's Admission Record (undated), indicated Resident 76 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (lung disease), heart failure, adult failure to thrive (the feeling of wanting to give up on life), and depression.</p> <p>During a concurrent observation and interview on 10/22/24 at 10:14 P.M., Resident 285 was observed lying in bed looking at the wall. The bed's right side was up against the wall of the room. The wall had mud (a white/beige joint compound, paste used to prepare a wall for painting) on it that was the full length of the bed and one foot wide. Resident 285 confirmed that she looked at the wall while she was in bed and that it needed to be painted.</p> <p>During an observation on 10/22/24 at 12:26 P.M., Resident 76 was observed lying in her bed. The wall next to Resident 76's bed was scratched, chipped, and had black scratches on it. The area measured about a foot horizontal (side to side) and three feet vertical (up and down) in length.</p> <p>During a concurrent observation and interview on 10/23/24 at 11:48 A.M., with the Maintenance Supervisor (MS), Resident 285 and 76's rooms were observed. The MS confirmed that the walls needed fixing. He said, We have problems around the beds because the beds scratch the wall. Sometimes they put people (residents) in there (the rooms) to fast and I do not have time to paint. The MS indicated he had mudded Resident 285's room many times and that it now needed painted.</p> <p>43031</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a review of the facility's Policy and Procedure titled, Cleaning and Disinfecting of Resident-Care Items and Equipment, dated September 2023, indicated, Reusable resident care equipment is cleaned between residents according to manufacturers' instructions .DME [Durable Medical Equipment] is cleaned and disinfected before reuse by another resident.</p> <p>During an observation on 10/21/24 at 11:30 AM, in the hallway outside of room [ROOM NUMBER], a dirty Hoyer lift was observed with dried, caked-on brown and white gunk on its base.</p> <p>During a concurrent observation and interview on 10/21/24 at 1:50 PM, with Licensed Vocational Nurse (LVN) 5 outside of room [ROOM NUMBER], the Hoyer lift was observed in the same dirty condition, LVN5 stated, The Hoyer was being used on residents. It is the night shift's responsibility to clean the equipment, including the hoyer lifts and wheelchairs. It (Hoyer lift) is dirty, we will clean it.</p> <p>During an observation on 10/22/24 at 3:30 PM, in the hallway outside of room [ROOM NUMBER] the same dirty Hoyer lift had been moved in the hall, but the dried gunk remained at the base of the Hoyer.</p> <p>During an observation on 10/23/24 at 08:30 AM, in the hallway outside of room [ROOM NUMBER], 12, and throughout the facility, the Hoyer lift previously observed dirty with gunk at the base is not located.</p> <p>During an interview on 10/23/24 at 4:00 PM, the Administrator (Admin) stated, I do not know what that stuff was (on the Hoyer) but I took it to be washed. I expect staff to clean the equipment and they should have taken care of it, especially after they were informed of 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40204</p> <p>Based on record review and interview, the facility failed to report an allegation of abuse to The California Department of Public Health (CDPH), when Resident 25 alleged that she heard Resident 20 rape Resident 36, and the facility had not reported this allegation to CDPH.</p> <p>Failing to report allegations of abuse to CDPH created the potential for ongoing undetected resident abuse.</p> <p>Findings:</p> <p>Resident 20 was admitted to the facility on [DATE] with diagnoses that included dementia and heart failure. On 8/01/2024, Resident 20 received a Brief Interview for Mental Status (BIMS) test to assess his mental function. Resident 20 scored 11 on a scale of 0-15, demonstrating mild cognitive impairment.</p> <p>Resident 25 was admitted to the facility on [DATE] with diagnoses that included diabetes and chronic obstructive pulmonary disease (COPD- breathing difficulty related to lung damage). On 8/29/2024, Resident 25 received a BIMS score of 15, demonstrating normal mental function.</p> <p>Resident 36 was admitted to the facility on [DATE] with diagnoses that included diabetes and COPD. On 9/26/2024, Resident 36 received a BIMS test with a score of 15.</p> <p>On 8/04/2024, Resident 25 reported she had heard Resident 20 raping Resident 36 to Licensed Vocational Nurse (LVN) 4. LVN 4 reported the incident to the oncoming day shift nurse, LVN 1.</p> <p>On 10/22/2024 at 11:00 AM, during a record review no documentation of the incident was discovered in Resident 25's medical record.</p> <p>On 10/22/2024 at 1:00 PM, during an interview the ADM stated, She (Resident 25) told the staff that she heard her next-door neighbor (Resident 36) being raped by (Resident20). ADM stated, We did an investigation and didn't substantiate anything. ADM confirmed, No, we didn't report it to you (CDPH). The ADM confirmed that the facility had not filed the SOC-341 (Elder Abuse) report with CDPH.</p> <p>On 10/22/2024 at 1:05 PM, the Director of Nursing (DON) joined the interview with the ADM and stated, She (Resident 25) has made up stories. The DON confirmed, We didn't report it.</p> <p>On 10/23/2024 at 8:38 AM, LVN 1 was interviewed regarding the incident and required reporting. LVN 1 stated, I came in on AM shift and noc shift nurse (LVN 4) heard from the CNA that Resident 25 said Resident 20 was raping Resident 36. Resident 25 said she was in the room and something was going on. Resident 25 called PD (Police Department) and they came. Resident 20 needs assistance to get in his wheelchair. It is not possible. The police came and they asked if we had a rape kit but we explained the situation, this time and another she had those thoughts. You can try to explain to her that is not possible. She thinks that is occurring. I think (LVN 4) reported it but I can't completely remember.</p> <p>(continued on next page)</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>On 10/24/2024 at 9:45 AM, Resident 20 was interviewed and has no recollection of the incident stating, I get along with all of them (residents). No problems.</p> <p>On 10/24/2024 at 9:50 AM, Resident 25 was interviewed and has no recollection of the incident answering, No when asked if she has heard any suspicious or worrisome noises from other residents.</p> <p>On 10/24/24 at 9:55 AM, Resident 36 was interviewed. When asked if she had been subjected to abuse or being made uncomfortable Resident 36 stated, They treat me ok and denied any problems.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40204</p> <p>Based on observation, interview, and record review, the facility failed to ensure that there was sufficient, qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being for nine of 22 sampled residents (Residents 43, 62, 52, 17, 42, 19, 65, 12, and 285), and three of five confidentially interviewed residents, when their call lights were not answered timely and resulted in falls, being left in stool and urine because they were not taken to the bathroom.</p> <p>This failure had the potential to result in skin breakdown, infection, increased pain, increased accidents and injuries, and a decline in physical health status and have a negative impact on the resident's mental and psychosocial well-being.</p> <p>Findings:</p> <p>During a confidential interview of 5 residents on 10/23/2024 at 9:30 AM, three residents responded, Sometimes they are slow in answering the light when I put it on. My roommate had an accident because of waiting on the all light. We called and called but nobody came so he got up out of bed and fell on the floor.</p> <p>43031</p> <p>During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, dated September 2023, Answering the Call Light indicated, the purpose of the procedure is to ensure timely responses to the resident's requests and needs .Answer the residents' call light as soon as practicable.</p> <p>A review of Resident 43's medical record indicated that Resident 43 was admitted on [DATE] with diagnoses that included, Paralysis of vocal cords and larynx, Pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit, and Hypertension (high blood pressure). The Minimum Data Set (MDS, tool for evaluating and implementing a standardized assessment) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function) dated 8/5/24, indicated, Resident 43 scored 15/15 which equates to being cognitively intact.</p> <p>During an interview on 10/21/24 at 12:00 PM, with Resident 43 in the resident's room at bedside, Resident 43 stated, The call lights get answered based on who is on and if there have been call offs. I do not think there is adequate staffing. If you need something you have got to plan it out in order to have your light answered. Meaning, if you need something and turn your call light on during meals, you will not get it answered. I sometimes spend too much time waiting for pain medication. There are not enough staff on the floor to pass trays, and assist with meals, and also answer the rest of the people's call lights.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 62's medical record indicated that Resident 62 was admitted on [DATE] with diagnoses that included, Vesicovaginal Fistula (an abnormal opening that forms between the bladder and the wall of the vagina), Rectovaginal Fistula (abnormal opening between the rectum and vagina), and Encephalopathy (brain disorder or damage that affects the brain's structure or function). MDS BIMS, Section C dated 10/16/24, indicated, Resident 62 scored 15/15, which equates to being cognitively intact.</p> <p>During an interview on 10/21/24 at 12:00 PM, with Resident 62 in the resident's room at bedside, Resident 62 stated, Call lights can take a very long time. Feeding times are the worst. There just isn't enough staff to take care of meals and answer call lights. Every time they come in they tell us how many people have called off for the shift. They tell us to press the call button or they will not come, but they might not come when you press the button, so it's a chance either way.</p> <p>A review of Resident 52's medical record indicated that Resident 52 was admitted on [DATE] with diagnoses that included, Traumatic Hemorrhage of Left Cerebrum (brain bleed in left side of the brain), Systolic and Diastolic Congestive Heart Failure (CHF, stiff and weak left ventricle which cannot contract or relax normally, heart is unable to pump blood effectively), and Chronic Obstructive Pulmonary Disease (COPD, ongoing lung damage and inflammation inside the airways). MDS BIMS, Section C dated 8/27/24, indicated, Resident 52 scored 12/15, which equates to being moderately impaired.</p> <p>During an interview on 10/21/24 4:18 PM, with Resident 52 in the resident's room at bedside, Resident 52 stated, Call lights take a long time to answer. I have waited over 30 minutes. I think they are short staffed. There aren't enough CNAs to get to the call lights timely. I have fallen because I didn't want to wait for someone to answer.</p> <p>A review of Resident 17's medical record indicated that Resident 17 was admitted on [DATE] with diagnoses that included, COPD, Systolic and Diastolic CHF, and Malignant Neoplasm of Lower Lobe, Right Bronchus or lung (Lung Cancer). The MDS BIMS, Section C dated 9/9/24 indicated Resident 17 scored 13/15, which equates to being cognitively intact.</p> <p>During an interview on 10/21/24 at 4:35 PM, with Resident 17 in the resident's room at bedside, Resident 17 stated, They are very short staffed. Sometimes the call light just does not get answered. They will turn it off and not come back. During mealtime the lights just don't get answered. Not enough staff to do meals and answer lights too.</p> <p>A review of Resident 41's medical record indicated that Resident 41 was admitted on [DATE] with diagnoses that included, Activated Protein C Resistance (hereditary condition that affects the clotting factors in blood), Degenerative Disease of the Nervous System (Progressive and chronic conditions that damage and destroy parts of your nervous system, especially the brain), and Anemia (Condition where blood does not have adequate amounts of healthy red blood cells to provide enough oxygen to body tissues). MDS BIMS, Section C dated 8/26/24, indicated, Resident 41 scored 9/15, which equates to moderate impairment.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 10/22/24 at 10:53 AM, with Resident 41 in the resident's room. The resident is sitting in a large reclining chair in the corner of the room by the window across and away from the bed. The call light button is observed to be located across the room on the resident's bed. A tray of food is sitting on Resident 41's bed table in front of the resident in the chair. The tray of food was placed by staff indicating staff knew the resident was not in the bed but in the chair. Resident 41 stated, They tell me to push my button, but I cannot see it most of the time. I feel like there are not enough staff, and they can't be everywhere. I am not the only person here, I know they are busy and they can't get to me all the time. I find myself on the floor sometimes and am not aware of the circumstances that put me there.</p> <p>During a review of Resident 12's clinical record, Resident 12 was admitted to the facility on [DATE] with diagnoses that included Bipolar (a mental illness that causes mood swings), diabetes, depression, muscle weakness, difficulty in walking, and difficulty swallowing. The MDS dated [DATE], indicated Resident 12's BIMS score was 15.</p> <p>During an interview on 10/22/24 at 10:05 AM, with Resident 12, Resident 12 stated, It takes 30 minutes or more to answer my call light. They put my call bell out of reach so I can't use it.</p> <p>During an observation on 10/23/24 at 10:20 AM, in room [ROOM NUMBER] B, Resident 12 put her call light on at 9:30 AM. Several staff walked by the room without acknowledging the call light. Observed six staff members at station 1 (nursing station), no one appeared to notice or hear the call light. Forty-five minutes later, a staff member finally came into room [ROOM NUMBER] B to answer Resident 12's call light.</p> <p>During a review of Resident 19's clinical record, Resident 19 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, difficulty walking, depression, left leg above the knee amputation, diabetes, high blood pressure, hypoxia (lack of oxygen to brain), and muscle spasm. The MDS dated [DATE], indicated Resident 19's BIMS score was 15 (cognitively intact).</p> <p>During an interview on 10/22/24 at 1:01 PM, with Resident 19, Resident 19 stated, It takes them 30 minutes to an hour to answer my call light. By the time they get here I forget what I needed, so they leave then I remember what I needed I put my call bell on again and it takes them 30 minutes to an hour again to answer it. When they do answer my call light I forgot again. So why bother to ask for anything when it takes them that long to help me.</p> <p>During a review of Resident 65's clinical record, Resident 65 was admitted to the facility on [DATE], with diagnoses that included depression, dependence on supplemental oxygen, low blood pressure, dizziness, multiple rib fractures, and difficulty walking. The MDS dated [DATE], indicated Resident 65's BIMS score was 14.</p> <p>During an interview on 10/22/23, at 1:08 PM, with Resident 65, Resident 65 stated, It takes them 30 minutes to an hour sometimes to answer my call light. My urinal (container for urine) sits on the bedside table full. I can't use it without spilling it. Sometimes they don't come answer it in time and I can't wait any longer and I end up spilling it on myself. It is embarrassing and I have to change all my clothes.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 285's Admission Record (undated), indicated Resident 285 was admitted on [DATE] with the diagnoses including anxiety disorder, adult failure to thrive (the feeling of wanting to give up on life), weakness, and mild cognitive impairment.</p> <p>A review of Resident 285's Admission MDS dated [DATE], indicated her cognition was moderately impaired (she had difficulty making decisions, reasoning, and thinking), and she required moderate assistance with dressing, transferring in and out of bed and on and off the toilet. Resident required the help of staff to be pushed in her wheelchair to meals. Resident 285 required the assistance from staff for the setting up of her meals before she was able to eat.</p> <p>During an observation and interview on 10/22/24 at 10:14 AM, Resident 285 was observed lying in bed. Resident 285 stated, Usually at night it might take up to 45 minutes for the staff to come answer my call light. When that happens I have to go (urinate) in my briefs (adult diaper). I have to pull my pants (pajama bottoms) down because I do not want them to get wet.</p> <p>During an interview on 10/22/24 at 3:30 PM, with Certified Nursing Assistant (CNA) D in the hallway, CNA D stated, I have seen other CNAs not answer call lights that are going off for whatever reason, maybe it isn't their resident, but they walk by without providing assistance. Some nurses will assist, some won't.</p> <p>During an interview on 10/23/24 at 4:00 PM, with Director of Nurses (DON) in the old therapy room, DON stated, There are good staff and some that need extra coaching to answer lights and do all the things they should automatically do.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>43755</p> <p>Based on observation, interview, and record review, the facility had a 10 percent (%) medication error rate, when three medication errors out of 30 opportunities were observed during a medication pass.</p> <p>These failures resulted in medications not given in accordance with the prescriber's orders which may result in residents not receiving the full therapeutic effects of their medications.</p> <p>Findings:</p> <p>A review of the facility policy titled, Administering Medications revised April 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed.</p> <p>During a concurrent observation and interview on 10/23/24 at 7:47 A.M, Licensed Vocational Nurse (LVN) 6 was observed dispensing medications to Resident 17. LVN 6 prepared 12 medications for Resident 17 including physician orders for:</p> <ol style="list-style-type: none"> 1. COQ-10 (a dietary supplement that the body uses for growth and maintenance) 100 milligrams (mg- a unit of measure) capsule, give two capsules by mouth one time a day (for a total dose of 200 mg). LVN 6 obtained a bottle of COQ-10 50 mg capsules from her medication cart drawer and put two capsules in the medication cup (which totaled 100 mg). 2. Omega-3 (fish oil, a supplement) 1000 mg capsule, give one capsule by mouth one time a day (for a total dose of 1000 mg). LVN 6 obtained a bottle of Omega-3 500 mg from her medication cart drawer and put one capsule in the medication cup (which totaled 500 mg). 3. Lasix (a medication that treats fluid retention [build-up] and swelling), 20mg tablet, give 20 mg by mouth one time a day. LVN 6 indicated they were out of Lasix. LVN 6 documented in the Resident 17's chart not given due to medication unavailable. <p>LVN 6 indicated she was ready to administer the medication to Resident 17 with the medication she had in the medication cup. LVN 6 was asked to review the COQ-10 order and the Omega-3 order. LVN 6 confirmed that the COQ-10 should be a total dose of 200 mg, and she had 100 mg in the medication cup instead. The Omega-3 should be a total of 1000 mg, but she had 500 mg in the medication cup instead. LVN 6 indicated the orders did not match the medication they had available in the medication cart, and they should. LVN 6 indicated she was unable to give Lasix because she did not have any to give Resident 17 at this time.</p> <p>During a concurrent observation and interview on 10/23/24 at 8:55 A.M., with LVN 1, the medication room was observed. LVN 1 indicated that if she did not have an ordered medication available for a resident, then she would call the pharmacy and get a code for the facility's Cubex (a locked cabinet containing emergency medications). LVN 1 continued to indicate that she would use that code to get into the Cubex and retrieve the needed medication so she could administer it to the resident. LVN 1 confirmed that Lasix 20 was in the Cubex.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 10:42 A.M, the Director of Nursing (DON) verified the Lasix should have been taken from the Cubex and given at the time prescribed and it was not. DON indicated that if the order indicated for COQ-10 to be a 100 mg capsule then there should have been a bottle with 100 mg capsules and if the order indicated for Omega-3 to be 1000 mg capsules then there should have been a bottle with 1000 mg capsules.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755</p> <p>Based on observation, interview, and document review, the facility failed to ensure an open multi-dose vial (contains more than one dose of medication) Tubersol (a solution that aids in the detection of infection with Mycobacterium tuberculosis-TB, a potentially deadly lung infection) 5TU/0.1mL (Tuberculin units / milliliters, a measurement of the solution for injection) was dated when the vial was opened.</p> <p>This deficient practice had the potential for the TB skin test solution to be outdated and ineffective and therefore, lose the inability to correctly detect TB in a resident or staff member and spread a potentially deadly infection.</p> <p>Findings:</p> <p>A review of the facility policy titled, Medication Labeling and Storage revised February 2023, indicated, 5. Multi-dose vials that have been opened or accessed (e.g., [for example] needle punctured) are dated and discarded within 28 days unless the manufacture specifies a shorter or longer date for the open vial.</p> <p>During a concurrent observation, interview and review of the TB manufacturer instructions on 10/23/24 at 10:07 A.M., with the Director of Nursing (DON), the refrigerator in Medication room [ROOM NUMBER] was observed. An open vial of Tubersol 5TU/0.1 mL was in the refrigerator and available for use. The DON confirmed that the vial of Tubersol was not dated. A review of the manufacturer's instructions indicated the medication should be discarded 30 days after it was opened. The DON confirmed that this should have been dated when opened and since it did not, it should not be used because it might not be effective.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40204</p> <p>Based on observation, interview, record and policy review, the facility failed to provide meals that were served at a palatable temperature when 10 of 22 sampled residents (Residents 12, 67, 28, 19, 65, 43, 62, 52, 17, and 41), and five of five confidentially interviewed residents, stated the food was cold and bland.</p> <p>This failure had the potential for the residents to experience a loss of appetite, decreased nutrient intake, and result in unintentional weight loss and adverse clinical outcomes.</p> <p>Findings:</p> <p>A review of the facility's policy titled, Assistance with Meals revised March 2023, indicated that, Hot foods shall be held at a temperature of 135 degrees or above until served. Cold foods shall be held at 41 degrees or below until served. Nursing and dietary services will establish procedures such that delivery of food to serving areas accommodates this requirement.</p> <p>2. To minimize the risk of foodborne illness, the time that potentially hazardous foods remain in the danger zone (41 F to 135 F) will be kept to a minimum. Foods that are left on trays without a source of heat (for hot foods) or refrigeration (for cold foods) longer than 2 hours will be discarded.</p> <p>During an observation on 10/22/24 at 7:55 AM, the resident meal trays were placed in the tray transportation cart in the kitchen.</p> <p>The cart arrived in the dining room at 8:06 AM, and the cart doors were immediately opened by staff, which contributed to the trays being exposed to cold air, and no trays were served out of the cart. Approximately four residents were present in the dining room.</p> <p>At 8:10 AM, the meal tray cart doors remained open and staff were observed bringing residents in to be seated for breakfast.</p> <p>At 8:20 AM, Certified Nursing Assistant B (CNA) B stated she was leaving the dining room to, Bring in Station 2 people.</p> <p>At 8:22 AM, the first food tray was pulled from the cart and served to a resident, 27 minutes after the meal tray cart had arrived in the dining room and the cart doors opened.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/22/24 at 8:35 AM, an observation and interview was conducted with the Registered Dietitian (RD), in the resident's dining room. The last resident's meal tray was observed to be served from the cart. The RD was observed checking food temperatures and palatability. The RD indicated that the scrambled eggs were 126 degrees and cold and stated, We need to get the trays to them (residents) faster.</p> <p>40425</p> <p>During a review of Resident 12's clinical record, Resident 12 was admitted to the facility on [DATE] with diagnoses that included Bipolar (a mental illness that causes mood swings), diabetes, depression, muscle weakness, difficulty in walking, and difficulty swallowing. The most recent Minimum Data Set (MDS, a standardized resident assessment) dated 10/15/24, indicated Resident 12's Brief interview for mental status (BIMS) score was 15 out of 15 (cognitively intact).</p> <p>During an interview on 10/22/24 at 10:05 A.M., with Resident 12, Resident 12 stated, I get things I don't like at every meal. For example, I dislike bananas. However, this morning there was the yogurt I received had bananas in it. The food tasted bland and the eggs are cold. I ask for something else, but it takes an hour to get something different.</p> <p>During a review of Resident 67's clinical record, Resident 67 was admitted to the facility on [DATE] with diagnoses that included broken right leg, irregular heartbeat, difficulty swallowing, muscle weakness, and bipolar. The most recent MDS, dated [DATE], indicated that Resident 67's BIMS score was 12 (moderately impaired).</p> <p>During an interview on 10/22/24, at 12:31 P.M., with Resident 67, Resident 67 stated, The food is okay, hot food is cold and it is bland at times.</p> <p>During an interview on 10/23/24, at 9:10 A.M., with Resident 67, Resident 67 stated, My breakfast was cold again this morning. I asked a staff member to heat it up, but they never did so I skipped breakfast this morning.</p> <p>During a review of Resident 28's clinical record, Resident 28 was admitted to the facility on [DATE] with diagnoses that included Parkinson's (a disease that causes problems with movement, balance, and coordination), weakness, dementia (disease that affects a person's ability to think, remember, and reason). The most recent MDS, dated [DATE], indicated Resident 28's BIMS score was 11 (moderately impaired).</p> <p>During an interview on 10/22/24, at 12:31 P.M., with Resident 28, Resident 28 stated, The food is cold and doesn't taste very good.</p> <p>During an interview on 10/23/24, at 9:10 A.M., Resident 28 stated, This morning my eggs were cold. So, I didn't eat them.</p> <p>During a review of Resident 19's clinical record, Resident 19 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, difficulty walking, depression, left leg above the knee amputation (removal), diabetes, high blood pressure, hypoxia (lack of oxygen to brain), and muscle spasm. The most recent MDS dated , 08/21/24, indicated Resident 19's BIMS score was 15 (cognitively intact.)</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/22/24, at 12:58 P.M., with Resident 19, Resident 19 stated, The food never comes on time, and it is always cold and not very good.</p> <p>During an interview on 10/23/24, at 9:16 A.M., with Resident 19, Resident 19 stated, It was no different this morning. The trays were late again, and my breakfast was cold.</p> <p>During a review of Resident 65's clinical record, Resident 65 was admitted to the facility on [DATE], with diagnoses that included depression, dependence on supplemental oxygen, low blood pressure, dizziness, multiple rib fractures, and difficulty walking. The most recent MDS, dated [DATE], indicated Resident 65's BIMS score was 14 (cognitively intact).</p> <p>During an interview on 10/23/24, at 9:05 A.M., with Resident 65, Resident 65 stated, At breakfast the eggs are usually cold, and lunch is hit and miss, sometimes cold sometimes warm. The food hot food is never hot.</p> <p>43031</p> <p>A review of Resident 43's medical record indicated that Resident 43 was admitted on [DATE] with diagnoses that included, paralysis of vocal cords and larynx, Pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit, and Hypertension (high blood pressure). The MDS, dated [DATE], indicated Resident 43 scored 15/15 which equates to being cognitively intact.</p> <p>During an interview on 10/21/24 at 12:00 P.M., with Resident 43 in the resident's room at bedside, Resident 43 stated, Food is typically cold.</p> <p>A review of Resident 62's medical record indicated that Resident 62 was admitted on [DATE] with diagnoses that included, Encephalopathy (brain disorder or damage that affects the brain's structure or function). MDS BIMS, Section C dated 10/16/24, indicated Resident 62 scored 15/15 which equates to being cognitively intact.</p> <p>During an interview on 10/21/24 at 12:00 P.M., with Resident 62 in the resident's room at bedside, Resident 62 stated, Food is cold.</p> <p>A review of Resident 52's medical record indicated that Resident 52 was admitted on [DATE] with diagnoses that included, traumatic Hemorrhage of Left Cerebrum (brain bleed in left side of the brain), Systolic and Diastolic Congestive Heart Failure (CHF, stiff and weak left ventricle which cannot contract or relax normally, heart is unable to pump blood effectively), and Chronic Obstructive Pulmonary Disease (COPD, ongoing lung damage and inflammation inside the airways). MDS BIMS, Section C dated 8/27/24, indicated Resident 52 scored 12/15 which equates to being moderately impaired.</p> <p>During an interview on 10/21/24 4:18 P.M., with Resident 52 in the resident's room at bedside, Resident 52 stated, The food is sometimes not good, portions are poor, and temperature is cold.</p> <p>A review of Resident 17's medical record indicated that Resident 17 was admitted on [DATE] with diagnoses that included, COPD, Systolic and Diastolic CHF, and lung cancer. The MDS BIMS, Section C, dated 9/9/24, indicated Resident 17 scored 13/15 which equates to being cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/21/24 at 4:35 P.M., with Resident 17 in the resident's room at bedside, Resident 17 stated, It takes a long time for food to get to certain areas. If I eat in the dining room, I will come back to my room and my roommates don't get fed for an hour after I have finished eating in the dining room. It takes a very long time for food to get out, and by the time they get theirs it is cold.</p> <p>A review of Resident 41's medical record indicated that Resident 41 was admitted on [DATE] with diagnoses that included, Activated Protein C Resistance (hereditary condition that affects the clotting factors in blood), Degenerative Disease of the Nervous System (Progressive and chronic conditions that damage and destroy parts of your nervous system, especially the brain), and Anemia (Condition where blood does not have adequate amounts of healthy red blood cells to provide enough oxygen to body tissues). MDS BIMS, Section C, dated 8/26/24, indicated, Resident 41 scored 9/15 which equates to moderate impairment.</p> <p>During an interview on 10/22/24 at 10:53 AM, with Resident 41 in the resident's room at bedside, Resident 41 stated, The food is cold usually when I get it. I don't eat much anyway.</p> <p>On 10/23/24 at 9:30 A.M. during a confidential resident interview, 5 of 5 residents present voiced concerns over food being served cold.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40204</p> <p>Based on observation, interview, and record review, the facility failed to ensure that one of 22 sampled residents (Resident 27) and five of five confidentially interviewed residents, were offered snacks between meals and at bedtime, without the residents having to ask.</p> <p>This failure had the potential to result in undesired weight loss, hunger, discomfort, and the humiliation of having to ask staff for food.</p> <p>Findings:</p> <p>On 10/23/24 at 9:30 AM, during confidential interviews, five of five residents interviewed indicated that;</p> <p>All five residents indicated that they were not being offered snacks between meals or at bedtime and that they get hungry between meals and at bedtime.</p> <p>One resident stated, They stopped snacks a long time ago. They used to bring it to us. I don't know why they stopped.</p> <p>Another resident stated, We used to get it in the day too. Not now. We don't get anything. They don't offer us anything.</p> <p>Another resident stated, We got them, and it kept our stomachs full but I don't know why they stopped.</p> <p>43755</p> <p>2. A review of the facility policy titled, Snacks (Between Meal and Bedtime), Serving revised September 2010, indicated The purpose of this procedure is to provide the resident with adequate nutrition. Steps in this procedure indicated Place the snack on the overbed table or serving area Arrange the supplies so that they can be easily reached by the resident.</p> <p>A review of the facility policy titled, Resident Food Preferences revised July 2023, indicated, The food services department will offer a variety of foods at each scheduled meals, as well as access to nourishing snacks throughout the day and night.</p> <p>A review of Resident 27's Admission Record (undated) indicated he was admitted to the facility on [DATE] with diagnoses including lung disease, disorders of psychological development (a brain disorder), and chronic pain, muscle weakness, and repeated falls. Resident 27's cognition (thinking and reasoning) was intact.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 9:38 A.M., Resident 27 stated, They do not bring around the snacks to the room, they set it out in the hallway, and we have to go get it. They used to bring it around to the room. Resident 27 indicated he wanted staff to bring the snacks to the room.</p> <p>During an interview on 10/24/24 at 9:07 A.M., the Registered Dietitian (RD) indicated the facility had changed their 10 A.M., and 2 P.M., snack pass procedure a few months ago from delivering the snacks to the resident's rooms to giving the snacks to the residents on demand only (the resident would have to ask for it). The RD confirmed that the residents had voiced their dislike for the new system. RD stated, The residents should have good quality of life and if they want snacks delivered to them then they should be able to have that. We will be working on that.</p>		

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 10/24/2024
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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40204</p> <p>Based on observation and interview, the facility did not ensure that the kitchen was clean when;</p> <ol style="list-style-type: none"> 1. An electrical pest control device had a dark substance on the surface. 2. The floor and wall near food preparation areas was covered with black debris and patches of a gray substance. 3. There was grime on the door and doorknob of the food storage room. 4. There were black stains on the ceiling from the air that was blowing out of the vents in two storage rooms. <p>This had the potential of contaminating food that was prepared in these areas and result in germs getting into the residents' food and make them physically sick.</p> <p>Findings:</p> <p>During a kitchen observation conducted on 10/22/24 at 6:30 AM, the following was observed;</p> <ol style="list-style-type: none"> 1. A white electric pest control device (like a bug Zapper), that hung above the Victory refrigerator was covered with a dark substance. 2. The wall base and floor where the kitchen's large mixer, Victory refrigerator, and the food preparation table, had black debris and patches of gray substances accumulated on the surfaces. 3. There was visible grime and dirt on the door and doorknob of two storage rooms. 4. The ceiling in two storage rooms were stained black from the air that blew from the dirty ceiling vents. <p>On 10/22/24 at 7:05 AM, an observation and concurrent interview was conducted with the Registered Dietitian (RD). The RD confirmed that the above areas in the kitchen were not clean. The RD stated, We have a cleaning schedule and those [dirty areas] should be addressed at least monthly. They [staff] need to do a better job.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective infection control program when:</p> <ol style="list-style-type: none"> 1. Licensed Vocational Nurse (LVN) 6 did not perform hand hygiene (cleaning and disinfecting hands) while doing medication pass (when a nurse goes from resident to resident to give them their prescribed medication). 2. Resident 285's water tumbler's (a water drinking cup that did not have a straw) lid/drinking hole was covered with brown and white spots, dust, and black particles. <p>These failures placed residents receiving medication and Resident 286 at an increased risk of healthcare-associated infections (infections caused by facility practices).</p> <p>Findings:</p> <p>A review of the facility's policy titled, Handwashing/Hand Hygiene revised October 2023, indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand Hygiene is indicated: a. immediately before touching a resident; . d. after touching a resident; . e. after touching the resident's environment.</p> <p>A review of the facility's policy titled, Administering Medications revised April 2019, indicated, Medications are administered in a safe and timely manner .25. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 10/23/24 at 8:07 A.M, LVN 6 was observed giving medication, administering a breathing treatment, and dispensing two different nasal sprays to Resident 17 in their room. When LVN 6 was done passing medication to Resident 17 she came back to her medication cart and without doing hand hygiene LVN 6 proceeded to start preparing the next resident's medications. LVN 6 indicated she did not do hand hygiene after helping Resident 17 with his medications and before preparing the next resident's medications and she should have. LVN 6 indicated that doing hand hygiene between residents keep infections from spreading from resident to resident. <p>During a concurrent observation and interview on 10/23/24 at 8:41 A.M., LVN 6 was observed standing at the medication cart. Clear liquid was noted on top of the medication cart. LVN 6 used her hand to wipe off the liquid from the top of the cart and then dried her hand on her clothes. Without doing hand hygiene, LVN 6 proceeded to go into the next resident's room with a cup of medications in her hand. LVN 6 indicated she did not do hand hygiene after she cleaned up the liquid with her hand and before passing medications and she should have.</p> <ol style="list-style-type: none"> 2. A review of Resident 285's Admission Record (undated), indicated Resident 285 was admitted on [DATE] with the diagnoses including anxiety disorder, adult failure to thrive (the feeling of wanting to give up on life), weakness, and mild cognitive impairment. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview dated 10/22/24 at 10:13 A.M., Resident 285 was observed in her room and drinking out of her water tumbler. The tumbler lid was covered with dust, white and brown spots, and black particles. Resident 285 stated I wish they would wash it (the tumbler).</p> <p>During a concurrent observation and interview on 10/23/24 at 3:14 P.M., Resident 285's water tumbler was observed with the Director of Staff Development (DSD). The DSD confirmed that Resident 285's water tumbler was dirty and should be washed. The DSD indicated she did not know the process for washing this particular tumbler, since the tumbler was owned by Resident 285.</p> <p>During an interview on 10/23/24 at 3:15 P.M., the Registered Dietitian (RD) indicated the facility had not been washing resident's personal items and they should be in order to keep them sanitary.</p>