STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555231	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tahoe Forest Hospital D/P Snf	10121 Pine Ave. Truckee, CA 96161

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pharmacy Consultant's (PC) recommendations were followed for three of 13 sampled residents (Resident 2, Resident 9 and Resident 12), when Resident 2, Resident 9 and Resident 12's monthly medication regimen reviews (MRRs) for December 2025 and January 2026 were not reviewed by the attending physician.This failure decreased the facility's potential to prevent the residents' unnecessary medication use and experiencing of adverse drug reactions.Findings: 1. A review of Resident 2's Record of Admission, indicated he was admitted to the facility on [DATE] with diagnoses including diabetic polyneuropathy (a progressive type of nerve damage caused by long-term high blood sugar, causing burning or pain), traumatic brain injury (an acquired injury to the brain caused by external physical force), and gastroesophageal reflux disease with esophagitis (GERD-a serious form of acid reflux in which stomach contents flow back into the esophagus, irritating its lining). A review of Resident 2's Physician Orders, indicated he was prescribed the following medications on 7/24/25: -pregabalin (treats neuropathic pain) 25 milligrams (mg; a unit of measure) every 12 hours for peripheral neuropathy, -clopidogrel hydrogen sulfate (reduces the risk of stroke and heart attack) 75 mg daily for cerebrovascular accident (stroke), and -pantoprazole sodium (treats excess stomach acid and erosive esophagitis) 40 mg daily for GERD. A review of a facility document titled, Consultant Pharmacist's MRR: Note to Attending Physician/Prescriber, dated 12/31/25, indicated there was no response to CP's recommendation for dose reduction and medication replacement regarding Resident 2's use of clopidogrel and pantoprazole. A review of a facility document titled, Consultant Pharmacist's MRR: Note to Attending Physician/Prescriber, dated 2/2/26, indicated there was no response to CP's recommendation for discontinuation of Resident 2's pregabalin. During an interview on 2/12/26 at 11:15 a.m. with the Director of Nursing-Hospital District (DON HD), DON HD stated the MRRs were incomplete for the months of December 2025 and January 2026 because there was no documented response to CP's medication recommendations. DON HD further (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated he was unable to locate further documentation for these MRR months. 2. A review of Resident 9's Record of Admission, indicated Resident 9 was admitted to the facility in October 2020 with diagnoses including congestive heart failure (heart cannot pump enough blood throughout the body) and dementia with behavioral disturbance (a progressive state of decline in mental abilities). A review of Resident 9's physician order, dated 6/19/25, indicated an order for quetiapine (medication used to treat psychosis [a severe mental condition in which thought, and emotions are so affected that contact is lost with reality] and major depression [feeling of sadness]) 75 mg oral three times daily for psychosis. A review of Resident 9's MRR PC recommendation, dated 12/31/25, indicated Resident 9 was taking quetiapine and was due for a gradual dose reduction attempt. The MRR was not signed by the physician. 3. A review of Resident 12's Record of Admission, indicated Resident 12 was admitted to the facility in October 2013 with diagnoses including congestive heart failure and chronic kidney disease. A review of Resident 12's physician order, dated 8/4/23, indicated an order for furosemide (medication to treat excess fluid) 20 mg oral once daily for edema (swelling cause by excess fluid) and spironolactone (medication to treat excess fluid and high blood pressure) 25 mg oral once daily for hypertension (HTN - high blood pressure). A review of Resident 12's MRR PC recommendation, dated 12/31/25, indicated Resident 12 was taking diuretics (medications to remove excess fluid) and the recommendation was to monitor for any possible electrolyte imbalance, and redo all labs if necessary. MRR further indicated if Resident 12's fluid retention (excess fluid) improved then to consider discontinuing the medication. The MRR was not signed by the physician During a concurrent interview and record review on 2/12/26 at 10:34 a.m. with DONHD, Resident 9 and Resident 12's MRRs were reviewed. DONHD confirmed the MRRs were not signed and stated he could not find any documentation of the MRR recommendations being reviewed and implemented by the physician. DONHD further stated reviewing the MRR was needed to help prevent the residents from receiving unnecessary medications. A review of the facility's procedure titled, ECC Monitoring; Drug Regimen Review (Monthly Report), AEP-97, revised April 2024, indicated, Absence of regular and timely review of medication regimens increases the risk for medication-related adverse events and patient harm. The procedure further indicated, Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure proper labeling and storage of medications and biologicals for a census of 31 residents, when:1. Opened and unlabeled insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) pens were found in medication cart 1;2. Expired Coronavirus disease 2019 (COVID 19; an infectious disease that causes respiratory illness) test kits were found inside the medication storage room; and3. A metered dose inhaler (MDI, puffer handheld pressurized device delivers measured amount of medication to the lungs) with no name and use by date was available for use inside medication cart 2.These failures decreased the facility's potential to safely store medications.Findings:1. During a concurrent observation and interview on 2/9/26 at 10:16 a.m. with Licensed Nurse (LN) 3, medication cart 1 was inspected. LN 3 confirmed two unlabeled insulin pens were stored in the top drawer of the medication cart. LN 3 stated she was unsure which resident the insulin pens belonged to because they had no pharmacy labels attached.During an interview on 2/10/26 at 2:02 p.m. with the Pharmacy Consultant (PC), PC stated prescribed medications should have pharmacy labels to ensure residents were provided with the correct medications and were within their expiration date.2. During a concurrent observation and interview on 2/9/26 at 2:45 p.m. with LN 5, the medication storage room was inspected. LN 5 confirmed thirty-eight boxes of COVID 19 test kits, each with an expiration date of 3/13/25, were stored inside the Infection Preventionist (IP) cart within the medication storage area.During a concurrent observation and interview on 2/10/26 at 1:49 p.m. with the IP, IP stated the COVID 19 test kits were all expired and should have been discarded. IP further stated using expired test kits could result in inaccurate staff results.3. During a concurrent observation and interview on 2/10/26 at 1:53 p.m. with LN 4, medication cart 2 was inspected. LN 4 confirmed an MDI with no name and use by date was available for resident use inside the cart. LN 4 stated the MDI should have proper labeling to make sure the medication was for the right resident and was not expired.During an interview on 2/12/26 at 10 a.m. with the Director of Nursing - Hospital District (DON HD), DON HD stated medications should have been labeled properly at least with the resident's name and expired medications should have been disposed of according to the facility's policy.A review of the facility's policy titled, Single and Multi-Dose Medications and Expirations in Clinical Area, APH-28, revised in 4/2025, indicated, Insulin pens . once opened shall be labeled with a beyond use date of a maximum 28 days post entry and two patient identifiers . Vaccines . should be inspected for viability prior to vaccination . vaccines may be discarded per the manufacturer's expiration which is usually the expiration date printed on the FDA packaging.A review of the facility's policy titled, ECC Delivery Process, Medication Labels, AEP-79, revised in 4/2024, indicated, Labels are permanently affixed to the outside of the prescription unit dose . The resident's name . must be maintained directly on the actual product .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow professional standards for food service safety for a census of 31 residents, when:Cook (CK) 1 was observed without a beard restraint (facial hair covering) in the kitchen, andOutdated food items were found in the residents' fridge.These failures decreased the facility's potential to prevent food contamination and illnesses among vulnerable residents.Findings: 1.During a concurrent observation and interview on 2/9/26 at 8:30 a.m. with CK 1, CK 1 was observed in the kitchen without wearing a beard restraint. CK 1 stated he normally did not wear a beard restraint.During an interview on 2/9/26 at 8:50 a.m. with the Executive Chef (EC), EC confirmed CK 1 was not wearing a beard restraint and stated he should have put one on.During a concurrent interview and record review on 2/11/26 at 1:14 p.m. with the Dietary Director (DD), the 2022 Food Code (FC -guidelines for safety and protection of foods) was reviewed. DD stated she agreed with the FC guidelines and expected staff to follow the guidelines.A review of the Food and Drug Administration 2022 Food Code section 2-402.11, dated 1/18/23, indicated, Hair restraints - food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment and utensils .A review of the facility's policy and procedure (P&P) titled, Dietary Staff Dress Code, revised 1/2025, indicated, The risk of not following staff dress code is a violation of . food code and potential of contaminating food. 2. During a concurrent observation and interview on 2/12/26 at 9:25 a.m. with Licensed Nurse (LN) 1, the residents' refrigerator at station two was observed, the following were found: - One clear bag containing several pouches of single serve thousand island dressing with a use by date of 12/25/25,- One clear bag containing several pouches of single serve ranch dressing with a use by date of 1/16/26, and- One clear undated bag containing several containers of single serve low-fat cream cheese.LN 1 confirmed all findings and stated she would consider all those items expired and should be disposed. LN 1 further stated residents could potentially get ill from using outdated foods.During an interview on 2/12/26 at 12:15 p.m. with the DD, DD confirmed the items were outdated and stated outdated food items should have been removed from the fridge, because they can cause a food borne illness among residents if used.A review of the facility's P&P titled, Food Storage, revised 12/2023, indicated, Refrigerator Storage - All refrigerated and frozen food shall be dated . discard any product of questionable quality and if past use by date.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for one of 13 sampled residents (Resident 7), when Resident 7's care plan did indicate the use of safety lap belt due to fall risk.This failure decreased the facility's potential to address Resident 7's specific health care needs.Findings:A review of Resident 7's Record of Admission, indicated she was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (a chronic condition where the immune system damages the protective covering of nerve cells, causing muscle weakness and coordination problems) and blindness. A review of Resident 7's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/10/25, indicated she had a Brief Interview for Mental Status score (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) of 15 out of 15 with intact memory.During a concurrent observation and interview on 2/9/26 at 11:05 a.m. with Resident 7 in her wheelchair, Resident 7 had a lap belt fastened across her thighs. Resident 7 stated she fell out of her wheelchair many times and the lap belt protected her from falling.During an interview on 2/11/26 at 9:51 a.m. with Resident 7, Resident 7 stated she worn the belt since 2025 and verbally consented to the facility that she wanted to use it on a long-term basis.A review of Resident 7's progress note, dated 11/28/25, indicated the physician approved Resident 7's use of belt for wheelchair.A review of Resident 7's Plan of Care, dated 9/18/22, indicated, Resident 7 was at risk for falls due to progressive multiple sclerosis with functional decline and history of falls at home. Resident 7's care plan did not indicate the use of the lap belt.During an interview on 2/11/26 at 12:34 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated the facility missed inputting necessary documentation for Resident 7's lap belt after they determined the trial for the lap belt was successful. RNS 1 further stated no one would know how long Resident 7 had been wearing it or how she was to use it, which could lead to safety issues.A review of the facility's policy titled, Extended Nursing Admit Assessment-Reassessment and Documentation, DECC-010, revised September 2025, indicated, The care plan shall be . updated as indicated for change in condition, onset of new problems and resolution of current problems.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services according to professional standards of quality for two of 13 sampled residents (Resident 7 and Resident 8), when:1. A wheelchair lap belt was used for Resident 7 without a physician's written order; and 2. Omeprazole (a medication that reduces stomach acid production) was not administered to Resident 8 as prescribed.These failures decreased the facility's potential to follow the residents' physician orders.Findings: 1. A review of Resident 7's Record of Admission, indicated she was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (a chronic condition where the immune system damages the protective covering of nerve cells, causing muscle weakness and coordination problems) and blindness. A review of Resident 7's Minimum Data Set (MDS – a federally mandated resident assessment tool), dated 12/10/25, indicated she had a Brief Interview for Mental Status score (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) of 15 out of 15 with intact memory. A review of a facility document titled, Fall Risk Evaluation, dated 2/3/26, indicated Resident 7 was at risk for falling. During a concurrent observation and interview on 2/9/26 at 11:05 a.m. with Resident 7 in her wheelchair, Resident 7 had a lap belt fastened across her thighs. Resident 7 stated she fell out of her wheelchair many times and the lap belt protected her from falling. During an interview on 2/11/26 at 9:51 a.m. with Resident 7, Resident 7 stated she had the belt on her wheelchair since 2025. During a concurrent observation and interview on 2/11/26 at 10:21 a.m. with Licensed Nurse (LN) 1, LN 1 stated Resident 7 had problems with sliding out of her wheelchair onto the floor. LN 1 further stated the lap belt helped her in preventing falls and was not aware of an order for the lap belt. A review of Resident 7's progress note, dated 11/28/25, indicated the physician approved the resident's use of a belt for her wheelchair. A review of Resident 7's Physician Orders, dated 2/11/26, indicated no written order had been entered for the wheelchair lap belt. During a concurrent interview and record review on 2/11/26 at 12:34 p.m. with Registered Nurse Supervisor (RNS) 1, Resident 7's physician's orders were reviewed. RNS 1 confirmed the lap belt order was missing and stated no one would know how long Resident 7 had been wearing it or how she was to use it, which could lead to safety issues. A review of the facility's policy titled, ECC [Extended Care Center] Structures Standards, DECC-061, revised September 2025, indicated, It is mandatory that all admitted residents have Physician orders. The nursing staff must have adequate medical direction and support . These orders must include . Activity, Medications/Treatment . (continued on next page)

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	555231	A. Building B. Wing	02/12/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 8's Record of Admission, indicated she was admitted to the facility in October 2024 with a diagnosis of symptomatic gastroesophageal reflux disease (GERD, chronic condition where stomach acid flows back into the esophagus causing irritation). A review of Resident 8's Physician Orders, dated 8/12/25, indicated an order for omeprazole 20 milligrams (mg, a unit of measurement) was to be given daily in morning for GERD. During an observation on 2/10/26 at 8:29 a.m., LN 4 was observed during medication pass. LN 4 gave Resident 8 a slice of bread then passed her morning medications. Resident 8 ate the slice of bread before taking her medications including omeprazole. During an interview on 2/10/26 at 1:53 p.m. with LN 4, LN 4 confirmed she administered omeprazole to Resident 8 along with other morning medications after eating a piece of bread. LN 4 stated omeprazole should have been given separately before the meal as indicated on the medication's bubble pack. During an interview on 2/10/26 at 2:02 p.m. with the Pharmacy Consultant (PC), PC stated omeprazole should have been given before meals as indicated on the medication bubble pack. PC further stated staff should have followed the instructions indicated as prescribed by the doctor to ensure the medication achieved its maximum effectiveness and assisted residents with their symptoms. A review of the facility's policy titled, ECC Monitoring Standard Medication Administration times AEP-110, revised in 4/2024, indicated, Medications that require special times to be scheduled will be accommodated based on pharmacology needs . oral proton pump inhibitor like omeprazole defaults to Q AM AC (before meals) at 6 a.m.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 13 sampled residents (Resident 11) was safe from falling, when Resident 11's bed headrail was not in place as ordered.This failure increased Resident 11's risk to fall and injure himself.Findings:A review of Resident 11's Record of Admission, indicated he was admitted to the facility on [DATE] with a diagnosis of vascular dementia (cognitive decline caused by reduced blood flow to the brain).A review of Resident 11's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/4/25, indicated he had a Brief Interview for Mental Status score (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) of one out of 15 with severely impaired memory.A review of a facility document titled, Fall Risk Evaluation, dated 2/7/26, indicated Resident 11 was at risk for falling.A review of Resident 11's Physician Orders, dated 10/26/23, indicated both his bed's head siderails were to be placed in the up position.During an observation on 2/9/26 at 11:28 a.m. Resident 11 was awake and lying in bed diagonally, with his legs on the right edge of the bed. Resident 11's right headrail was in the down position. He waved but did not talk when prompted. A four-wheel walker was near his bed. During a concurrent observation and interview on 2/9/26 at 11:35 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 11's room, CNA 1 stated due to his severe memory problems, Resident 11 had a position change alarm on his bed in addition to head siderails in the up position because he was prone to wander and tended to fall. CNA 1 stated Resident 11 was supposed to have both headrails up and that someone forgot to put the right headrail up.During an interview on 2/11/26 at 10:26 a.m. with Licensed Nurse (LN) 1, LN 1 stated Resident 11 had a history of falling when attempting to get out of his bed, was very confused and did not use his call light, so there was a concern of falling from his bed. LN 1 also stated both headrails should have been up when the resident was in his bed to coincide with current physician orders. LN 1 further stated if one headrail was down then it could cause Resident 11 to fall and injure himself.During an interview on 2/11/26 at 11:25 a.m. with RN Supervisor (RNS) 1, RNS 1 confirmed that Resident 7 had orders for bilateral headrails.A review of the facility's policy titled, ECC [Extended Care Center] Structures Standards, DECC-061, revised September 2025, indicated one of the facility's objectives was To provide an environment that will be conducive to maintaining resident comfort, dignity, and safety. The policy further indicated, Side rails are to be used as indicated on the resident Care Plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow proper infection control measures for one of 13 sampled residents (Resident 3), when a housekeeper (HK) did not wear the required personal protective equipment (PPE, any gear to protect your body from germs, hazardous chemicals in a medical setting like gloves, gowns, and masks) while cleaning a room on Enhanced Barrier Precaution (EBP, an infection control method).This failure decreased the facility's potential to prevent the spread of infection among vulnerable residents.Findings:A review of Resident 3's Record of Admission, indicated he was admitted to the facility in August 2023 with a diagnosis of urinary retention.A review of Resident 3's Physician Orders, dated 11/2/25, indicated an order for the insertion of a urinary catheter due to urine retention.During a concurrent observation and interview on 2/9/26 at 9:35 a.m. with HK, HK was observed cleaning inside Resident 3's room without wearing a gown. HK confirmed she was not wearing a gown because there was no sign indicating that Resident 3 was on EBP which required the use of a gown while cleaning.During a concurrent observation and interview on 2/10/26 at 8:40 a.m. with Licensed Nurse (LN) 3, LN 3 confirmed Resident 3 had an orange magnet by the door, a signage indicating he was on EBP due to the use of a urinary catheter.During an interview on 2/10/26 at 2 p.m. with the Infection Preventionist (IP), IP expected staff to follow proper infection prevention and control practices before entering a room on any precautions to prevent the spread of infection in the facility and placing residents at risk.A review of the facility's policy titled, ECC Enhanced Barrier (Enhanced Standard) Precautions, DECC-1502, revised in 11/2025, indicated, Enhanced Barrier Precautions (also known as Enhanced Standard Precautions) are designed to reduce transmission of resistant organisms . Implement Enhanced Barrier Precautions on those residents who . are at risk of transmitting and/or contracting MDROs [Multidrug-resistant organisms; a germ that is resistant to many antibiotics]. Residents who have indwelling medical devices . including foley catheters . Use of PPE such as gowns and gloves is one component of Standard Precautions . along environmental cleaning and disinfection . activities that provide opportunities for transfers of MDROs to staff hands and clothing.