STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 facilityˆfailed toˆensure that wheelchairs wereˆmaintainedˆin safe condition when found with cracked and exposed armrest for three of 13 sampled residents (Resident 13, Resident 30, and Resident 43). This failure had the potential to place Resident 13, Resident 30, and Residentˆ43ˆatˆrisk for injury and infection.ˆA review of Resident 13's admission Record (AR), dated 4/10/26 (print date), indicated Resident 13 was admitted in Winter 2023 with the diagnoses which included right artificial hip joint (replaced joint for damaged hip), polymyalgia rheumatica (severe stiffness of neck, shoulders and hips), and chronic pain.ˆ A review of Resident 13'sˆ Minimum Data Setˆ(MDS- a federally mandated resident assessment tool), dated 1/30/26,ˆthe MDSˆindicated Residentˆ13 had no memory impairment and was dependent on a wheelchair and walker.ˆ A review of Residentˆ13's Resident Care Guide (RCG) [Care Plan], dated 3/26, the RCG indicated, Residentˆ13 frequentlyˆused her wheelchair for short distances around the facility.ˆ During an observation onˆ4/8/26ˆatˆ9:29 a.m.ˆin Residentˆ13's room,ˆResidentˆ13'sˆwheelchair arm handles wereˆfound with cracks on the surface and with exposed foam inside cushion. Resident 13ˆconfirmed the cracks and exposed foamˆandˆstatedˆthe wheelchair was uncomfortable and would like it changed.ˆ During aˆreview of Residentˆ30'sˆAR,ˆdatedˆ4/10/26 (print date),ˆthe AR indicatedˆResident 40 was admitted inˆWinter 2025 with the diagnoses which included history of falling and failure to thrive (gradual decline in physical and mental functioning).ˆˆ A review of Resident 30's MDS, dated [DATE],ˆindicatedˆResident 30ˆhad no memory impairment and was dependent on a wheelchair and walker.ˆ A review of Resident 30's RCG, dated 3/26, the RCG indicated, Resident 30 was often found propelling his wheelchair around the facility.ˆˆ During an observation and interview onˆ4/8/2026ˆatˆ12:19ˆp.m.,ˆResidentˆ13's wheelchair arm handles wereˆfound with cracks on the surface and with exposed foam inside cushion.ˆResident 30 indicatedˆhe preferred the wheelchair arm handles to be not crackedˆto avoid his arm being pinched, and stated, Soˆitˆlooks better.ˆˆ A review of Resident 43'sˆAR, dated 4/10/26 (print date), the ARˆindicatedˆResident 43 was admitted ˆin Winter 2023 withˆdiagnosesˆwhich includedˆpain in right knee, right artificial knee jointˆ(replaced joint for damagedˆknee),ˆand chronic pain.ˆˆ A review of Resident 43'sˆMDS,ˆdated 1/2/2026, the MDSˆindicatedˆResidentˆ43ˆhad no memory impairment and was dependent on a wheelchair and walker.ˆ A review of Residentˆ43's RCG, datedˆ1/25, the RCG indicated Residentˆ43ˆused a wheelchair for mobility and should be encouraged to use her wheelchair instead of walker due to severe knee pain.ˆ During an observation on 4/9/26 atˆ2:15 p.m., Resident 43 wasˆbeing pushed throughout the facility hallway by a family member. Resident 43'sˆwheelchair arm handles wereˆfound withˆsurface cracks andˆexposed insideˆfoamˆcushion.ˆˆ During a concurrent observation and interviewˆonˆ4/9/26 at 5:25 p.m.,ˆResident 43 sat in her wheelchair accompanied by a family member.ˆResident 43's wheelchairˆarmsˆwereˆfound withˆcracks on the surface with exposed foam inside cushion. Resident 43 and familyˆagreed that the cracks and exposed foamsˆcould cause discomfort or skin issues and should be replaced.ˆˆ During a concurrent (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
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation and interview on 4/9/26 at 4:39 p.m. with the Physical Therapist (PT), the PT confirmed Resident 13's, Resident 30's, and Resident 43's wheelchair arm pads were cracked and exposed and were expected to beˆreplacedˆto avoid discomfort. The PTˆstatedˆwheelchair repair concerns were expected to be reported by staff. The PT was unable to provide a wheelchair repair request log when asked.ˆˆ During a concurrent interview on 4/9/26 at 5:30 p.m.ˆwith Certified Nursing Assistant (CNA) 3, CNA 3 stated wheelchair with cracked and exposed pads couldˆcause injury and pain. CNA 3 furtherˆstatedˆcracked and unrepaired arm pads could cause skin irritation and the expectation was to report disrepair to the nurse or supervisor.ˆˆ During an interview on 4/10/26 at 10:20 a.m. with the Infection Prevention Nurse (IP), the IPˆstated the expectation was that wheelchairsˆremainedˆclean for the residents, and cracked arm pads were not safe and could cause skin tears and infection.ˆ During an interview on 4/10/26 at 12:10 p.m. with the Director of Nursing (DON), the DONˆstatedˆwheelchairs were expected to be in good repair and cracked and exposed wheelchair arm padsˆwere considered uncleanable andˆcould cause discomfortˆorˆinfection to residents.ˆˆ During a review of the facility's policy and procedureˆ(P&P)ˆˆtitled,ˆ SNF Equipment Cleaning, dated month 8/2024, the P&P indicated, Purpose: .to reduce the risk of transmission of infection and to always ensure cleanliness of patient care items and equipment. equipment is routinely monitored for damage that could hinder function, result in uncleanable surfaces, or adversely affect functionality.ˆˆ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure the administration time for morphine (a narcotic controlled medication) on the Medication Administration Record (MAR) matched with the Controlled Drug Record (CDR - a log used to track the administration and disposition of Schedule II drugs, substances with a high potential for abuse) for one of 13 sampled residents (Resident 5).This failure resulted in inconsistency in morphine administration for Resident 5 and had the potential to impact accountability of the controlled drug.A review of Resident 5's admission Record indicated she was admitted to the facility in 2022, with diagnoses that included chronic pain and osteomyelitis (a serious infection in the bone, caused by bacteria or fungi, resulting in inflammation and tissue damage, and is often very painful).A review of Resident 5's Order Summary Report, dated 3/27/25, indicated she was prescribed morphine sulfate extended release 15 milligram (mg-a unit of measure) two tablets by mouth at bedtime for chronic pain.A review of Resident 5's MAR, dated March 2026, indicated she was to take her morphine at 9 p.m. The nurses administering the medication documented 2 tablets of morphine were given at 9 p.m. on 3/29/26 and 3/31/26.A review of Resident 5's CDR, dated March 2026, indicated that on two dates, 3/29/26 and 3/31/26, the morphine was administered to Resident 5 at 7:50 p.m., an hour and 10 minutes before the scheduled time.During an interview on 4/9/26 at 10:16 a.m. with the Director of Nursing (DON) and Patient Safety and Quality Nurse (PSQN), DON stated if a resident is prescribed regularly scheduled morphine for pain management, the administration window is one hour before or one hour after the time specified on the MAR. DON confirmed the administration times on the MAR and CDR are supposed to match to account for oversight of narcotic medications, and it was not acceptable to administer a narcotic more than an hour before it was due - if given too early, it could cause harmful effects. PSQN said it had potential to cause respiratory depression (a life-threatening condition where breathing is too slow or ineffective, leading to low oxygen levels frequently caused by excessive drug amounts).A review of the facility's policy and procedure titled, Skilled Nursing Facility Medication Administration and Monitoring, revised 5/2025, indicated, Medications will be administered within one hour of the ordered time on the Medication Administration Record. The document further indicated, When there is a discrepancy in the narcotic count, an investigation will ensue. If the medication cannot be reconciled, the Controlled Drug Discrepancy Report form will be completed, two nurses will sign the form, and the form will be turned into the Director of Nurses.A review of a facility document titled, Pharmacy Products and Services Agreement (contract between the pharmacy on CDR and the facility), dated 6/15/21, indicated, Consultant shall assist Facility in developing and implementing safeguards and systems to control, account for, and periodically reconcile controlled medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 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 store medications in accordance with professional standards for a census of 45, whenAn expired bottle of carboxymethylcellulose sodium 0.5% solution (artificial tears eye drops for dry eyes) was still being administered to Resident 17;An open tube of hydrocortisone cream 1% (a topical steroid used to reduce inflammation and itching caused by conditions like allergic rashes) for general resident use was found without an open date; An open bottle of Resident 20's ascorbic acid (Vitamin C) had a smudged illegible expiration date written on it;A treatment cart containing prescription creams and ointments was left unlocked in the hall accessible to residents;Treatment Cart 1 contained a tube of Mupirocin 2% ointment (a prescription antibiotic to treat skin infections) without resident's name and unlabeled Premarin 0.625 milligram tube (hormonal cream) and multiple ointments and creams were found inside Treatment Cart 1 and available for residents' use with expiration dates of 2024 and 2025. This failure placed facility's residents at risk for receiving medications and treatments that may have reduced potency, compromised safety, and increased the potential of administering ineffective medications and treatments to residents.A review of Resident 17's admission Record indicated she was admitted to the facility in 2024. A review of Resident 17's Order Summary Report, dated 2/25/24, indicated she was prescribed artificial tears eye drops, to instill 2 drops twice a day for dry eyes. A review of Resident 20's admission Record indicated she was admitted to the facility in 2024. A review of Resident 20's Order Summary Report indicated she was prescribed vitamin C 500 milligram (mg) daily on 11/19/24. During a concurrent observation and interview on 4/7/26 at 1:15 p.m. with Licensed Nurse (LN) 1 at the medication cart, a review of medications storage was conducted: 1. Resident 17's eye drops had an expiration date of 4/5/26 written on the box. LN 1 stated the eye drops had expired, and Resident 17 should not have gotten the drops past 4/5/26 because according to policy, eye drops were considered expired thirty days after opening. LN 1 pointed to a guide affixed to the top of the medication cart that indicated, Eye Drops – Discard 30 days after opening. A review of Resident 17's Medication Administration Record (MAR - a daily documentation record used by a licensed nurses to document medications and treatments given to a resident) indicated she had been given the expired eye drops through the morning of 4/8/26. 2. LN 1 confirmed the hydrocortisone cream had been opened, but no open date was written on the box or tube. LN 1 also stated the medication was available for residents use if ordered by the physician. LN 1 pointed to the guide the facility had posted on the cart that indicated, Date and initial all items when opened. 3. LN 1 confirmed the expiration date on the vitamin C bottle was smudged and illegible and stated the nurses would not know when the vitamins expired. During an interview and record review on 4/9/26 at 10:01 a.m. with the Director of Nursing (DON) and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Patient Safety and Quality Nurse (PSQN), medications were reviewed from the medication cart. DON acknowledged the guidance on the medication cart indicated eye drop medications were to be discarded after 30 days and further stated using expired eye drops could have adverse effects on the patients' eyes. PSQN stated expired medications could lead to ineffectiveness of the medication. DON stated hydrocortisone creams were to be labeled upon opening and asserted if they were not labeled, they should be discarded because no one would know if the medication was expired or not. DON stated vitamins with unknown expiration dates could cause unwanted side effects for the resident. A review of the facility's policy and procedure titled, Medication Administration and Monitoring, revised 5/2025, indicated, .the medication nurse is responsible for all medications stored in the medication cart. The document further indicated medications are to be dated when opened and discarded by the expiration date. 4.During an observation on 4/7/26, at 12:09 p.m., Treatment Cart 1 was observed in the 400's hall. The cart was unlocked, unattended, and facing towards the hall. Multiple prescription ointments and creams were observed in unlocked middle drawer. Several residents were observed moving in their wheelchairs in the hall. During a concurrent observation and interview on 4/7/26 at 12:12 p.m., LN 3 stated he was assigned to administer treatments in this hall and had the key for the treatment cart. LN 3 acknowledged that the treatment cart was unlocked and unattended and accessible for residents and visitors. LN 3 stated that it was not safe to keep the treatment cart unlocked with prescription ointments and creams and the cart should have been locked. During an interview with DON, on 4/9/26 at 1:39 p.m., the DON stated that treatment carts containing medicated ointments and creams should never be left unlocked. The DON stated nursing staff were expected to keep the medication and treatment carts locked if they were unattended and away. The DON added, Residents can access and it's not safe. A review of the facility's policy titled, Medication Administration and Monitoring, dated 5/2025, All medications will be administered.in accordance with established [name of the facility] policies and procedures, State and Federal regulations.All medications will be stored in lockable containers, carts, or specific locked medication storage areas.Medication cart must be locked when not in use. An unlocked cart is never left unattended. 5. During a concurrent observation and interview with LN 3 on 4/7/26 at 12:15 p.m., an inspection of the Treatment Cart 1 identified the following undated and expired medications: a. An undated tube of Mupirocin 2% ointment with an open date of 10/29/24 and expiration date of 9/2025; b. An undated tube of Premarin 0.625 milligram tube (hormonal cream); c. An unlabeled and undated tube of Permethrin 5% cream 60 gram (medication for treatment of lice or scabies) with expiration date of 5/2025; d. A tube of Betamethasone Dipropionate 0.005 % ointment (a strong steroid medication used for skin itching, redness, and inflammation) with expiration date of 5/31/25, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Three tubes of lubricating jelly 59 each with an open date of 10/8/2024. Each tube indicated it was for single use only and it was sterile [free of germs] in unopened undamaged package. During a concurrent interview on 4/7/26 at 12:15 p.m., LN 3 validated that all ointments, creams, and lubricating jelly were available for residents' use. LN 3 stated all expired ointments and creams should be discarded and not be used past their expiration date because they might not be effective. During an interview with DON on 4/9/26 at 1:39 p.m., the DON stated that all medications, including ointments and creams should be dated after the opening and expired medications should be discarded and not in use. The DON stated nursing staff were expected to check expiration dates of ointments and creams during treatments administration. The DON stated that expired ointments could have decreased potency and should not been administered. A review of the facility's policy titled, Medication Administration and Monitoring, Product Dating and Expiration, dated 5/2025, Non repackaged.solids will be dated when opened and discarded by the expiration date or after 1 year of opening, whichever comes first.Multi-dose vials will be dated and initialed when opened. Discard when empty.or the manufacturers expiration date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 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 ensure food was stored and prepared in accordance with professional standards for food service safety for a census of 45, when:1.Food items were found expired and with no open dates in the resident's refrigerator and2. Crumbs and debris were found in clean and sanitized areas in the kitchen.These failures had the potential to cause food-borne illnesses to a vulnerable population.1.During an observation on 4/8/26 at 4:45 p.m., of the resident's refrigerator, the following was noted: a. one-gallon plastic bag full of expired individual butters (expiration date 3/20/26); b. one bottle of cranberry cocktail juice with an open date of 12/10/25; c. one opened bottle of cranberry juice, undated and unlabeled (no resident's name and no open date and expiration or used-by date); and d. one opened and undated jar of mayonnaise.During a concurrent interview on 4/8/26 at 4:45 p.m. with Licensed Nurse (LN 4), LN 4 confirmed the unlabeled and outdated items in the residents' refrigerator and stated the resident's items from home were expected to be labeled to identify the resident and make sure they [residents] are safe. LN 4 stated the expectation was that food should have open dates and not be expired or unlabeled to avoid patient getting sick.During an interview on 04/8/2026 at 4:53 p.m. with LN 3, LN 3 stated the expectation was that food from home stored in the residents' refrigerator should have the resident's name and be dated so they [residents] do not get sick.During an interview on 04/8/2026 at 4:57 p.m. with Certified Nursing Assistant (CNA 1), CNA 1 stated, resident food should be labeled with the name, room number, date and time the food item went in the fridge to avoid harmful bacteria growth.During an interview on 4/9/26 at 7:45 a.m. with the Dietary Manager (DM), the DM indicated staff were expected to follow policy for food dated from kitchen to other departments policy, and stated, The used by date and the expiration date provided on the package should be written on the food items. The DM stated staff were expected to also follow the policy for food brought in by family. During an interview on 4/9/26 at 7:45 a.m. with Dietary Aide (DA 1), DA 1 stated received and used by dates are written on bags and confirmed expired items are expected to be thrown away. During an interview on 4/10/26 at 12:10 p.m. with the Director of Nursing (DON), the DON stated the expectation was that food should be labeled and expired food should be removed from the residents' refrigerator to avoid food-borne illnesses to residents. A review of the facility's policy and procedure titled Food handling and storage from outside SNF [Skilled Nursing Facilities], dated 11/2025, indicated, 3. Food of any type, once opened, will remain in the refrigerator for no more than 7 days.6. Anything found in the refrigerator without a name and/or date will be immediately discarded.2. During a concurrent kitchen inspection tour and interview on 4/9/26 at 7:51 a.m. with the DM, food preparation utensils were found stored in a metal bin with crumbs and debris. The DM confirmed the utensils were lying in debris and stated the bin was expected to be clean and free of debris. During an interview on 4/10/26 at 10:20 a.m. with the Infection Prevention Nurse (IP), the IP indicated crumbs and debris in clean and sanitized areas were not safe and could harbor bacteria that could make a resident sick. During an interview on 4/10/26 at 12:10 p.m. with the DON, the DON stated the expectation was that crumbs and debris should not be inside a clean area to avoid illness to residents.A review of the facility's policy and procedure titled (P&P), Departmental Safety : Food Service, dated 2023, the P&P indicated, .Dishes .1.Ensure cleanliness and serviceability .2. Store properly in kitchen service area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain electrical equipment in a safe condition for a census of 45 residents, when the facility did not routinely remove lint buildup from the dryer in the laundry room.This failure had the potential to affect residents' safety due to fire hazard.During a tour of the laundry room on 4/9/26 at 2:45 p.m., accompanied by Infection Prevention Nurse (IP), a thick layer of lint accumulation was observed in the lint trap compartment of the dryer. The IP stated the lint trap was to be cleaned on a regular basis to remove lint accumulation and validated that lint compartment had accumulated lint. The IP was unable to provide documentation or a log confirming routine lint removal from lint compartment. The IP stated she did not inspect the laundry room for cleanliness and explained that laundry room was managed by Director of Environmental Services.During a concurrent observation and interview with the Director of Environmental Services (DES) on 4/9/26 at 3:02 p.m., the DES acknowledged that the lint compartment had accumulation of lint and added, looks like it was not cleaned today. The DES stated that dryer needed to be inspected and cleaned of lint accumulation every day. The DES was unable to provide documentation or a log confirming routine lint removal. The DES confirmed the facility did not have formalized schedule requiring routine inspection and cleaning of dryer lint compartment. The DES stated the facility did periodical inspection of the laundry area, but there were no documents available when the last inspection of dryer lint compartment was done.A review of the facility's policy titled, Clean Linen Room Cleaning Procedure, dated 11/5/21 indicated, Purpose: To maintain the hospital linen room in a clean, safe, sanitary and outstanding condition. The policy had no specific procedures or guidance addressing routine cleaning and maintenance of laundry equipment, including dryers to prevent lint accumulation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure the Physician Orders for Life Sustaining Treatment (POLST, a form signed by the resident or representative and physician, outlining specific treatment wishes and end-of-life preferences) was signed by Public Conservator (PC, a legally recognized and authorized surrogate decision maker) for one of 13 sampled residents (Resident 33), when Resident 33's POLST form indicated Do Not Resuscitate (DNR) status, but lacked the required name and signature of PC.This failure had the potential for Resident 33 not to receive treatment and care in the event of a medical emergency and deprived the resident's Public Guardian ability to make informed decisions affecting Resident 33's care.A review of the admission record indicated the facility admitted Resident 33 in 2019 with multiple diagnoses which included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills) and hearing loss.A review of Resident 33's physician order dated 9/23/19 indicated that Resident 33 did not have capacity to make decisions. The physician order indicated, .surrogate decision maker: [Name of the County] Public Guardian. A further review of Resident 33's clinical record contained a document titled, Letter of Conservatorship, dated 1/2/2020. The letter indicated that Public Guardian was court appointed conservator for Resident 33 and had Exclusive authority to give consent for and to require the conservatee [Resident 33] to receive medical treatment that the conservator in good faith based on medical advice determines to be necessary.A review of the clinical record for Resident 33 contained a POLST form indicating that Resident 33's code status was Do Not Resuscitate (do not prolong life during an emergency). The POLST form was signed by two physicians on 12/20/22. Section D of the POLST did not list the name as required by instructions and did not indicate if Resident 33's DNR status was discussed with Legally Recognized Decisionmaker (LRD). The POLST form did not contain the signature of Resident 33's Legally Recognized Decisionmaker. The back portion of the POLST contained the instructions for completion of the form which indicated, A legally recognized decisionmaker may include a court-appointed conservator or guardian.POLST must be signed by a physician and the patient or decisionmaker to be valid.During an interview on 4/8/26 at 4:22 p.m., with Licensed Nurse (LN 3), LN 3 explained that in order for the POLST to be valid, the form must be signed by physician and public guardian if the resident lacked capacity to make decisions and had no family members identified.During a concurrent interview and record review conducted on 4/8/26 at 4:27 p.m., with Director of Nursing (DON) and Director of Patient Safety and Quality (DPSQ), Resident 33's POLST form was reviewed. The DON validated that the POLST dated 12/20/22 was not completed properly with required sections left blank and was not signed by Resident 33's appointed Public Guardian.During a further review of Resident 33's clinical records on 4/8/26 at 4:27 p.m., with DON and DPSQ, the DON explained that on 12/22/22 the facility conducted a care conference addressing Resident 33's progressive decline in functioning and decreased food intake. The DON stated that Resident 33's code status was changed to DNR and the new POLST addressing DNR status was discussed with appointed Public Guardian who participated in the care conference by phone. The DON stated that Public Guardian did not want to sign the new POLST with DNR status. When the DON was asked if Resident 33's Public Guardian agreed with DNR status, the DON stated, Not really. He did not want to take that responsibility. The DON explained that Resident 33 did not have Advance Directive (AD, a legal document in which persons specify their wishes for their health needs if they were no longer able to make decisions for themselves). The DON added that Public Guardian explained that in absence of AD, he assumed that the resident wanted to be full code [all life-saving measures, including cardio-pulmonary resuscitation-CPR] and he refused to sign. The DON was asked if POLST form was considered valid in the absence of resident's appointed Public Guardian, and the DON replied, We informed him. The DPSQ agreed that without Public Guardian's signature, the POLST with DNR status was not valid.During a follow up interview and record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with DON on 4/9/26, at 11:16 a.m., the DON stated Resident 33's functional decline was addressed by her physician on 12/20/22 and 1/21/23.A review of the physician progress notes dated 12/20/22 indicated that Resident 33 was Stable with current medications.Currently full code on her POLST form.I would support switching her to DNR.Nursing is already initiated evaluation.through the ethics committee. The physician's note did not indicate if Resident 33's DNR status was addressed with Public Guardian. A review of Resident 33's physician progress notes dated 1/21/23 indicated, Stable with current medications.With review of ethics committee and her public guardian, she was changed from full code to DNR. The DON stated she did not recall if Resident 33's code status was discussed during one of the ethics committees.On 4/9/26 the facility was requested to provide a policy addressing POLST and the DON stated there was no specific policy addressing POLST available. The DON explained, We follow state requirement and explanation on the POLST form. During an interview on 4/9/26 at 12:01 p.m., the DPSQ stated there was no documented evidence that Resident 33's DNR status was discussed during one of the ethics committees in 2022 or later. The DPSQ stated that per Chief Medical Officer, two (2) physicians can sign DNR without guardian's approval in emergency situations, when the resident has to go to surgery or something emergent. The DPSQ explained that on 12/20/22 Resident 33 did not have planned surgery and there was no emergency situation with the resident's health.On 4/10/26 at 12:35 p.m., the DPSQ provided a policy titled, Health Care Decisions for Unrepresented Patients, dated 3/17/21. The policy indicated that its purpose was to provide a process for making ethically, legally, and medically appropriate treatment decisions on behalf of persons who lack health care decision capacity and for whom there is no surrogate decision-maker. If a patient is incapacitated, a surrogate maker can be designated. This person can be.a court-appointed conservator of the person. The policy further indicated, This policy may be used when the following conditions are met: The patient has been determined by the primary physician.to lack capacity to make health care decisions.No agent, conservator, or guardian has been designated to act on behalf of the patient.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' confidentiality was maintained for one resident (Resident 52) for a census of 45 when a computer screen was open and unattended by staff; publicly displaying Resident 52's private medical information.This failure decreased the facility's ability to protect Resident 52's private health information.Findings:A review of Resident 52's admission Record indicated he was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease and gangrene (a serious, potentially fatal condition involving tissue death caused by lack of blood supply or severe bacterial infection) of the left foot.A review of Resident 52's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/9/2026, indicated his Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 14 out of 15, showing his cognition was intact.A review of Resident 52's admission packet, signed by Resident 52 on 4/6/26, indicated his Resident Rights [involved]. confidentiality of information including medical records.During a concurrent observation and interview on 4/8/26 at 8:09 a.m. in the hallway, an unattended medication cart's computer screen displayed a section of Resident 52's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), which included Resident 52's code status (a medical order that specifies what type of life-saving measures a patient desires) and medications he was taking. Licensed Nurse (LN 1) finished administering medications to Resident 52 and returned to the medication cart and stated she had partially closed the computer's screen flap to conceal his medical information. LN 1 stated she should not have left the unattended computer screen open, and that it was a breach of privacy because visitors or other residents could view the resident's medications.During an interview on 4/9/26 at 10:10 a.m. with the Director of Nursing (DON), DON stated nurses are expected to lock the computer screen each time they leave the cart to administer medication to residents, which effectively blanks out the screen. DON stated LN 1 violated the Health Insurance Portability and Accountability Act (HIPAA - a federal law that mandates strict standards for protecting the privacy and security of patient health information in healthcare settings), which could expose Resident 52's private health information to anyone walking down the hallway.A review of the facility's policy and procedure titled, HIPAA Privacy Rule-Confidentiality, revised 4/3/25, indicated the facility's purpose was to .ensure management and staff are committed to efforts to protect the privacy and security of our patients. The document further indicated, [Facility name] shall expect all employees to comply with privacy and security policies [by] .securing patient records containing individually identifiable health information so that they are not readily available to those who do not need them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure physician's order was followed for one of 13 sampled residents (Resident 7), when monthly weights were not obtained as ordered. This failure had the potential risk for Resident 33 to have unrecognized weight loss.A review of Resident 7's admission Record indicated Resident 7 was admitted in Fall 2024 with the diagnoses which included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills) and Crohn's Disease (an immune disorder where the immune system attacks healthy gut tissue). A review of Resident 7's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/12/26, the MDS indicated that Resident 7 did not have the capacity to make decisions and was at risk for weight loss. A review of review of Resident 7's Order Summary Report, dated 4/10/26, indicated Weigh resident monthly. CNAs [Certified Nursing Assistants] to document in POC [Plan of Care]. Every day shift every 30 day(s) for monthly weights (measurement in pounds [lb.] and ounces [oz]). A review of Resident 7's Weight and Vital Summary (WVS), dated 4/10/26, reflected Resident 7's weight had not been measured for the month of December 2025 and February 2026. The WVS further showed Resident 7 had a 13 lb. 4 oz. decline in December 2025 and a 3 lb. 4 oz. decline in February. During a concurrent observation and interview on 4/9/26 at 2:20 p.m. with Certified Nursing Assistant (CNA) 4 in Resident 7's room, Resident 7 was found with a partially eaten pureed diet at her bedside. ˆCNA 4 stated Resident 7 was on a pureed diet.hasn't been eating today. CNA 4 further stated Resident 7's weights were expected to be obtained monthly using a Hoyer lift (a lift system to provide accurate weights for bedbound residents). During an interview on 4/9/26 at 5:30 p.m. with CNA 3, CNA 3 stated Resident 7 had a risk for weight loss and that the expectation was to weigh Resident 7 monthly. During a concurrent interview and record review on 4/10/26 at 10:15 a.m. with Licensed Nurse (LN 5), Resident 5's weight record and orders were reviewed. LN 5 confirmed Resident 7 had not been weighed in December 2025 and February 2026 and that the expectation was for Resident 7's weight to be obtained monthly to monitor weight or boost increase Resident 7's calories. During an interview on 4/10/26 at 12:10 p.m. with the Director of Nursing (DON), the DON stated weights were expected to have been completed monthly if the order indicated monthly weights and that monitoring the weight was important so staff could recognize the changes and the actions needed for the residents. A review of the facility's policy and procedure (P&P) titled, Assessment and Reassessment, dated 2025, indicated, To ensure residents are provided adequate and appropriate care data collection and analysis are ongoing.information from the resident's medical history.will provide * a unique path toward achieving or maintaining his or her highest practical level of well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide standard quality care to one resident (Resident 4) of a sample of 13 when catheter placement and care were not included in Resident 4's care plan, orders, treatment record, and urine output log.This failure increased the potential for Resident 4 to get a urinary tract infection (UTI - an infection caused by bacteria entering the urinary tract, including the bladder and kidneys) and be readmitted to the hospital.Findings:A review of Resident 4's admission Record [AR] indicated she was admitted to the facility on [DATE] with diagnoses that included the removal of the left cancerous kidney (a disease condition caused by an uncontrolled division of abnormal cells) and acute right kidney failure. The AR indicated Resident 4 was her own responsible party. A review of Resident 4's nursing Progress Notes, dated 3/24/26, indicated she was admitted to the hospital for a UTI.A review of nursing Progress Notes, dated 4/1/26, indicated Licensed Nurse (LN 1) performed Resident 4's nursing admission assessment upon her return to the facility from the hospital on 4/1/26. The progress note indicated the hospital inserted Resident 4's urinary catheter (an indwelling tube inserted into the urethra- a tube allowing urine to drain out into a urine bag) on 3/27/26 to monitor exact urine output.A review of Resident 4's Interim Care Plan, dated 4/1/26, indicated LN 1's documentation that Resident 4 had an indwelling urinary catheter, with no further information. A review of the facility's policy and procedure titled, Assessment and Reassessment, revised 11/2025, indicated, The interim care plan is started within 24 hours of admission by the admitting nurse. The interim care plan is based on the medical doctor orders, the initial nursing assessment . It must minimally contain information about.devices, toileting needs.[and] guides all care until the comprehensive care plan is completed. A review of Resident 4's Care Plan Report, dated 4/9/26, indicated no goal had been entered regarding an individual plan of care for her catheter.A review of Resident 4's Order Summary Report, dated 4/9/26, indicated no medical orders were written for her catheter care.A review of Resident 4's Treatment Administration Record (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident), dated April 2026, indicated no orders for the catheter care (e.g. cleaning).A review of Resident 4's urinary output log indicated no data was entered for urinary output amounts from 4/1/26 to 4/10/26.A review of the facility's policy and procedures titled, Intake and Output, revised 11/2024, indicated, If residents have an indwelling catheter, Intakes and Outputs will be documented in the Electronic Health Record.During a concurrent interview and record review on 4/10/26 at 9:03 a.m. with Licensed Nurse (LN 2), LN 2 stated Resident 4 was sent to the hospital the last week of March 2026 for a UTI and stated there was concern for the resident's remaining kidney. LN 2 looked for a urinary catheter order and stated it was not in Resident 4's records, nor could she find treatment instructions for catheter care in the TAR and stated the orders should have been written. LN 2 stated the nurses know how to perform cleaning of the urinary catheter, but there was nowhere for them to document the care on the TAR. LN 2 stated that the lack of catheter orders was not up to quality standards of practice.During a concurrent interview and record review on 4/10/26 at 9:15 a.m. with the Director of Nursing (DON), DON looked at Resident 4's care plan, orders, treatments, and urinary output log, and confirmed she could not find the order for the catheter, nor its care or urinary output amounts. DON stated the orders should have been entered soon after Resident 4's readmission from the hospital on 4/1/26. DON stated that since the catheter was not in the care plan, staff would not be aware she had one and needed catheter care. DON stated the failure to include the presence of the catheter could cause inadequate or missed nursing care, leading to recurrence of Resident 4's UTI and a second hospitalization. DON also stated Certified Nursing Assistants should have had an order to measure and chart urinary output amounts each shift, but confirmed no charting was completed for urinary output from 4/1/26 through 4/10/26.A review of the facility's policy and procedures titled, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Insertion, Management and Removal of an Indwelling Urinary Catheter, revised 5/5/23, indicated, The physician or advanced practice professional is responsible for writing the order for.management.of the urinary catheter. The Registered Nurse (RN) is responsible for following the provider's orders. The document further described the daily care procedure for indwelling catheters: Catheter care performed daily and as needed (i.e., when soiled) with approved wipe product. and ensure documentation is completed for cleaning the catheter as well as the amount of urine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure psychotropic medications (medications that affect mood and behavior) were administered in accordance with acceptable standards of practice for one of 13 sampled residents (Resident 6), when Resident 6 was administered Citalopram (an antidepressant medication) without documentation of a diagnosis of depression or other clinically appropriate indication for use.This failure placed Resident 6 at risk for unnecessary exposure to psychotropic medications and potential adverse effects (unwanted, uncomfortable, or dangerous effects) related to the use of Citalopram. A review of the admission record indicated the facility admitted Resident 6 in 2024 with multiple diagnoses which included high blood pressure, diabetes mellitus (elevated blood glucose), and fracture of right upper arm.A review of Resident 6's clinical record contained a physician order dated 10/22/25 for Citalopram 10 milligram (mg, a dose of measurement) every day for depression as manifested by feeling of hopelessness and lack of interest. A review of Resident 6's profile did not indicate that the resident had diagnosis of depression.A further review of Resident 6's clinical record indicated that Resident 6 was initially prescribed Citalopram 40 mg every day for depression upon admission on [DATE]. Resident 6's clinical record indicated that the Citalopram dose was gradually decreased to 30 mg, then to 20 mg, and then to 10 mg.A review of physician's admission history for Resident 6 dated 4/5/24 and physician's progress notes dated 8/1/24, 9/29/24, 12/8/24, 12/31/24, 2/24/25, 4/17/25, 7/6/25, 10/16/25, 11/18/25, 1/26/26, and 3/26/26 did not contain depression listed on resident's profile as one of the resident's diagnoses.A review of the Minimum Data Set (MDS, a federally mandated assessment) dated 4/11/26 indicated that Resident 6 was cognitively intact. According to MDS section for mood assessment, Resident 6 never experienced symptoms of depression, including Little interest or pleasure in doing things. Feeling down depressed or hopeless. Resident 6's list of diagnoses listed in MDS assessment did not contain diagnosis of depression.A review of MDS assessments dated 4/11/24, 7/11/24, 1/9/25, 4/10/25, 7/10/25 indicated Resident 6's depression score as 00. Resident 6's list of diagnoses listed in MDS assessment dated [DATE], 7/11/24, 1/9/25, 4/10/25, 7/10/25 did not contain diagnosis of depression.A review of Psychotropic Medication Evaluations (MUE's, a clinical review used to determine whether medications that affect mood, behavior, or thinking were appropriate, necessary, safe, and effective) from June 2025 through December 2025 indicated Resident 6 had 0 episodes of hopelessness and lack of interest. The MUE's did not contain the diagnosis of depression and required indication for administration of Citalopram.During an observation and interview on 4/6/26 at 11:10 a.m., Resident 6 was observed in her room, working on sudoku crossword. Resident 6 was pleasant, smiling, and answered appropriately to all questions in the language other than English. Resident 6 explained that she was very private person and liked to stay in her room watching news or working on crosswords.During a follow up observation and interview on 4/7/26 at 4:30 p.m., Resident 6 was in her room, listening to the news. When Resident 6 was asked about Citalopram, the antidepressant medication that she was taking, Resident 6 started laughing. Resident 6 stated, I don't think I have depression. Resident 6 explained that her family did not visit her frequently, but she had friends who visited her, and she talked to them on the phone. Resident 6 stated that sometimes she would go to activities for bingo or other games. Resident 6 explained, I am not very social person, never been, plus that fact that I do not speak English well, so I like to stay in my room. I prefer to stay in my room - working on puzzles, crosswords, listening to news. Resident 6 stated she was not aware that she had diagnosis of depression and added, I don't think I feel hopeless and lacking interest in life, it's my choice not to go to activities.During an interview with Licensed Nurse (LN 3) on 4/7/26 at 5 p.m., LN 3 stated Resident 6 was talking Citalopram for depression. When LN 3 was asked to describe Resident 6's symptoms of depression, LN 3 stated, She's always calm and pleasant. I have not seen her crying or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complaining of being depressed.During an interview with Certified Nursing Assistant (CNA 2) on 4/10/26 at 10:35 a.m., CNA 2 described Resident 6 as calm, very quiet. CNA 2 stated, She's never sad, and I have not seen her crying or talking that she's depressed.We offer activities, and she decides if she wants to go or not.During a concurrent interview and record review on 4/10/26 at 8:35 a.m., with Director of Nursing (DON), the DON stated that Resident 6 was taking Citalopram for depression since her admission to facility in 2024. Upon reviewing Resident 6's clinical records, including list of diagnoses, the DON validated that the resident's clinical records did not include a diagnosis of depression. The DON confirmed that multiple physician progress notes did not indicate that the resident had depression. The DON stated that depression was not listed on Resident 6's MDS assessments since 2024. The DON reviewed Resident 6's records and stated that diagnosis of depression was listed on Resident 6's profile before the resident's admission to facility but was not carried over to her list of diagnoses upon admission to the facility. The DON stated that residents receiving antidepressant medications were required to have a documented diagnosis of depression reflected in their clinical profile. The DON validated that Resident 6 did not have documented diagnosis of depression. The DON stated there was no pharmacy consultant's recommendations to the prescribing physician to clarify the diagnoses of depression that was missing on Resident 6's active diagnoses list.During a telephone interview and record review on 4/10/26 at 10:50 a.m., with Pharmacy Consultant (PC) and DON present, the PC stated that any resident receiving antidepressant therapy was required to have a documented diagnosis of depression listed in their profile. The PC stated Resident 6 was prescribed Citalopram 10 mg for depression. The PC stated she had limited access to Resident 6's clinical records and was not aware that the resident did not have a diagnosis of depression listed in her profile.A review of the facility's policy titled, Psychotropic Drug Use, with revision date of 1/2026, indicated the purpose of the policy was to outline proper procedures and proper documentation for psychotropic medications use. The policy indicated, Psychotropic medications are defined as Anti-Psychotics, Anti-Depressants, Hypnotics, and Anti-Anxieties. The policy did not specify that residents will be administered psychotropic medication to treat specific condition or diagnosis documented in resident's clinical records.