STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056198	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kit Carson Nursing & Rehabilitation Center	811 Court Street Jackson, CA 95642

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47369 Based on interview and record review the facility failed to use appropriate and safe transfer methods according to resident's care needs for one of three sampled residents (Resident 2) when, Certified Nursing Assistant (CNA) 2 transferred Resident 2 from the shower chair (a waterproof chair on wheels used to transport residents to and from the shower room) to her bed using a bear-hug (a transfer technique where a caregiver wraps their arms around the individual under the armpits, like a bear hug, to assist in standing and moving them) and one person assist. This failure resulted in a fracture of Resident 2's right seventh rib, and had the potential to cause increased pain, decreased mobility, skin breakdown, and other negative health outcomes for Resident 2. Findings: A review of Resident 2's ADMISSION RECORD, indicated Resident 2 was admitted to the facility in November of 2019, with diagnoses which included, age-related osteoporosis (condition that decreases bone density and strength, causing bones to be more fragile and susceptible to fractures) and muscle weakness. During a concurrent interview and record review on 3/28/25, at 11:03 AM, Licensed Nurse (LN) 1 confirmed she could not find any documentation in Resident 2's orders or active care plans to indicate how Resident 2 should be transferred. LN 1 stated the only transfer information she could find in the HER (Electronic Health Record) was in Resident 2's baseline care plan (document developed within 48 hours of admission to outline the initial care instructions needed to ensure effective and person-centered care) dated 2019, which indicated Resident 2 required a two-person assist for Bed Mobility (ability to move oneself in bed) and Transfer. LN 1 stated a two-person transfer was correct for Resident 2. A review of Resident 2's Minimum Data Set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) with a target date of 5/23/24, indicated, .Section GG_ Functional Abilities and Goals .GG0170.Mobility . Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed .E. Chair/bed to chair transfer: The ability to transfer to and from a bed to chair (or wheelchair) . Both areas were coded 02. The legend indicated, .Coding .02. Substantial/maximal assistance- Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's clinical document titled, Care Plan Report, initiated 3/6/21, revision on 9/12/24, indicated, .Focus .[Resident 2] is at risk for spontaneous pathological fractures related to skeletal fragility and loss of bone mass secondary to AGE RELATED OSTEOPOROSIS .Interventions .Handle gently during care giving .Protect resident from sudden movement or bumps during care . A review of Resident 2's clinical document titled, Progress Notes, dated 1/26/25, at 7:33 AM, indicated, . Nurses Notes .Reported by CNA [Certified Nurse Assistant] in charge that after showering resident yesterday at 0745 [7:45 AM], and transferring resident back to bed, while pivoting back to bed hugging her to prevent resident from falling, resident shouted Ow my rib! CNA reported the incident to charge nurse right away Nursing assessment done along with charge -RN from NOC [night] shift, no noted skin discoloration at the complaint area at RT [right] upper quadrant of abdomen [area of the abdomen located above the waistline and below the ribs] just under the right breast .Pain scale 5/10 [a scale from 0-10 used to measure pain, 4-6 is considered moderate pain] .New order to send to .ER for further evaluation andtreatment [sic] . A review of Resident 2's clinical document titled, EMERGENCY DEPARTMENT PHYSICIAN NOTE, dated, 1/26/25, indicated, .CHIEF COMPLAINT .Rib pain .RADIOLOGY INTERPRETATION .Acute [sudden or traumatic] anterolateral [in front and to the side] right seventh rib fracture . During a concurrent interview and record review on 3/28/25, at 10:35 AM, CNA 1 stated Resident 2 required two staff during transfers. CNA 1 further stated when Resident 2 was transferred she was placed in a seated position with a CNA on each side of her. CNA 1 stated the information on how to transfer residents was in the facility's electronic charting system. CNA 1 reviewed Resident 2's chart and confirmed she could not find any information to indicate how Resident 2 should be transferred. CNA 1 stated the nurse could access transfer information in the resident's electronic health record (EHR) and inform the CNA. A review of Resident 2's clinical document titled, Care Plan Report, initiated 1/26/25, indicated, Focus .At risk for recurrent pain secondary to witnessed transferring back to bed from shower wheelchair, and complaint of RT [right] rib pain .Goal .Resident will have less to no episodes of pain daily x 90 days if possible . A review of Resident 2's clinical document titled, Progress Notes, dated 1/25/25, at 11:12 AM, indicated, . Resident unable to stand up and hold weight on feet . signed by restorative nursing assistant (RNA, a CNA who specializes in helping patients regain or maintain physical function). A review of Resident 2's clinical document titled, Progress Notes, dated 1/25/25, at 12:55 PM, indicated, . Nurses Notes .pain 7/10 .resident on monitoring for pain under the right breast, res. [resident] was shouting it hurts under there, when attempting to assess/palpate [examine by touch] the area resident removed my hand and began to shield the area .after further assessment the area under the breast is slightly red, but skin tear present . A review of Resident 2's clinical document titled, Progress Notes, dated 1/26/25, at 6:15 AM, indicated, . Nurses Notes .Resident under monitoring for right breast redness. Noted redness, and resident refused touch on the area due to pain .0605 [6:05 AM] RN [registered nurse] supervisor requested undersigned to assess resident's right-lateral abdomen. Upon palpation by the RN Supervisor, the resident exhibited pain through her facial expression/withdraws to pain .RN supervisor will seek advise [sic] if resident will be sent out to [hospital] for further evaluation . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/28/25, at 12:38 PM, LN 1 stated on the morning of 1/25/25, she informed CNA 2 she would help transfer Resident 2 back to bed after her shower. LN 1 further stated when she went to Resident 2's room to help assist CNA 2 place Resident 2 back into the bed, Resident 2 was already in bed. LN 1 stated CNA 2 reported she may have hurt Resident 2. LN 1 further stated CNA 2 told her she heard a crack when she moved Resident 2. During an interview on 3/28/25, at 3:42 PM, Occupational Therapist 1 (OT, healthcare provider who helps residents regain or maintain skills needed for daily living, like dressing and bathing) stated OT staff helped to train CNAs on transfer techniques. OT 1 further stated when transferring a resident, a hug technique was not recommended. OT 1 stated a resident would require a two person assist to transfer, with a gait belt, if they could not stand and pivot. During an interview on 3/28/25, at 4:50 PM, CNA 2 stated she gave Resident 2 a shower on 1/25/25. CNA 2 further stated Resident 2 transferred from her bed to the shower chair with the assistance of two CNA's. CNA 2 stated Resident 2 was usually more awake after her shower and could transfer back to bed with one assist. CNA 2 further stated when she transferred Resident 2 back to bed from the shower chair on 1/25/25, she hugged her for support. CNA 2 stated when she sat Resident 2 on the bed, she did not sit her back far enough. CNA 2 further stated she had to stand up straighter to move Resident 2 further back on the bed. CNA 2 stated when she straightened up, she heard a crack from Resident 2, and it was very disturbing. CNA 2 stated after she finished getting Resident 2 back in bed, she explained to the nurse what had happened. CNA 2 stated she told the nurse she had held Resident 2 under her arms like she was giving her a hug, then she lifted her up more. CNA 2 stated she knew Resident 2 had fragile bones. CNA 2 further stated she was trained to transfer residents with two-person assistance if they needed more support and to use a gait belt. CNA 2 stated she was not taught to hug a resident to perform a resident transfer. During an interview on 4/1/25, at 12:50 PM, the Director of Staff Development (DSD) stated the DSD and the rehab staff (rehabilitation staff who work with residents to restore their function and mobility and improve overall physical health) trained the CNAs to perform transfers. The DSD further stated the CNAs were taught to always use a gait belt when they transferred a resident. The DSD stated to perform a two person transfer staff members stood on each side of the resident and grasped the gait belt. The DSD stated to transfer with one assist staff stood on one side of the resident and held the gait belt. The DSD stated a hug was never the appropriate way to transfer a resident. The DSD further stated transferring a resident using a hug could result in an injury to the resident and/or the staff. During a telephone interview on 4/4/25, at 10:27 AM, RNA 1 stated Resident 2 began to have difficulty standing in November 2024. RNA 1 stated Resident 2 required a two person transfer since then because she would not stand, and her feet would slide out from under her. During an interview on 4/4/25, at 11:38 AM, the Physician's Assistant (PA) stated Resident 2 had a history of osteoporosis and had fractured ribs in the past. The PA further stated osteoporosis made Resident 2's bones fragile, therefore it was possible that the method of transfer contributed to Resident 2's fractured rib. The PA stated the facility needed to have a protocol to ensure residents were transferred safely. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a facility policy and procedure (P&P) titled, Transfer/Gait Belt, dated, 6/12, indicated, . It is the policy of this facility to provide safety [sic] transfer by using gait belt for the dependent resident, to aid in transfer and to prevent injuries to employees and resident (i.e., back strain or potential for chronic disability, resident falls or fractures), and to allow the resident and aide to feel more secure during a transfer . TRANSFER FROM BED TO CHAIR, COMMODE, OR WHEELCHAIR (One Person Transfer, Resident Able to Bear Weight) .Place gait belt around resident's waist; snug but not tight. Avoid ribs, hipbone, or breasts . Straighten your knees and, with spine straight, aid resident to lead with the strong leg and stand close to you with both feet flat on the floor .The residents hands may help to push on the bed or may be placed on your arms or shoulders but not around your neck .Using the gait belt to angle and lift residents buttocks, lower resident into chair while flexing your knees and pushing them against the residents to help position buttocks into chair . A review of an undated facility document titled, Nursing Supervisor (RN), indicated, .The primary purpose of your job position is to .ensure that the highest degree of quality care is maintained at all times .Ensure that all Nursing Service personnel follow established facility policies and procedures including .the use of proper body mechanics in lifting or moving residents or supplies, including the use of a gait belt .