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	08/20/2025

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 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. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure one of six residents (Resident 1) with an indwelling catheter (catheter; a thin, flexible tube inserted into the bladder to drain urine) received catheter care and services when:1. Resident 1's suprapubic catheter (a temporary or permanent drainage route for urine, through a small incision in the abdominal wall, from the bladder directly into a collection bag) was not changed as ordered by the physician;2. Resident 1's suprapubic catheter was not consistently monitored following suprapubic catheter changes; and3. Care plans (a personalized, written document that details a resident's specific health and personal care needs, goals, and interventions) were not in place for Resident 1's catheter changes and Resident 1's urinary tract infection (UTI - A condition in which bacteria invade and grow in the urinary tract) in June of 2025.These failures could have been the cause of Resident 1's UTI and 10 out of 10 pain, (pain scale of 1 through10; with 10 being the worst pain) which resulted in Resident 1 being transferred to the emergency room for an evaluation.1. During a review of Resident 1's clinical document titled, admission RECORD, (contains Resident 1's clinical and demographic data) indicated Resident 1 was admitted to the facility with diagnoses which included obstructive and reflux uropathy (a condition where the urinary tract becomes blocked and prevents the normal flow of urine). A review of Resident 1's clinical document titled, Order Summary Report, dated 4/17/25, indicated, . Routine Monthly Suprapubic Cath [catheter] changes at [local hospital] once a month starting on the 20th and ending on the 27th of every month . Order Date . 4/17/25 . During a concurrent interview and record review on 8/20/25, at 2:11 PM, with the Director of Nursing (DON), Resident 1's record titled, Progress Notes, dated 4/26/25 through 8/8/25 were reviewed. The DON confirmed Resident 1's suprapubic catheter changes were done every other month, not monthly as ordered. The DON explained the importance of completing the suprapubic catheter change was to ensure the physician orders were carried out. The DON further stated there was a risk for Resident 1 to acquire an infection and experience pain. A review of the facility policy titled, Physician's Orders, revised 7/12, indicated, . Physician's orders shall be carried out as prescribed . 2. A review of Resident 1's clinical document titled, Progress Notes, dated 4/26/25 through 4/28/25, 6/21/25 through 6/24/25, and 8/5/25 through 8/8/25 indicated Resident 1's post catheter change monitoring was not done for five out of nine opportunities for April of 2025, six out of nine opportunities for June of 2025, and three out of nine opportunities for August of 2025 as follows: 4/26/25 PM shift (2 PM through 10 PM); monitoring not noted 4/27/25 AM shift (6 AM through 2 PM); monitoring not noted 4/27/25 NOC shift (10 PM through 6 AM); monitoring not noted 4/28/25 AM shift; monitoring not noted 4/29/25 AM shift; monitoring not noted 6/21/25 PM shift; monitoring not noted 6/21/25 NOC shift; monitoring not noted 6/22/25 AM shift; monitoring not noted 6/22/25 NOC shift; monitoring not noted 6/23/25 AM shift; Resident 1 sent to emergency for 10 out of 10 pain 6/23/25 NOC shift; monitoring not noted 6/24/25 AM shift; monitoring not noted 8/5/25 NOC shift; monitoring not noted 8/7/25 AM shift; monitoring not noted 8/7/25 NOC shift; monitoring not noted A review of Resident 1's clinical document titled Progress Notes, dated 6/23/35, indicated, . Resident [1] sent out to [local hospital] via ambulance on 6/23/25 @ [at] 1317 [1:17 PM] for c/o [complaint of] 10/10 [assessment tool for pain - pain is rated 1 through 10 with 10 being the worst pain] pain in SP [suprapubic] catheter site. Catheter was just replaced at [local hospital] on 6/21/25. Resistance was noted when flushing [the process of rinsing the tube with sterile water or saline to clear out any blockages] and no output [urine] was noted during flush. Resident [1] requested to be sent out to ED [emergency department]. A review of Resident 1's clinical document titled, [Outside hospital] ED Provider Notes, dated 6/23/25, indicated, . UA [urinalysis - urine test that checks for signs of infection] suggests catheter-associated UTI [urinary tract infection] . Given UA consistent with UTI and prior culture [a laboratory test that checks a urine sample for bacteria, or other germs that can cause a UTI] history, empiric [brand name antibiotic] [antibiotic used to treat suspected infection] prescribed . During a concurrent interview and record review on 8/20/25 at 2:11 PM, with the DON, Resident 1's record titled, Progress Notes, dated 4/26/25 through 8/8/25 were reviewed. The DON confirmed Resident 1's suprapubic catheter monitoring were not consistently completed for the 72-hour duration as required on the above dates and shifts. The DON stated monitoring the suprapubic catheter for 72 hours after it was changed was to ensure if there was a change in Resident 1's condition, nursing could coordinate with the physician in case there were additional changes or orders that needed to be carried out. The DON further stated there was a risk for Resident 1 to acquire an infection and was at risk for pain. A review of the facility policy titled, Change of Condition, revised 7/24, indicated,