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	01/06/2026

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 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. Based on interview, and record review, the facility failed to develop a care plan for one of three sampled residents (Resident 1) when Resident 1's care needs for fall awareness and fall prevention were not addressed on re-admission.This failure placed Resident 1 at risk for injuring herself in another fall within the facility. Findings:During a record review of a document titled, SBAR [Situation Background Assessment Recommendation] communication form, dated, 12/17/25, the record indicated, Resident 1 was found by a Certified Nurse Assistant (CNA) on the floor lying on her back in the hallway of the facility. Resident 1 complained of pain in her lower extremities and was sent to the hospital to be evaluated.During a review of Resident 1 ' s admission RECORD, dated 12/22/25, the admission Record indicated, Resident 1 was re-admitted to the facility with diagnoses which included, .FRACTURE OF LEFT FEMUR [broken bone in left leg] .FRACTURE, HIP.MUSCLE WEAKNESS.KIDNEY DISEASE.AGE RELATED OSTEOPOROSIS [bone loss].A review of Resident 1's nurses progress note, dated 12/22/25, indicated, .[Resident 1] readmitted from [Hospital].DX [Diagnosis] hip fracture .left hip.During a concurrent interview and record review on 1/7/26 at 3:50 PM, with Licensed Nurse (LN) 1, of Resident 1's care plan located in her clinical record LN1 confirmed that Resident 1 did not have a care plan for falls in her clinical record. LN 1 stated a fall care plan was important for the resident's safety and was initiated as part of the facility's protocol when a resident falls.During a concurrent interview and record review on 1/7/26 at 4:16 PM, with the Director of Nursing (DON), of Resident 1's care plan the DON confirmed that Resident 1's clinical record did not have a fall care plan. The DON stated the care plan was used for all staff so they have a guide on how to take care of the residents. The DON stated the risk of not having a care plan would be the nursing staff would have a lack of guidance about the residents care. The DON stated she expected the staff to have initiated a fall care plan due to the residents fall history and risk of falls.During a review of the facility's policy and procedure titled, Falls Management, dated 12/24, indicated, .It is the policy of the facility to provide consistent process for evaluation, managing and reducing falls to minimize risk and improve quality of life, for residents who are at risk for falls.Staff will periodically monitor and document the individual's response to the interventions intended to reduce falling.Successful interventions in preventing falls should be continued until the cause of the falls(s) has resolved.The licensed nurse will document interventions, periodically and as needed.

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