| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056198 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kit Carson Nursing & Rehabilitation Center | 811 Court Street<br>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 0580<br>Level of Harm - Actual harm<br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to notify the physician of a significant change in condition for one of four sampled residents (Resident 1) when,1.The facility did not notify Resident 1's physician after Resident 1 had consistent moderate to severe hip pain and decreased mobility following a fall on 1/31/26. This failure resulted in Resident 1's left hip fracture (break) going undiagnosed for six days resulting in Resident 1 experiencing pain and a decline in the ability to move in bed, transfer (move from one location to another) from the bed to a wheelchair, (a wheeled mobility device, designed as a chair for individuals with limited mobility due to illness, injury, or disability) maintain a standing position, and ambulate (walk) over 50 feet (unit of measurement) while using a front wheeled walker (FWW - a lightweight, four-legged metal frame designed to help people walk with better balance and stability). Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis that included bilateral primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the left hip and vascular dementia (a progressive state of decline in mental abilities).A review of Resident 1's clinical document titled, Nurses Note, dated 1/31/26, indicated, Resident 1 had an unwitnessed fall at around 7:30 AM. Resident was found on the floor in his room lying on his left side right next to his bed.Upon assessment, resident reported pain scale of 5/10 [a 1 through 10 numerical pain scale that measures the intensity and impact of pain on daily life: 0 = no pain, 1 through 3 = mild pain, 4 through 6 = moderate pain, 7 through 9 = severe pain, and 10 = the worst pain imaginable] on the left site [sic] of the hip . Painful to touch. Pain was sharp.Notified . the Medical Doctor [MD]. Order received as following: Norco [a strong pain medication only available with a prescription] . for moderate to severe pain 4-10/10 [pain medication ordered for pain of 4 out of 10 through 10 out of 10 using the numerical pain scale] PRN [as needed] Q [every] 6hrs [hours] .A review of Resident 1's clinical document titled, Order Summary Report, dated 1/1/26 through 1/31/26, indicated Resident 1 had a physician's order dated 1/10/26 for acetaminophen 325 MG (milligrams, unit of measurement) 2 tablets by mouth every 6 hours as needed for a pain score of 1 through 3 (mild pain) and a physician's order dated 1/31/26 for hydrocodone-acetaminophen 5-325 MG (Norco) give 1 tablet orally every 6 hours as needed for a pain score of 4 through 10 (moderate to severe pain) on a 1-10 numerical pain scale.A review of Resident 1's clinical document titled, MEDICAL NECESSITY-PHYSICIAN FOLLOW-UP VISIT NOTE, dated 2/1/26, indicated, .Seen and examined today for change of condition related to.recent unwitnessed fall with reported pain . New order: Hydrocodone-Acetaminophen [Norco] 5/325 mg. give [sic] 1 tablet PO [by mouth] every 6 hours as needed for moderate to severe pain (4-10/10) for 14 days. New Order: X-ray [a diagnostic test that uses electromagnetic waves to indicate the condition of bones] of bilateral [both] hips and pelvis . Therapy to reassess as indicated.A review of Resident 1's clinical document titled, Order Summary, dated<br><br>(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 |
|---|---|---|---|
| | 056198 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kit Carson Nursing & Rehabilitation Center | 811 Court Street<br>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 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 2/1/26 by the MD, indicated, . Communication Method: Phone . Order Summary: may have follow up appointment with Radiology department to get an x-ray of both hips and pelvis . A review of Resident 1's clinical document titled, Nurses Note, dated 2/2/26, indicated, .Pain scale of 4/10 [four out of 10] reported when the resident is being changed or being transferred [moved] to wheelchair.A review of Resident 1's clinical document titled, Physical Therapy Treatment Encounter Note(s), dated 2/2/26, indicated, .Pt [patient] c/o [complained of] pain 10/10 [the worst pain imaginable] upon movement of LLE [left lower leg]. Pt had a reported fall 1/31/26. Pt assisted x 2 [2 person assist] bed mobility [movement in bed] and proper positioning to prevent skin breakdown [skin tear injuries] and contractures [structural changes to the soft and connective tissues that cause them to stiffen, tighten and contract] .Pain at Rest Intensity = 0/10 [no pain] Pain with Movement Intensity=10/10 [the worst pain imaginable].A review of Resident 1's clinical document titled, Physical Therapy Treatment Encounter Note(s), dated 2/3/26, indicated, .Pt still unable to move LLE without significant pain. Pt able to tolerate sitting in chair with minimal to no movement of LLE.Pain at Rest Intensity=2/10 [mild pain] Pain with Movement Pain Intensity=9/10 [severe pain] .A review of Resident 1's clinical document titled, Physical Therapy Treatment Encounter Note(s), dated 2/4/26, indicated, .Pt unable to ambulate. Any movement of LLE increased pain to 9/10 or 10/10. no [sic] exercises done on LLE.Pain at Rest Intensity=2/10 Pain with Movement Pain Intensity =10/10.A review of Resident 1's clinical document titled, Physical Therapy Treatment Encounter Note(s), dated 2/5/26, indicated, .Pt still having pain on LLE upon gentle ROM [range of motion -the full, maximum distance and direction a joint or body part can normally move]. NWB [non weight bearing- the injured leg must not bear any weight] observed at this time until further examination done. Pain at Rest Intensity 2/10 [mild pain], Pain with Movement Paint intensity = 10/10 [the worst pain imaginable] .During a review of Resident 1's clinical record from the [ACUTE CARE HOSPITAL] titled, XR [x-ray] HIP 2 TWO 3 VIEWS LEFT WO [without] PELVIS, dated 2/6/26, indicated Resident 1 had a new left hip fracture.A review of Resident 1's clinical document titled, Physical Therapy Discharge Summary, dated 1/12/26 through 2/6/26, indicated the following assessment dates and functional level of Resident 1 from the start of physical therapy on 1/12/26 to Resident 1's discharge to [ACUTE CARE HOSPITAL] on 2/6/26, .Bed Mobility: 1/12/2026 Baseline Minimum Assistance Min (A) [patient can perform 75% of the mobility task while the one therapist assists with 25%] required with verbal cues [verbal cues to a resident to help them complete a task] 35% of the time, 2/1/2026 Stand by Assistance (SBA) [assistance of one therapist within arm's reach to ensure safety during the tasks, without touching or helping the patient] required with occasional verbal cues, 2/6/2026 Maximum Assistance (Max A) [assistance of one therapist required to perform approximately 75% of the work of a mobility task while the patient performs 25% of the work] with 75% verbal cueing.Transfers: 1/12/2026 Baseline Moderate Assistance Mod (A) [a person can do about 50%-75% of a task (like bathing, dressing, or walking) on their own but requires significant, hands-on help from a caregiver or therapist for the other 25%-50%] with 35% verbal cueing, 2/1/2026 Contact Guard Assist (CGA) [assistance of one therapist who has one or two hands on the patient's body but provides no other assistance to perform the functional mobility task. The contact is made to help steady the patient's body or help with balance] with 10% verbal cueing, 2/6/2026 Max A x 2 with 75% verbal cueing.Ambulation Distance on Level Surfaces: 1/12/2026 Baseline 20 feet Mod (A), 50% verbal cueing, 2/1/2026 50 feet Min (A) 75% verbal cueing, 2/6/2026 NA [not applicable], DNT [did not attempt due to safety concern] .Patient was discharged from PT when discharged to the acute on 2/6/2026.A review of Resident 1's clinical document titled, Occupational Therapy Treatment Encounter Note(s), dated 2/2/26, indicated .Patient approached for scheduled OT [Occupational Therapy, a form of therapy<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056198 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kit Carson Nursing & Rehabilitation Center | 811 Court Street<br>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 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | that focuses on dressing, eating, and grooming] session patient reported 10/10 [severe] pain and refused to get out of bed. OT attempted to initiate bed mobility tasks to assess functional tolerance and promote participation; however, patient stated, 'please No' and declined all therapeutic activity due to pain. Nursing staff confirmed patient experienced a fall over the weekend, which may be contributing to increased pain and decreased activity tolerance. OT assisted CNA with brief [adult diapers that collects urine and stool] change to ensure patients safety, hygiene, and skin integrity. Patient remained verbally expressive of pain throughout encounter and was unable to safely participation skilled OT services at this time due to medical limitations.A review of Resident 1's clinical document titled, Occupational Therapy Treatment Encounter Note(s), dated 2/3/26, indicated, .Patient reported [NAME] [lower extremity - leg] pain and declined any weight bearing activities. [NAME] pain is impacting ability to safely perform transfers and is limiting OT sessions.A review of Resident 1's clinical document titled, Occupational Therapy Treatment Encounter Note(s), dated 2/4/26, indicated, .LLE [left lower extremity] pain is impacting ability to safely perform transfers, patient states, '10/10 pain' this is limiting OT sessions to in chair adls [activities of daily living-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves] and UE [upper extremity] strengthing [sic].A review of Resident 1's clinical document titled, Occupational Therapy Treatment Encounter Note(s), dated 2/5/26, indicated, .LLE pain continues to impact patients [sic] ability to safely perform transfers, toileting [using the bathroom to void or stool] and [NAME] exercises. patient [sic] states, '10/10 pain' with rolling and transfers this is limiting OT sessions to in chair adls and UE strengthing [sic].A review of Resident 1's clinical document titled, Occupational Therapy Discharge Summary, dated 1/12/26 through 2/5/26, indicated the following assessment dates and functional level of Resident 1 from the start of occupational therapy on 1/12/26 to Resident 1's discharge to [ACUTE CARE HOSPITAL] on 2/6/26, .Functional Mobility during ADLS: 1/12/2026 Baseline Mod (A) [patient does 50-75% of the work, and the Occupational Therapist (OT) assists with the remainder] with 35% verbal cueing, 2/1/2026 Min (A) [patient does 75% if the work, and OT does 25% or less of the work] with 20% verbal cueing, 2/5/2026 Max (A) [patient can perform 25-50% of the task and the remainder is completed by OT] with 20% verbal cueing.Dynamic Standing Balance [the ability to maintain an upright, stable posture while moving or shifting one's center of gravity outside the base of support]: 1/12/2026 Baseline Poor + Mod A [resident has significant, but not total, impairment requiring moderate physical assistance to maintain balance and perform tasks safely] and UE [upper extremity] support to stand and reach ipsilaterally [same side] w/o [without] LOB [loss of balance]; unable to weight shift, 2/1/2026 Fair - Min (A) or UE support to stand w/o LOB & to reach ipsilaterally; unable to weight shift, 2/5/2026 Poor (Max (A) & UE support to maintain standing balance and reach ipsilaterally; unable to weight shift.Patient was discharged from OT when sent to the [ACUTE CARE HOSPITAL] on 2/6/2026.A review of Resident 1's clinical documents, titled MEDICATION ADMINISTRATION RECORD (MAR- a document that indicates medications ordered, held, or discontinued along with pertinent lab values that are used for discernment in medication administration), dated 1/1/26 through 1/31/26, indicated Resident 1 received acetaminophen 325 mg 2 tablets on the following dates for the corresponding pain level:1/13/26 pain level 2 out of 101/16/26 pain level 0 out of 101/20/26 pain level 0 out of 101/21/26 pain level 3 out of 101/23/26 pain level 3 out of 101/24/26 pain level 4 out of 101/31/26 pain level 8 out of 10The report indicated that the pain level reported on 1/31/26 and rated as an 8 out 10, corresponded to Resident 1's pain level after the unwitnessed fall that occurred on 1/31/26, and the order for hydrocodone 5/325 mg (Norco) was obtained by Resident 1's physician.A review of Resident 1's clinical document titled, MEDICATION ADMINISTRATION<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056198 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kit Carson Nursing & Rehabilitation Center | 811 Court Street<br>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 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | RECORD, dated 2/1/26 through 2/6/26, indicated after the unwitnessed fall on 1/31/26, Resident 1's pain level significantly increased and Resident 1 received hydrocodone-acetaminophen (Norco) 5/325mg 1 tab on the following dates and times with the corresponding reported pain level:2/2/26 at 7:25 AM pain level 7 out of 102/2/26 at 2:48 PM pain level 7 out of 102/2/26 at 11:45 PM pain level 8 out of 102/3/26 at 7:56 AM pain level 5 out of 102/4/26 at 7:55 AM pain level 7 out of 102/4/26 at 2:22 PM pain level 6 out of 102/4/26 at 8:22 PM pain level 7 out of 102/5/26 at 3:14 AM pain level 8 out of 102/5/26 at 9:29 AM pain level 5 out of 102/6/26 at 4:28 AM pain level 8 out of 10A review of Resident 1's clinical documents titled, Progress Notes, dated 1/31/26 through 2/6/26, indicated that at no time was Resident 1's physician made aware of Resident 1's significant pain increase and the declines in Resident 1's inability to move in bed, stand to transfer, bear weight while sitting up in a wheelchair, or walk.During an interview on 2/20/26, at 2:23 PM, with CNA (Certified Nursing Assistant) 1, CNA 1 stated that on 1/31/26 Resident 1 was assisted back to bed after the unwitnessed fall, but Resident 1 was in quite a bit of pain and Resident 1 had difficulty rolling from side to side in the bed as he had been able to do prior to the fall. CNA 1 stated after the unwitnessed fall on 1/31/26, it took two CNAs to help him move in bed, unlike before when it had only taken one CNA. CNA 1 stated that Resident 1 was unable to fully extend his left leg.During an interview on 2/20/26, at 4:23 PM, with CNA 3, CNA 3 stated that on 2/1/26 CNA 3 and another CNA attempted to provide incontinent care (the management of involuntary bladder or bowel leakage) to Resident 1 while he was in bed, Resident 1 was not able to turn in bed using the handrail (a device attached to the bed to assist with repositioning in bed) to pull himself to the side of the bed as he had been able to do prior to the fall on 1/31/26. CNA 3 stated that Resident 1 cried out in pain and stated, 'please, no' repeatedly. CNA 3 stated that Resident 1's pain level and inability to turn in bed was reported to Licensed Nurse (LN) 1.During a concurrent interview and record review on 2/19/26 at 1:30 PM with LN 1, Resident 1's clinical document titled, Nurse Note, dated 1/31/26, which contained information regarding Resident 1's pain level, mobility level, and physician notification of a change of condition was reviewed. LN 1 stated a change of condition in a resident, whether it was an improvement or decline should have been reported to the resident's physician. LN 1 confirmed the Nurse Notes, dated 1/31/26 indicated that on 1/31/26 Resident 1 complained of pain rated at 5/10 when the left hip was touched and there was some decrease in Resident 1's ability to fully move the left leg. LN 1 stated he notified Resident 1's physician of the unwitnessed fall (1/31/26) and resulting pain and the MD gave an order for hydrocodone/acetaminophen (Norco). LN 1 stated that Resident 1's physician came to the facility on 2/1/26 and gave a routine order for an x-ray to both hips and pelvis. LN 1 stated the order request was given to social services (a department in the facility that sets up resident's appointments) to schedule the x-ray to be completed at the acute hospital on 2/6/26.During a concurrent interview and record review on 2/20/26 at 8:10 AM with PT (Physical Therapist), Resident 1's Physical Therapy Treatment Encounter Note(s), Occupational Therapy Treatment Note(s), both dated 1/12/26 through 2/6/26, and Resident 1's record was examined for any Stop and Watch forms [a checklist used by caregivers to identify early signs of a resident's change in condition] were reviewed. PT stated Resident 1 was able to fully straighten the left leg without pain and had full range of motion (ROM), walked between 50 and 60 feet with the use of a FWW and contact guard prior to the fall on 1/31/26. PT stated that after the unwitnessed fall on 1/31/26, Resident 1 was not able to walk at all, could not bear weight on the left leg, was not able to extend or move the left leg, and could not roll from side to side in bed without severe pain. PT confirmed that this information was not documented as being communicated to the licensed nurses or to Resident 1's physician so further assessment and treatment<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056198 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kit Carson Nursing & Rehabilitation Center | 811 Court Street<br>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 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | could have been provided.During a follow up concurrent interview and record review on 2/24/26 at 11:03 AM with LN 1, Resident 1's clinical record for physician notifications from the dates of 1/31/26 through 2/6/26 were reviewed. LN 1 stated that following Resident 1's unwitnessed fall, LN 1 suspected that Resident 1 had a possible dislocation or fracture of the left hip because of Resident 1's increased pain level and inability to fully straighten the left leg. LN 1 was unable to confirm that he had documented reporting this information to the physician. LN 1 stated that from 1/31/26 through 2/6/26 therapy had reported that Resident 1 experienced moderate to severe pain of the left hip and a decrease in mobility. LN 1 stated he did not report it to the physician because the hydrocodone/acetaminophen (Norco) was effective in reducing Resident 1's pain and there was an x-ray scheduled to be completed on 2/6/26. LN 1 stated that the CNAs had reported that Resident 1 was having pain during incontinent changes, bed mobility and transfers and that prior to the unwitnessed fall on 1/31/26 pain was never reported as a concern during these ADL tasks.During an interview on 2/24/26 at 12:32 PM with Resident 1's physician (MD), the MD stated that he expected the licensed nurses, physical and occupational therapists to have reported changes of condition in any resident they were treating. The MD stated that when the LN reported Resident 1's unwitnessed fall on 1/31/26, the report did not include that Resident 1 had any change in Resident 1's ability to bear weight on the left leg or fully extend or flex the left leg. The MD stated he ordered the x-ray to be done as routine instead of STAT (no delay) based on his assessment on 2/1/26 and the report he received from LN 1. The MD stated that from 2/1/26 through 2/6/26 he was not contacted by a licensed nurse or a therapist regarding any decline in Resident 1's ability to bear weight on the left leg, transfer from a sitting to standing position, roll side to side in bed, or walk. The MD stated had the facility reported those issues, he would have sent Resident 1 to [ACUTE CARE HOSPITAL] for further evaluation sooner than 2/6/26.During a concurrent interview and record review on 2/24/26 at 3:16 PM with the Director of Nurses (DON), Resident 1's Progress Notes, dated 1/31/26 through 2/6/26 that contained information regarding Resident 1's fall, pain, mobility decline, and physician notification were reviewed. The DON stated assessments of a possible change of condition should have been coordinated between a Licensed Vocational Nurse (LVN) and a Registered Nurse (RN). The DON stated that therapy staff should have also discussed Resident 1's change of condition with a licensed nurse or the MD for further evaluation and treatment. The DON confirmed that there was no documentation that indicated Resident 1's mobility declines and Resident 1's prolonged moderate to severe pain concerns were communicated to Resident 1's physician by a LN, PT, or OT. The DON stated that not reporting these declines and ongoing pain concerns to Resident 1's physician, delayed the diagnosis of Resident 1's left hip fracture and resulting treatment and caused Resident 1 to have continued declines in his mobility as well as unneeded pain and suffering.During a concurrent interview and review on 2/25/26 at 2:24 PM with the DON of the facility's policy and procedure (P&P) titled, Assessing Falls and Their Causes, dated 1/25, was reviewed. The P&P indicated, .Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility. The DON stated that any of these signs or symptoms would be considered a change of condition and as such should have been reported to Resident 1's physician for further assessment and treatment.A review of the facility's P&P titled, Acute Condition Changes-Clinical Protocol, dated 1/25, indicated, . Treatment and Management . The physician will help identify and authorize appropriate treatments .If it is decided after sufficient review, that care of observation cannot reasonably be provided in the facility, the physician will authorize transfer to an acute hospital . Monitoring and Follow-Up The staff will monitor and document the resident/patient's progress and response to treatment, and the physician will adjust treatment accordingly. The physician<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056198 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kit Carson Nursing & Rehabilitation Center | 811 Court Street<br>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 0580<br>Level of Harm - Actual harm<br>Residents Affected - Few | will help the staff monitor a resident/patient with a recent acute change of condition until the problem or condition has resolved . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056198 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kit Carson Nursing & Rehabilitation Center | 811 Court Street<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and treatment in accordance with professional standards of practice for one of four sampled residents (Resident 2) when,1. The facility did not monitor Resident 2's fasting blood glucose (FSBS, measures the amount of sugar [glucose] in the blood, which serves as the body's main energy source) results before Resident 2 ate breakfast for 11 out of 13 days or ensure Resident 2 did not need further treatment to maintain safe blood glucose levels.This failure placed Resident 2 at risk for experiencing further health complications related to possible fluctuations in blood sugar (hyperglycemic [high blood sugar with can cause confusion and blurred vision] and/or hypoglycemic [low blood sugar which can cause rapid heartbeat, confusion, dizziness, headache and/or loss of consciousness]).Findings: 1. A review of Resident 2's clinical document titled, admission RECORD, indicated Resident 2 was admitted to the facility on [DATE] with diagnosis that included but were not limited to type 2 diabetes mellitus (DM Type 2 - a chronic condition where the body cannot properly use or make enough insulin, leading to high blood sugar levels), osteomyelitis (a serious infection within the bone, usually caused by bacteria or fungi), and non-pressure chronic ulcer of left heel and midfoot, (a long-lasting, slow-to-heal open sore on the back or middle part of the left foot, caused by underlying issues like poor circulation, diabetes, or nerve damage rather than direct pressure) and cellulitis of the left lower limb (a common, potentially serious bacterial infection of the deep layers of the skin and the tissue underneath on your left leg).A review of Resident 2's clinical document titled, Order Summary Report, dated 12/1/25 through 12/31/25 indicated on 12/24/25 Resident 2's physician had given the following order, FSBS before breakfast. In [sic] the morning for DM Type 2 Notify MD for BG [blood glucose] more than 200mg/dl (milligrams per deciliter - measure the concentration of a substance, commonly blood sugar within a specific volume of blood).A review of Resident 2's clinical document titled, Physician Progress Note, dated 12/30/25, indicated .Continue current diabetes management regimen. Monitor blood glucose levels closely to support wound healing.A review of Resident 2's clinical document titled, Care Plan Report, dated 12/31/25, indicated a focus problem of nausea [feeling sick to one's stomach] and vomiting with a corresponding goal that indicated, .Patient will have better control of BG in 14 days . Further review of the same document indicated there were no interventions that addressed how Resident 2 was to meet the goal for better control of BG in 14 days.A review of Resident 2's clinical document titled, MEDICAL NECESSITY - PHYSICIAN FOLLOW-UP VISIT NOTE, dated 1/1/26, indicated .Seen and examined today for follow-up of reported change in condition due to nausea/vomiting.ASSESSMENT & PLAN.Nausea/Vomiting Monitor frequency and tolerance of oral intake.Type 2 Diabetes Mellitus.Monitor blood glucose per facility protocol.A review of Resident 2's clinical document titled, MEDICATION ADMINISTRATION RECORD, (MAR, a document that contains the resident's list of ordered medications and pertinent lab values related to the medications ordered) dated 12/1/25 through 12/31/25, indicated there were no FSBS test done before breakfast on 12/24/25, 12/25/25, 12/27/25, 12/29/25, 12/30/25, and 12/31/25. A review of Resident 2's clinical document titled, MEDICATION ADMINISTRATION RECORD, dated 1/1/26 through 1/31/26, indicated there was no FSBS test done before breakfast on 1/1/26, 1/2/26, 1/3/26, 1/5/26, and 1/6/26, and there was a blood glucose result of 256 mg/dl (high result, normal fasting blood glucose is 70 and 100 mg/dl) documented on 1/6/26 at 8:30 AM.During a concurrent interview and record review on 2/20/26 at 3:24 PM with LN 2, Resident 2's Order Summary Report, dated 12/1/25 through 12/31/25; MAR, dated 12/1/25 through 12/31/25 and 1/1/26 through 1/31/26; and Blood Sugar Summary, dated 12/24/25 through 1/6/26 documents were reviewed. LN 2 confirmed that Resident 2 had a physician's order that<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056198 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kit Carson Nursing & Rehabilitation Center | 811 Court Street<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | started on 12/24/25 to check Resident 2's blood sugar levels before breakfast to report any results that were greater than 200mg/dl to Resident 2's physician. LN 2 stated that the blood glucose results were supposed to be checked and documented in Resident 2's clinical record. LN 2 confirmed Resident 2's blood sugar checks (before breakfast) had not been completed for 11 out of 13 days from 12/24/25 through 1/6/26. LN 2 stated that the risk of not checking and assessing the results of the blood sugar placed Resident 2 at risk for hyperglycemic or hypoglycemic episodes that if left unidentified and untreated, placed Resident 2 at risk for serious health complications.During a concurrent interview and record review on 2/25/26 at 2:24 PM with the DON, Resident 2's Order Summary Report, dated 12/24/25 for FSBS checks, Resident 2's MAR, and the Blood Sugar Summary results from 12/24/25 through 1/6/26 were reviewed. The DON stated breakfast trays were delivered between 7:00 AM and 8:00 AM. The DON confirmed that on 1/6/26, Resident 2's blood glucose was 256 mg/dl, the physician was not notified, and no treatment was administered for hyperglycemia. The DON also verified 11 of 13 missing FSBS tests between 12/24/25 through 1/6/26. The DON stated the lack of interventions for the elevated blood glucose result and lack of FSBS placed Resident 2 at risk for further health complications related to fluctuations in Resident 2's blood sugar.During a review of the facility's P&P titled, Obtaining a Fingerstick Glucose Level, dated 1/25, the P&P indicated, .The licensed nurse performing this procedure should record the following information in the resident's medical record.The blood sugar results.Report results outside of physician ordered parameters promptly to the supervisor and the physician.and professional standards of practice.A review of the facility's P&P titled, Acute Condition Changes-Clinical Protocol, dated 1/25, indicated, . Treatment and Management . The physician will help identify and authorize appropriate treatments .If it is decided after sufficient review, that care of observation cannot reasonably be provided in the facility, the physician will authorize transfer to an acute hospital . Monitoring and Follow-Up The staff will monitor and document the resident/patient's progress and response to treatment, and the physician will adjust treatment accordingly. The physician will help the staff monitor a resident/patient with a recent acute change of condition until the problem or condition has resolved . |