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	03/17/2026

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 observation, interview, and record review, the facility failed to implement one of three sampled residents' (Resident 3's) care plan when Resident 3 experienced two episodes of brief loss of consciousness (LOC - fainting or passing out) on 3/17/26 and his care plan interventions to monitor V/S (vital signs-blood pressure, heart rate, breathing, and temperature) and O2 sats (oxygen saturation - oxygen levels in the blood), to place him in a supine position with legs elevated (laid flat with legs raised to help blood flow to the brain), nursing assessment, and physician notification after the first episode of LOC were not implemented.This failure resulted in another episode of brief LOC and placed Resident 3 at risk for falls, serious injury, worsening condition, and delayed medical intervention.Findings:A review of Resident 3's admission RECORD, indicated Resident 3 was admitted to the facility with diagnoses which included hypertension (high Blood Pressure), multiple segmental thrombotic pulmonary emboli (blood clots in the lungs), cerebral infarction (stroke), aphasia following cerebral infarction (difficulty speaking after a stroke), muscle weakness, and facial weakness.During a concurrent observation and interview on 3/17/26 at 10:43 AM with Resident 3's family member (FM) in Resident 3's room, Resident 3 was in a wheelchair next to the bed and a PTA (Physical Therapy Assistant) was holding Resident 3's wheelchair from behind when Resident 3 experienced a brief episode of LOC. At 10:44 AM, Resident 3 regained consciousness and attempted to vomit. CNA (Certified Nursing Assistant) 1 attempted to obtain Resident 3's V/S using a wrist blood pressure (BP) monitor but was unable to obtain a reading. CNA 1 left Resident 3's room to call for a Licensed Nurse (LN). At 10:46 AM, LN 1 entered Resident 3's room and stated he had just returned from lunch break, then left Resident 3's room without assessing Resident 3. At 10:47 AM, CNA 1 again attempted to obtain Resident 3's BP using the wrist BP monitor and was unable to obtain a reading. At 10:49 AM, CNA 1 obtained a BP reading of 120/60. At 10:51 AM, LN 1 returned to Resident 3's room and assessed Resident 3 using a stethoscope (a device used to listen to the heart and lungs). The FM stated this was the second episode of LOC on 3/17/26. The FM stated that during the first episode in the rehabilitation (rehab.) room at approximately 10:00 AM, no nurse came when staff left to look for one. The FM stated Resident 3 regained consciousness and staff had him resume PT (physical therapy) without monitoring his V/S.During an interview on 3/17/26 at 12:30 PM with the PTA, the PTA stated that Resident 3 had two episodes of LOC on the morning of 3/17/26. The PTA stated the first episode of LOC lasted about 30 seconds occurred in the rehab. room while Resident 3 was standing using parallel bars for PT. The PTA stated that during Resident 3's first episode of LOC, the PTA laid Resident 3 on a fall mat, and another rehab staff member left the room to look for LN and returned stating that LN could not be found. The PTA stated Resident 3 was already awake when the rehab staff member returned. The PTA stated he continued the mat program (exercises performed while lying down) with Resident 3 without checking his V/S. The PTA further stated no nursing staff came to evaluate Resident 3. The PTA stated continuing PT without a nurse's evaluation after a LOC episode could worsen Resident 3's condition and this was a safety concern.During an interview on 3/17/26 at 12:42 PM with LN 1, LN 1 stated that he did not receive any notification regarding Resident 3's first episode of LOC on the morning of 3/17/26. LN 1 stated that if he was on break, (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other nurses were available to cover for him, including the Minimum Data Set nurse (MDS - a nurse who assesses residents and helps plan their care), treatment nurse, and the Director of Nursing (DON). LN 1 stated during Resident 3's assessment, Resident 3 appeared pale, cold to touch, and sweaty. LN 1 stated that Resident 3 and the FM requested transfer to the hospital and LN 1 texted the physician at 11:28 AM. LN 1 stated he notified the physician more than 40 minutes after Resident 3's second episode of LOC. LN 1 stated that this delay in physician notification, especially given Resident 3's LOC, paleness, cold to touch, and sweating could result in worsening of Resident 3's condition and another episode of LOC. During an interview on 3/19/26 at 10:45 AM with the Director of Rehabilitation (DOR), the DOR stated that when Resident 3 had an episode of LOC in the rehab room on 3/17/26, the BP was not taken despite a BP machine being available in the rehab room which was a safety concern for Resident 3. The DOR stated that rehab staff should not have resumed Resident 3's PT after the LOC episode without a nursing assessment, as doing so could worsen Resident 3's condition and could lead to another episode of LOC or a fall. The DOR stated that if the assigned nurse was not available, another nurse, such as the MDS nurse, should have been called to assess Resident 3. The DOR further stated that assessing a resident's clinical condition was not within the scope of practice of the rehab staff. The DOR stated she expected rehab staff to implement Resident 3's care plan for LOC. The DOR further stated that continuing PT after an episode of LOC without a nursing clinical assessment could worsen Resident 3's condition, could lead to a fall with serious injury, hospitalization, or death. During a concurrent interview and record review on 3/19/26 at 10:50 AM with the DON, Resident 3's care plan initiated on 3/13/26 was reviewed. Resident 3's care plan indicated, .Focus.[Resident 3] Episode of brief loss of consciousness.Interventions.Assessment of resident [Resident 3].Monitor for further syncopal (fainting) episodes as ordered.Monitor V/S and O2 sats as ordered.Notify the MD [medical doctor] for COC [change of condition - any decline or change in health status].Place patient [Resident 3] supine with legs elevated. The DON stated Resident 3's care plan for brief LOC was not implemented when Resident 3 had an episode of LOC in rehab during PT and a licensed nurse was not notified to assess Resident 3, his V/S and O2 sats were not monitored, the MD was not notified, and Resident 3 was not placed in a supine position with legs elevated as per his care plan. The DON stated that failure to implement Resident 3's care plan for LOC resulted in a lack of appropriate interventions during the LOC episodes, which resulted in a repeated episode of LOC and hospitalization, and placed Resident 3 at risk for falls, serious injury, and delayed medical intervention. The DON further stated that a timely nursing assessment and prompt physician notification by nursing staff were expected, as LOC was an urgent condition requiring timely medical management to prevent harm to Resident 3.Review of facility's policy and procedure (P&P), titled POLICIES AND PROCEDURE ON NURSING ASSESSMENT revised in 1/2025, the P&P indicated .M.D. will be made aware of assessment findings and every time a significant change of condition is noted for appropriate interventions and or order.Review of facility's policy and procedure (P&P), titled Change of Condition revised in 1/2025, the P&P indicated .It is the policy of this facility that all changes in resident condition will be communicated to the physician.Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit immediately and/or acute care evaluation. The licensed nurse in charge will notify the physician.Review of facility's policy and procedure (P&P), titled Care Plans, Comprehensive Person-Centered revised in 4/2025, the P&P indicated .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.reflects currently recognized standards of practice for problem areas and conditions.interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control practices for two of three sampled residents (Resident 1 and Resident 2) when soiled towels were left on the floor of the shared bathroom used by Resident 1 and Resident 2 for two days, creating a potential source of contamination.This failure had the potential to spread infection to Resident 1 and Resident 2 and cause health problems for residents in the facility.Review of Resident 1's admission Record indicated Resident 1 was admitted to the facility with multiple diagnoses including nonrheumatic aortic valve stenosis (narrowing of the heart valve that affects blood flow), chronic atrial fibrillation (irregular heart rhythm), atherosclerotic heart disease of native coronary artery (heart disease caused by plaque buildup in the arteries), hypertensive urgency (severely elevated blood pressure), presence of cardiac pacemaker (a device that helps control heart rhythm), chronic kidney disease stage II (mild to moderate kidney damage), and dementia (a condition affecting memory and thinking).Review of Resident 2's admission Record indicated Resident 2 was admitted to the facility with multiple diagnoses including cerebral infarction (stroke caused by lack of blood flow to the brain), chronic atrial fibrillation (irregular heart rhythm), peripheral vascular disease (poor blood circulation in the limbs), hypothyroidism (underactive thyroid gland), sick sinus syndrome (irregular heartbeat due to a malfunction of the heart's natural pacemaker), presence of cardiac pacemaker (a device that helps control heart rhythm), and alcohol use.During a concurrent observation and interview on 3/17/26 at 11:30 AM in room [ROOM NUMBER], room [ROOM NUMBER] was observed to have a shared bathroom which was used by Resident 1 and Resident 2. Resident 2 was lying in her bed with a clear view of the bathroom and the bathroom door was left open. Multiple used towels were piled on the floor under the bathroom sink. Resident 2 stated the towels were dirty because she used them for cleaning herself. Resident 2 stated she did not know where to place the used towels and left the used towels under the sink, where the used towels had remained for two days. Resident 2 stated staff was expected to pick up the used towels. Resident 2 further stated used towels should not be left on the floor because molds (a type of fungus that grows in damp areas) and bacteria (germs that can cause infection) could grow. Resident 2 stated it was unclean to leave the used towels on the floor in the shared bathroom and could spread infection.During an interview on 3/17/26 at 11:38 AM with Resident 1, Resident 1 stated that he did not like used towels on the floor because he might accidentally use them.During an interview on 3/17/26 at 11:55 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNAs were expected to ensure residents' rooms were clean and that towels should not be left on the floor. CNA 1 further stated soiled towels left on the floor created an infection control concern, especially if another resident used them.During a concurrent observation and interview on 3/17/26 at 11:58 AM with Licensed Nurse (LN) 1 in room [ROOM NUMBER]'s bathroom, LN 1 confirmed a pile of towels left on the bathroom floor under the sink. LN 1 stated towels should not be placed on the floor. LN 1 further stated that if towels were soiled, staff should place the towels in a plastic bag, close the bag, and place it in a laundry bin outside the room to prevent contamination and the spread of infection.During an interview on 3/17/26 at 1:25 PM with the Infection Prevention Nurse (IP), the IP stated that when a resident used a towel, staff were expected to ensure used towels were not placed on the floor. The IP further stated used towels should be placed in a plastic bag, closed, and placed in the soiled bin because they may contain hazardous material (body fluids or substances that can carry germs), to prevent the spread of infection.During an interview on 3/17/26 at 1:59 PM with the Director of Nursing (DON), the DON stated that used towels left on the floor could harbor germs and microorganisms (tiny living organisms) and could serve as a source for the spread of infection. The DON further stated staff were expected to place used towels in a bag, close the bag, and transport it outside the room to the soiled bin for laundry to prevent contamination from body fluids.Review of facility's policy and procedure (P&P), titled Infection (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevention and Control Program revised in 1/2026, the P&P indicated, .An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Prevention of Infection.educating staff and ensuring that they adhere to proper techniques and procedures.