STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/30/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide quality care and services as per professional standards of practice for one of four sampled residents (Resident 4), when:1a. Facility staff did not assess, notify physician, and treated Resident 4 when she had abdominal pain and did not have a bowel movement for 3 days from 12/14/25 to 12/16/25, from 12/20/25 to 12/22/25, and for 6 days from 12/30/25 to 1/4/26 and had multiple bowel movements of foul odor,b. Licensed Nurses did not completely assess, address, and notify physician of Resident 4's change in condition of abdominal tenderness, increased weakness, and progressive decline in ADL (Activities of Daily Living) when Resident 4 was no longer able to shower herself on 2/5/26, dress herself on 2/6/26 and transfer herself on 2/7/26,c. Infection Preventionist (IP) did not complete a comprehensive assessment of Resident 4 when she had a change in condition on 2/10/26 with sign and symptoms including diarrhea, being in fetal position holding stomach, and decreased oral intake, and the IP did not inform the physician of Resident 4's entire condition, andd. A Registered Nurse (RN) did not assess Resident 4 when Resident 4 had a change in condition on 2/5/26 and 2/10/26, and Resident 4's weekly summary assessments were not completed on 12/10/25, 12/17/25, 12/24/25, 12/31/25, 1/21/26, 1/28/26, and 2/4/26.These failures resulted in Resident 4 requiring transfer to the hospital for evaluation and treatment of a worsening condition, where subsequent documentation indicated findings including perforated sigmoid colon (a medical emergency where a hole forms in the lower part of the colon, allowing fecal matter and bacteria to leak into the abdominal cavity) requiring surgical intervention and a hospital course complicated by septic shock and Resident 4 died on 2/25/26. Findings:1a. Review of Resident 4's admission Record, indicated Resident 4 had multiple diagnoses including but not limited to constipation, muscle weakness and chronic kidney disease (a condition where the kidneys do not filter blood properly).During an interview on 3/4/26 at 12:59 PM with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 4 frequently complained of abdominal pain, which she reported to the assigned nurse. CNA 2 stated she reported Resident 4's complaints of abdominal pain to the assigned nurse and was told Resident 4 would be given medications. CNA 2 stated that when she re-reported continued complaints of pain, she was told the nurse would follow up with Resident 4 and described the situation as repetitive and not fully addressed by nursing staff. CNA 2 stated that during Resident 4's last week in the facility before hospital transfer, Resident 4 had decreased oral intake, progressing from approximately 80% of meals to minimal intake, with occasional sips of fluids. CNA 2 further stated Resident 4 experienced ongoing gastrointestinal (GI, related to the stomach and intestines) symptoms, including intermittent diarrhea lasting approximately 2-3 days at a time, nausea, and abdominal pain. During an interview on 3/4/26 at 4:37 PM with CNA 4, CNA 4 stated Resident 4 frequently complained of abdominal pain and would point to the mid-abdominal area when reporting discomfort. CNA 4 stated she consistently notified the assigned nurse when Resident 4 complained of pain, as Resident 4 would request pain medication; however, she was not aware of the specific medications administered. CNA 4 stated Resident 4 was typically independent with toileting but observed an increase in bathroom use. CNA 4 stated Resident 4 reported abdominal pain during these episodes and that Resident 4's bowel movements had foul (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 0684 Level of Harm - Actual harm Residents Affected - Few	odor. CNA 4 stated she reported these observations to the assigned nurse. During a concurrent interview and record review on 4/15/26 at 1:49PM, Resident 4's Bowel Movement (BM) records titled Follow Up Question Report for the month of December 2025, January 2026, and February 2026 were reviewed with the DON (Director of Nursing). The DON verified record indicated Resident 4 had four BMs on 12/12/25, twice of soft consistency and other two times of dry/hard consistency. The DON verified further record review indicated Resident 4 had no BM for 3 days from 12/14/25 to 12/16/25, had two BMs on 12/17/25, one time of soft consistency, and once of loose/liquid consistency. The DON confirmed further record review indicated Resident 4 had no BM for 3 days from 12/20/25 to 12/22/25 and then had a loose/liquid BM on 12/23/25 and did not have a BM for six days from 12/30/25 to 1/4/26. The DON stated if CNAs would have reported that it was not Resident 4's normal bowel pattern, then they could have applied a bowel regimen (a structured plan using lifestyle adjustments, fiber, and laxatives to prevent or treat constipation, especially for those on pain medication or following surgery) and notify the physician.During a concurrent interview and record review on 4/14/26 at 2:24PM, the DON verified Resident 4's Bowel Movement (BM) records titled Follow Up Question Report for the month of December 2025, January 2026, and February 2026, indicated Resident 4 did not have a recorded BM on 12/3/25, 12/4/25, 12/6/25, 12/7/25, 12/14/25 to 12/16/25, 12/20/25 to 12/22/25, 12/27/25, 12/30/25, 12/31/25, 1/1/26, 1/2/26, 1/3/26, 1/4/26, 1/7/26, 1/8/26, 1/13/26, 1/15/26, 1/16/26, 1/19/26, 1/21/26, 1/22/26, 1/25/26, 1/26/26, and 1/29/26. The DON stated she expected CNAs to notify the Licensed Nurse(LN) when a resident didn't have a BM for 2-3 days, then LN should check with resident, assess for constipation, complete thorough assessment of abdomen including percussion (a diagnostic technique used to assess the size and density of the structures and organs inside of the abdominal cavity, and to detect the presence of air, fluid and masses), listen to bowel sounds to assess if resident really constipated so they could inform the doctor appropriately of resident condition. The DON confirmed there was no documentation in Resident 4's change of condition and progress notes indicating if Resident 4 was assessed, physician was notified or any interventions were taken when Resident 4 did not have a recorded BM for 3 days from 12/14/25 to 12/16/25, from 12/20/25 to 12/22/25, and for 6 days from 12/30/25 to 1/4/26. The DON stated staff should have assessed Resident 4 when she did not have a BM for 2 or more days in December 2025 and January 2026., The DON added staff should have notified the physician and start her on a bowel regimen per physician order. The DON stated Resident 4 did not have a recorded BM on multiple days in December 2025 and January 2026. The DON stated it was important to assess a resident when had no BM for 2 or more days and notify the physician so they could find out if resident was constipated, was not eating or drinking enough, had GI (Gastrointestinal tract) issues. The DON stated untreated constipation could lead to a lot of issues including GI issues, discomfort, reduced appetite, blockage, and infection. The DON added that a lot of elders (individuals aged 65 and older) were needed to be encouraged to hydrate. The DON stated they had standing bowel regimen orders from the physician that physician ordered when notified of a resident's BM issues. The DON verified none of those bowel regimens were implemented for Resident 4. The DON stated foul odor was not a normal characteristic of BM. The DON stated if staff noted a resident had a BM with foul odor, then they should notify the physician. The DON verified Resident 4's BM characteristic records titled Follow Up Question Report for the month of December 2025, January 2026, and February 2026, indicated staff documented Resident 4 had a BM with foul odor twice on 12/1/25, 12/8/25, 12/11/25, 12/12/25 and once on 12/10/25, 12/13/25, 12/18/25, 12/26/25, 12/28/25, 1/6/26, 1/9/26, 1/10/26, 1/11/26, 1/23/26, 1/24/26, 1/28/26, 1/30/26, 2/2/26, 2/5/26, 2/6/26, 2/9/26, 2/10/26, and 2/11/26. The DON stated, It's all foul odor. The DON stated she expected staff to notify the physician if a resident had a BM with foul odor. The DON verified there was no documentation in Resident 4's progress note that the physician was notified of Resident 4's recorded foul odor BM characteristics. The DON confirmed on rest of the days when Resident 4 had a BM, staff recorded BM characteristic as other. The DON stated she did not know what did other mean.During an (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	interview on 3/30/26 at 2:25PM, CNA 5 stated it was not normal for Resident 4 to not have a BM for 3 days, she was very consistent. CNA 5 stated they would record BM characteristics as other when a resident had a BM of other color, had blood in stool or was not normal bowel movement that they needed to report to the nurse right away. During a concurrent interview and record review on 3/30/26 at 10:30 AM, Licensed Nurse (LN) 2 stated Resident 4 experienced multiple days without a BM and did not know if it was normal for Resident 4. LN 2 stated registry CNAs often did not inform nurses when residents had no BMs, causing nurses to miss information like that. LN 2 stated if a resident had no BM for 3 days, then nursing should assess the resident and initiate bowel regimen. LN 2 verified that there was no record that it occurred for Resident 4. LN 2 stated Resident 4 did not have a bowel regimen. LN 2 stated Resident 4 should have been on bowel regimen especially since she was on tramadol (a medication used for pain with possible side effects including constipation).During a concurrent interview and record review on 3/30/26 at 2:59PM, the Infection Preventionist (IP) stated Resident 4 did not have a BM for multiple days in January. The IP stated he would be concerned if a resident did not have a BM for 2 days and staff should offer more fluids, check for constipation and assess for impaction (a severe, solid mass of hardened stool stuck in the rectum due to chronic constipation, preventing normal defecation causing symptoms of severe abdominal cramping, inability to pass stool, and liquid leakage). The IP verified Resident 4 did not have a bowel regimen in place. The IP stated he was surprised that Resident 4 did not have a bowel regimen even though she received tramadol.1b. Review of Resident 4's SBAR (Situation-Background-Assessment-Recommendation: a communication mechanism used as a tool for framing any conversation, especially critical ones such as change in resident's condition, requiring a clinician's immediate attention and action) record dated 2/5/26, indicated, .SITUATION.Resident states I am to [sic] weak to shower by myself now. I need assistance. Lower back and abdominal pain. Resident moving slower.Blood Pressure: 116/48.Functional Status Changes 2a. ˆ Decreased mobility 2b. ˆ Needs more assistance with ADLs[Activities of Daily Living].Abdominal/GI Evaluation. ˆ Abdominal tenderness. APPEARANCE.Resident states she can no longer shower by herself. She is requesting ADL assistance because she feels weaker. She has chronic pain in lower back. Takes PRN[as needed] Tramadol 50mg and Tylenol Arthritis.Resident requesting to see [Physician name] to discuss her health the next time he is here for rounds. Further review indicated physician notified and awaiting for orders. Review of Resident 4's Nurses Progress Note dated 2/5/26 at 9:50 AM, indicated, .Resident states she is unable to shower by herself now and is requesting assistance during her showers. States she feels weaker. Decrease In ADL function. Has Chronic pain. PRN tramadol given at 0740 this morning for 5/10 lower back pain. States she would like to see Dr. [Name] the next time he is here for rounds. Non emergent left for Dr. [Name]. COC [Change of Condition] completed.Review of Resident 4's Nurses Progress Note dated 2/5/26 at 10:19 PM, indicated, .Alert. O[Oriented] x[times] 3. Verbal to needs. Monitored: ADL Decline. Resident insists needs help with Showers. Other ADLs remain unchanged. Resident fully participates.Review of Resident 4's Nurses Progress Note dated 2/6/26 at 4:10AM, indicated, .Monitored for decline in ADL abilities. Resident states/requesting help with showers, assist in getting dressed. Assistance provided by CNA as requested by resident. Further review of this record failed to show the physician was notified of Resident 4's progressed decline in getting dress.Review of Resident 4's Nurses Progress Note dated 2/6/26 at 10AM, indicated, . Resident states she needs help with showers now when she normally is able to take them on her own. She states she needs help getting dressed as well. She feels weaker. Assistance provided by CNA as requested by resident.Review of Resident 4's Nurses Progress Note dated 2/7/26 at 3:12AM, indicated, .monitored for ADL decline. Continues with increased weakness in transfers and need assistance to dress and ADL care. Further review of this record failed to show that Resident 4's progressive decline in ADLs of increased weakness in transfers was escalated to the physician.During a concurrent interview and record review on 3/30/26 at 10:30 AM, LN 2 stated, .non emergent left for MD. COC completed in Resident 4's SBAR dated (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	documented in SBAR on 2/5/26 that non-emergent left for physician. The DON verified SBAR on 2/5/26 indicated decline in showers and moving slower but did not indicate decline in dressing and transfer. The DON stated if a resident was getting worse progressively during the 72-hour monitoring then staff should notify the physician that the resident was getting worse.1c. Review of Resident 4's SBAR dated 2/10/26 indicated, .SITUATION.Resident experiencing diarrhea 2x a day and requested something to stop it.This started on: 02/09/2026.Abdominal/GI Evaluation. ˆ Diarrhea.APPEARANCE.Resident laying in fetal position holding stomach asking me if she could get something to help her stop having diarrhea.Review of Resident 4's Nurses progress note date 2/10/26 at 1:28PM, indicated, Resident was experiencing diarrhea 2x during the day and requested something to stop it. MD [Name]Notified. New order of imodium [medication used to stop diarrhea] 2mg tid [three times a day] PRN for 3 days added. Further review of this record failed to show that the physician was notified of Resident 4 being laying in fetal position holding her stomach. During a concurrent interview and record review on 3/30/26 at 2:59 PM, the IP stated he completed Resident 4's SBAR on 2/10/26. The IP stated he informed the physician that Resident 4 was experiencing diarrhea and requested medication to stop it and obtain an order for imodium. The IP stated he did not inform the physician that Resident 4 was in a fetal position holding her abdomen. The IP stated he did not obtain a new set of vital signs and instead added vital signs taken earlier in the morning in the SBAR report. The IP further stated he did not assess Resident 4, did not palpate her abdomen, did not auscultate bowel sounds, and did not assess Resident 4's pain level, which he stated was the reason no pain assessment was documented in the SBAR. The IP stated he did not assess Resident 4 for additional signs or symptoms because Resident 4 was alert and oriented and he relied on her report. The IP stated he received physician's order for Imodium 2mg on 2/10/26 but did not administer the medication. The IP stated he believed he endorsed the information to the oncoming nurse. The IP confirmed imodium was administered to Resident 4 the next day on 2/11/26 at 7:30 AM. The IP further stated that as needed pain medication was not administered or considered on 2/10/26, and no documentation was identified during review that Tramadol or Tylenol was administered at or around the time the SBAR was completed. Resident 4's meal intake record from 2/9/26 to 2/11/26 was reviewed with the IP. The IP verified that on 2/9/26 Resident 4 refused breakfast, consumed approximately 20% of lunch, and had no documented dinner intake, on 2/10/26, Resident 4 refused breakfast, with documentation indicating 100% total by category, which the IP reported was unclear, and Resident 4 refused lunch with no dinner intake documented, and on 2/11/26, Resident 4 refused breakfast. The IP confirmed that review of Resident 4's nurses progress notes for 2/9/26 through 2/11/26 did not include documentation of an assessment related to decreased intake. The IP stated a comprehensive assessment was not completed considering Resident 4's decreased intake, ADL decline, weakness, abdominal pain and diarrhea. The IP added based on Resident 4's presentation her signs and symptoms might have been related to gastrointestinal issues. During a concurrent interview and record review on 4/14/26 at 2:24PM, the DON stated she expected the CNAs to notify the nurse if a resident refused a meal or had decreased intake, then they should report it to the nurse, and the license nurse was expected to assess the resident and notify the doctor. The DON added if it was a single occurrence then staff should encourage the resident, assess their food preferences but if resident kept refusing meals or eating less than normal for multiple days like over 2-3 days then that was already alarming and staff were to report to the physician. The DON stated if a resident was refusing meals or had decreased intake and the nurse did not assess the resident then resident would have poor nutrition and could affect resident's health. 1d. During a concurrent interview and record review on 4/15/26 1:49pm, the DON verified Resident 4's weekly assessments were not completed weekly. The DON verified only one weekly summary assessment was completed for Resident 4 for the month of December 2025 on 12/3/25. The DON confirmed only two weekly summaries were completed for Resident 4 for the month of January 2026 on 1/7/26 and 1/14/26 and there were no weekly summaries completed for Resident 4 for the month of February 2026. The DON stated nurse (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	was expected to complete weekly summary assessments every week on Wednesdays for Resident 4. The DON state a weekly summary assessment should have been completed on 12/10/25, 12/17/25, 12/24/25, 12/31/25, 1/21/26, 1/28/26, and 2/4/26 for Resident 4 and verified those were not completed. The DON stated resident's weekly summaries provided weekly progress of the resident such as how resident was doing, stable, it was one of the ways of monitoring resident as well. The DON stated when weekly summaries were not completed then resident would not be assessed or monitored weekly. The DON stated weekly summary assessment included the assessment of resident's status including weight, skin, mental status, bowels, eating, feeding, dietary, dressing, hygiene, ADLs, medications, fluids. The DON added it was actually comprehensive assessment, continuation of checking of resident's baseline. The DON stated if staff noticed any changes in resident status during weekly summary assessment, then they would complete a COC, notify the physician, and implement interventions accordingly. The DON stated a Registered Nurse (RN) would assess the resident when had a COC. The DON stated Licensed Vocational Nurse (LVN) would observe and monitor the resident and inform RN of collected data and her assessment and then RN would assess the resident. The DON stated RN would sign off on COC assessment with LVN. The DON further stated there were two distinguish roles of these two LNs. The DON verified there was no record indicating RN assessed Resident 4 when she had COC on 2/5/26 and 2/10/26. The DON verified Resident 4's SBAR for COC on 2/5/26 and 2/10/26 was completed by the LVN and not RN. The DON stated an RN should have assessed Resident 4 after COC on 2/5/26 and 2/10/26. The DON stated there would have been different clinical assessment if an RN would have assessed Resident 4 because they had different scope of practice. During a phone interview on 3/4/26 at 2:01 PM with the MD, the MD stated he did not recall being informed of Resident 4 experiencing abdominal pain. The MD stated he believed Resident 4 had loose stools and did not recall reports of significant or unusual abdominal pain from the facility. Review of Resident 4's nurses progress notes dated 2/11/26 at 11:05AM indicated, Resident requesting to go to the hospital for increased weakness/fatigue, nausea, diarrhea. Recent potassium level of 6.6.Resident states she cannot drink the kayexalate [a prescription medication used to treat high blood potassium level] due to it making her nauseous. [MD] office contacted spoke with [MD's] assistant.New order from [MD's assistant] to send resident to the hospital for further evaluation and treatment. Review of Resident 4's nurses progress notes dated 2/11/26 at 11:40AM indicated, Resident left the facility via ambulance. Review of resident 4's hospital record titled HOSPITALIST H&P (History and Physical) dated 2/11/26, indicated, .CHIEF COMPLAINT: Pain abdomen, diarrhea and weakness.Resident 4.presents withabdominal pain, diarrhea and increasing weakness. Patient reports the symptoms started about 3 weeks ago with lower quadrant abdominal pain and diarrhea. Complains of dysuria [painful urination]. Symptoms gradually worsened with increasingly weakness so she came into the ED [Emergency department] for evaluation. Reports she had UTI [urinary tract infection] 3 weeks ago but her provider refused to give her Cipro [an antibiotic medication used to treat infection]. In the ED patient was found to be borderline hypotensive[low BP]. Blood work significant for leukocytosis [abnormally high white blood cell count indicative of infection], elevated CRP[C-reactive protein indicates inflammation in the body, commonly caused by infections], lactic acidosis [a serious, often fatal, medical condition characterized by the overproduction or underutilization of lactic acid], anemia [low blood count], thrombocytosis [high platelet count], metabolic acidosis [a buildup of acid in the body often due to kidney failure, severe dehydration], BUN/ creatinine 76/2.58 [significantly elevated Blood Urea Nitrogen and creatinine ratio]. UA[urinalysis] suggestive of UTI.CT [Computed Tomography scan] abdomen suggestive of colitis with possible microperforation [a tiny tear in the colon wall- a serious, potentially life-threatening medical condition]. Moderate to large stool in the colon proximal to the area of wall thickening likely due to constipation. surgery consulted. Review of Resident 4's hospital record titled Discharge Summary dated 2/25/26, indicated, .HOSPITALIST EXPIRATION SUMMARY.CAUSES OF DEATH: Perforated sigmoid colon [a medical emergency where a hole (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	develops in the lower part of the colon, allowing fecal matter and bacteria to leak into the abdominal cavity, causes include sever constipation].HOSPITAL COURSE: Patient initially presented with abdominal pain and elevated leukocytosis. CT abdomen and pelvis demonstrated concern for colitis [inflammation of the inner lining of the colon, often causing diarrhea, abdominal pain, fever, and rectal bleeding, causes include infection] with question of pneumatosis [abnormal presence of gas within the bowel wall], ischemic colitis [inflammation of the colon caused by reduced blood flow] not excluded. Patient was seen by surgery and was then status post exploratory laparoscopy with left colon resection [an invasive procedure to remove part of the left/sigmoid colon] and colostomy[a surgical procedure that creates an opening in the abdominal wall, connecting the colon to the outside of the body to allow stool to exit when the rectum or lower bowel is damaged or removed] on February 12th, with findings of perforated sigmoid colon with fecal contamination. She was placed on Levophed drip [a medication used in critical care to rapidly increase blood pressure in patients with severe low blood pressure, shock or cardiac arrest], and taken back to the OR[operation room] onFebruary 15, unfortunately was noted to have necrotic fascia with mucopurulent serosanguineous fluid [a life-threatening, rapidly progressing soft tissue infection that destroys the fascia (connective tissue) and subcutaneous fat, often referred to as flesh-eating disease] at that time. She was successfully extubated on February 16, initiated on peripheral nutrition, however has required Vapotherm [non-invasive ventilator used to treat respiratory distress] since then. Patient passed away on 0321 on 02/25. Review of a facility policy titled Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol, revised 1/2026, indicated nursing staff were to assess and document gastrointestinal symptoms, including a .quantitative and qualitative description of diarrhea (how many episodes.amount, consistency, etc). abdominal assessment, and onset, duration, frequency, and severity of signs and symptoms. The policy further indicated staff were to characterize symptoms, including location and nature of abdominal pain, and to monitor the resident's response and progression, including the frequency, severity, and duration of abdominal pain and bowel movements. Review of a policy titled Physician Notification, revised 1/2026, indicated licensed nursing staff were to promptly notify the physician of any significant change in a resident's condition, including changes in physical status such as pain, diarrhea, decreased intake, and abnormal laboratory results. The policy further indicated that if the physician did not respond within a reasonable timeframe, nursing staff were to notify an alternate physician. The policy indicated staff were to document all attempts to notify the physician, including, .date and time of physician notification. brief description of information communicated.and physician response. in the resident's clinical record. Review of a facility policy titled Change of Condition revised 7/2024, indicated, . It is the policy of this facility that all changes in resident condition will be communicated to the physician. PURPOSE To clearly define guidelines for timely notification of a change in resident condition for immediate intervention.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.All nursing actions/interventions will be documented in the licensed progress notes as soon as possible after resident needs have been met.All symptoms and unusual signs will be communicated to the physician promptly.Document resident change of condition and response in nursing progress notes, on Twenty-Four Hour Report and update resident Care Plan, as indicated. Review of a facility policy titled Licensed Nurses Notes revised 1/2025, indicated,.A nursing assessment shall be completed for each resident by a licensed nurse and coordinated with the Interdisciplinary Team.Changes in the resident's condition that require a telephone call to the physician shall be recorded by the nurse reporting. The physician shall be notified promptly, as well as the resident and the resident's personal representative or an interested family member (when appropriate), of the following events.Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a resident. All attempts to notify the physician shall be recorded in the resident's health record and shall include: date, time, name of the physician called, resident's condition, name of the person acknowledging contact, and the response to the call. Acute conditions of the resident shall have adequate follow-up notes concerni

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure that foods available were consistent with the physician-ordered diet for 1 of 1 sampled resident (Resident 1) who was prescribed a pureed diet (food that is blended until smooth, like mashed potatoes), mildly thick liquids (nectar-thick liquids - drinks that are slightly thicker than water to make swallowing safer) and a consistent carbohydrate (CCHO - a meal plan where the amount of carbohydrates is kept about the same at each meal) diet when a jar of peanut butter and jelly was available for consumption at Resident 1's bedside.This failure placed Resident 1 at risk for choking (when something blocks the airway and makes it hard or impossible to breathe), and aspiration (when food, liquid, or saliva goes into the lungs instead of the stomach), which could lead to serious complications such as airway obstruction, aspiration pneumonia (a lung infection caused by food, liquid, or saliva going into the lungs), or respiratory distress (difficulty breathing or not getting enough air).Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses of, but not limited to diabetes mellitus (a condition where the body cannot control blood sugar levels), anemia (a condition where the body does not have enough healthy red blood cells), atrial fibrillation (an irregular and often fast heartbeat), acute respiratory failure with hypoxia (a sudden and serious problem where the lungs cannot get enough oxygen into the blood), and chronic kidney disease (long term damage to the kidneys that makes them not work properly).A review of Resident 1's physician orders showed that Resident 1 was prescribed a pureed diet with mildly thick liquids and a consistent carbohydrate (CCHO) diet on 9/21/25.During a concurrent observation and interview on 3/4/26, at 10:18 AM, in Resident 1's room, a jar of Smucker's Goober Strawberry Peanut Butter & Jelly Stripes was observed on Resident 1's bedside table within reach. Resident 1 stated that he did not like the food served at the facility and confirmed that he had difficulty swallowing. Resident 1 stated that his wife usually brought white bread and a jar of peanut butter and jelly when she visited. Resident 1 stated that he sometimes ate the peanut butter and jelly directly from the jar without the bread. Resident 1 stated that he could grab the jar, open it, and eat it directly from the container. Resident 1 stated that he had been eating peanut butter and jelly this way since last year. Resident 1 stated that no one told him that eating peanut butter and jelly in this manner could be unsafe, despite his swallowing problem. Resident 1 also stated that he could not remember being evaluated by a speech therapist (ST - a healthcare professional who helps people with speaking, understanding, and swallowing) recently and reported that no one had recently checked his swallowing ability.During a concurrent observation and interview on 3/4/26, at 10:54 AM, with the Licensed Nurse (LN), the LN confirmed that a jar of peanut butter and jelly was present at Resident 1's bedside. The LN stated that Resident 1 was on a pureed diet with nectar-thick liquids. The LN stated that Resident 1 was sometimes non-compliant with his prescribed diet. The LN also stated that she had seen the resident eating peanut butter and jelly and did not observe any immediate problem but acknowledged that she was not sure whether it was safe for the resident to eat it. The LN confirmed that Resident 1 was on aspiration precautions due to swallowing problems. The LN also confirmed that safe swallowing precautions (safety steps to prevent food or liquid from going into the lungs) were posted at the head of the resident's bed.During an interview on 3/4/26, at 12:51 PM, with the Certified Nursing Assistant (CNA), the CNA stated that Resident 1 did not like the pureed food served by the facility, although staff still provided the resident's meal tray according to his prescribed diet. The CNA stated that she had seen Resident 1 eating peanut butter and jelly as a snack and had observed the jar of peanut butter and jelly at the resident's bedside. The CNA stated that she was not sure who brought the peanut butter and jelly to the resident. The CNA stated that she was aware that Resident 1 was sometimes non-compliant with his prescribed diet, but she was not aware of the resident's swallowing precautions. The CNA also stated that she did not know that peanut butter and jelly could be unsafe for the resident to eat due to his swallowing difficulty.During a concurrent interview and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review on 3/4/26, at 2:19 PM, with the Certified Dietary Manager (CDM), the CDM reviewed Resident 1's electronic health record (EHR) and stated that Resident 1 was on a CCHO diabetic dysphagia (difficulty swallowing) diet with pureed texture and nectar-thick liquids. The CDM stated that she was aware that Resident 1 did not like the pureed diet, and dietary staff had tried to offer substitutes, such as pureed soup, to encourage the resident to eat. The CDM stated that she was not aware that Resident 1 had been eating peanut butter and jelly. The CDM stated that peanut butter and jelly did not meet the resident's physician-ordered diet. The CDM explained that the peanut butter and jelly texture was thicker than nectar consistency and was not appropriate for Resident 1's swallowing diet. The CDM stated that she had two concerns: the food texture and the sugar content, noting that the peanut butter and jelly was not safe for the resident's swallowing condition and was not appropriate nutritionally for a resident on a CCHO diet. The CDM stated that a speech therapist should assess Resident 1 to determine if the peanut butter and jelly was safe to eat.During an interview on 3/4/26, at 3:20 PM, with the Director of Staff Development (DSD), the DSD stated that if Resident 1 was on pureed diet with nectar-thick liquids and the family brought peanut butter and jelly, staff should have followed the facility's Stop and Watch (a simple way for staff to notice and report early changes in a resident's condition) process. The DSD stated the CNAs should have reported the concern to the licensed nurse. The LN should have spoken with Resident 1 and assessed the resident's swallowing and safety. The DSD stated that staff should have notified the physician, documented the situation in the progress notes, and updated the care plan if needed. The DSD explained that these steps were important because Resident 1 had a risk for choking and aspiration due to swallowing problems. The DSD also stated that peanut butter and jelly could affect the resident's blood sugar because the resident had diabetes. The DSD stated that following these steps would help protect Resident 1's safety and could help prevent complications that might lead to hospitalization.During an interview on 3/4/26, at 3:59 PM, with the Director of Nursing (DON), the DON stated that she expected staff to follow the proper process when a resident did not follow the physician-prescribed diet. The DON stated that if Resident 1 was not following the ordered diet, the LN should complete an SBAR (a structured communication used to report a situation) and notify the physician and the resident's responsible party. The DON also stated that the IDT should review and discuss the situation with the resident and the resident's family or responsible party. The DON stated that the care plan should clearly address the issue, including the resident's use of peanut butter and jelly, to ensure the resident's safety and proper dietary management.During an interview on 3/5/26 at 11:07 AM with Resident 1's significant other (SO), the SO confirmed that she was the one bringing the peanut butter and jelly for the resident. The SO stated that she started bringing it about three months ago. The SO stated that if she did not bring the peanut butter and jelly, Resident 1 would not eat and would be starving. The SO explained that Resident 1 was a picky eater. The SO also stated that staff told her she could bring any food she wanted for the resident. The SO stated that she only wanted Resident 1 to eat something, and that peanut butter and jelly was what he wanted. The SO stated that she was aware that there could be safety concerns, but explained that she had continued bringing the peanut butter and jelly because he liked it and had been eating it for some time.During an interview on 3/5/26, at 2:42 PM, with the ST, the ST stated that she had not evaluated Resident 1 for quite some time. The ST stated that she was not aware that Resident 1 had been eating peanut butter and jelly directly from the jar without bread. The ST stated that no staff had shared this information with her. The ST stated that she had never tested or evaluated Resident 1's ability to safely swallow peanut butter and jelly. The ST explained that peanut butter requires caution for residents with swallowing problems because it can be thick and sticky. The ST stated that when family members bring food from outside, they should show the food to the licensed nurse first. The ST explained that nurses usually notify her in these situations, and they could contact her directly or report it to the Director of Rehabilitation so the issue could be reviewed. The ST stated that this process was important to help ensure the resident's safety. The ST stated that staff should have brought this situation to her (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attention. The ST also stated that if she had known that the family was bringing peanut butter and jelly, she would have contacted the family to discuss the situation. The ST explained that this would have been a good opportunity to educate the family about which foods were safe and which foods were not safe for the resident's swallowing condition. Review of an undated facility policy and procedure titled, [Name of facility] - Resident Food Preferences, indicated, POLICY: It is the policy of this facility that nutritional assessments will include an evaluation of individual food preferences. PROCEDURES: . The dietitian will discuss resident food preferences with the resident [Resident 1] when such preferences conflict with a prescribed diet. The clinical dietitian and nursing staff, assisted by the physician, will identify any nutritional issues or dietary restrictions that might affect the facility's efforts to accommodate resident [Resident 1] preferences. In conjunction with the physician, the dietitian or nursing staff will document reasons why restrictions are necessary and/or why the facility cannot accommodate resident [Resident 1] preferences.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff were available to meet resident needs on the evening shift of 2/21/26 for one of three sampled residents (Resident 2) when two certified nursing assistants (CNA) scheduled for the shift were unavailable, one having called off (CNA 8), and the second (CNA 9) leaving early without returning. No replacement staff were secured, and the facility was unable to produce accurate assignment documentation for the shift.This failure resulted in Resident 2, who was dependent on staff for toileting and always incontinent (no control of bowel and/or bladder), being left in a soiled condition for approximately two hours after activating the call light. This placed Resident 2 at risk for skin breakdown, infection, and loss of dignity. Findings: Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff were available to meet resident needs on the evening shift of 2/21/26 for one of three sampled residents (Resident 2) when two certified nursing assistants (CNA) scheduled for the shift were unavailable, one having called off (CNA 8), and the second (CNA 9) leaving early without returning. No replacement staff were secured, and the facility was unable to produce accurate assignment documentation for the shift.This failure resulted in Resident 2, who was dependent on staff for toileting and always incontinent (no control of bowel and/or bladder), being left in a soiled condition for approximately two hours after activating the call light. This placed Resident 2 at risk for skin breakdown, infection, and loss of dignity.Findings:During a review of Resident 2's admission Record, the record indicated diagnoses including constipation and Ogilvie syndrome (a condition characterized by severe abdominal distention and dilation of the colon). The record also indicated Resident 2 resided in room [ROOM NUMBER]A (Station 1).A review of Resident 2's Brief Interview for Mental Status (BIMS, an assessment tool) dated 12/22/25, indicated a score of 14, reflecting intact cognition (the ability to think, learn, remember, and make decisions necessary to manage daily life without significant impairment).During record review of Resident 2's Minimum Data Set (MDS, an assessment tool), Section GG, the record indicated Resident 2 was coded as .Dependent. for toileting and hygiene. Further review of the MDS, Section H, indicated Resident 2 was .Always incontinent. of bowel.During a concurrent observation and interview on 3/4/26 at 9:56 AM with Resident 2 in Resident 2's room, Resident 2 reported that on the evening shift of 2/21/26, a registry CNA (temporary or day-to-day personnel provided by a placement agency or registry to work in facilities, most commonly in healthcare) assigned to her left early and did not return for the remainder of the shift. Resident 2 was observed to become teary while recounting the event. Resident 2 stated she learned of the registry CNAs early departure from another CNA (CNA 6), who assisted her despite not being assigned to her care. Resident 2 stated she had a medical condition resulting in uncontrollable bowel movements, which she stated can be difficult to manage. Resident 2 stated that after becoming soiled, she activated her call light and waited approximately two hours before receiving assistance.During a review of the facility's NURSING STAFFING ASSIGNMENT AND SIGN-IN SHEET, dated 2/21/26, the document indicated that CNA 8 was assigned to group 1 (Rooms 1C-9A); however, the assignment sheet reflected that CNA 8 called in for the evening shift. The document indicated that CNA 9 signed the assignment sheet for Group 2 (Rooms 9B-15B, 24A-25A) for the same date. During an interview on 3/4/26 at 10:17 AM with the Director of Nursing (DON) and the Director of Staff Development (DSD), the DON stated the facility was aware of ongoing staffing challenges. The DON further stated the facility utilized registry staff to address staffing needs and indicated that current staffing practices impacted the delivery of care and required improvement.During an interview on 3/4/26 at 12:02 PM with Licensed Nurse (LN) 2, LN 2 stated she typically responded when Resident 2 activated the call light. LN 2 stated the facility utilized a call light monitoring system at the nurses' station and that staff were also able to identify activated call lights through indicators (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	located above resident room doors. LN 2 stated she had assisted Resident 2 on prior occasions. LN 2 stated that when staff called off and replacement staff were not available, staff work with available personnel and registry staff were utilized to meet staffing needs. LN 2 stated it was not ideal when only registry nursing staff were present, as additional time was required to orient registry staff to resident needs and unit processes. LN 2 further stated she had heard of occasions when only registry nursing staff were present in the facility without regular staff.During an interview on 3/4/26 at 12:59 PM with CNA 2, CNA 2 stated that when regular staff were not present, registry staff provided care, and she had observed differences in the consistency of care provided. CNA 2 stated that upon returning to work, she needed to address resident care needs that were not completed during prior shifts by registry CNAs. CNA 2 further stated that the registry staff might be less familiar with resident-specific care needs due to the temporary nature of their assignments.During an interview on 3/4/26 at 1:47 PM with the DSD, the DSD stated the facility had been transitioning away from allowing regular staff to work overtime, resulting in increased reliance on registry staff to meet staffing needs. The DSD stated CNAs and licensed nursing staff were frequently obtained through registry agencies. The DSD stated it was difficult to replace staff when call-offs occurred and that registry staff were utilized to fill vacancies. The DSD stated residents preferred care from regular staff due to familiarity and continuity. The DSD stated efforts were made to maintain sufficient staffing levels across shifts, however, when staff called off or were unable to complete full shifts, staffing levels might be reduced. During an interview on 3/4/26 at 2:24 PM with CNA 6, CNA 6 stated that on the evening of 2/21/26, she observed that call lights were not consistently answered and became aware of multiple unanswered call lights at times. CNA 6 stated that while walking down the hallway, she observed an activated call light for Resident 2 and responded, even though Resident 2 was not assigned to her. CNA 6 stated she found Resident 2 crying and in a soiled condition and she reported she had been waiting approximately two hours for assistance. CNA 6 stated Resident 2's skin appeared red when she changed her brief (adult underwear used for a lack of control of bowel and bladder).During a concurrent interview and record review on 3/4/26 at 4:47 PM with the Infection Preventionist (IP), the IP reviewed the NURSING STAFFING ASSIGNMENT AND SIGN-IN SHEET and confirmed that CNA 8 called in on 2/21/26, as documented. The IP stated that during staff shortages, CNAs might divide resident assignments among themselves to provide coverage.During a concurrent interview and record review on 3/4/26 at 4:54 PM with the DSD, the DSD stated that based on her recollection, CNA 9 left the facility early during that shift, resulting in reduced staffing on the unit. The DSD stated CNA 9 was a registry staff member obtained through an external staffing agency. During a concurrent phone interview and record review on 3/25/26 at 1:19 PM with the DON and DSD, the DSD stated the facility did not have documentation reflecting CNA staff assignments for Groups 1 & 2 after two of the scheduled staff were unavailable on 2/21/26. The DSD stated that when scheduled staff called in or left early, the facility process was to reassign residents by regrouping CNA assignments, which might be completed by the DSD or delegated to available staff, including in-house CNAs. The DSD stated that the nurse supervisor or floor nurse would have been responsible for staff assignment during that shift. The DSD stated she was responsible for coordinating staffing needs, including contacting staff and registry agencies when call-ins occurred, and stated communication might occur through group messaging for urgent staffing requests. During a concurrent interview and record review on 3/30/26 at 8:40 AM with the Human Resources/Maintenance Director (MAT), the MAT reviewed the NURSING STAFFING ASSIGNMENT AND SIGN-IN SHEET, and confirmed that CNA 8, from a registry agency, called in on 2/21/26 for the evening shift and stated a replacement staff member for CNA 8 was not identified. The MAT similarly confirmed that CNA 9, also from a registry agency, signed the NURSING STAFFING ASSIGNMENT AND SIGN-IN SHEET, on 2/21/26; however, CNA 9 left the facility early, and did not clock in or out, and a replacement staff member for CNA 9 was also not identified. The MAT confirmed documentation did not reflect CNA assignments for group 1 (rooms 1C-9A) and group 2 (rooms 9B-15B and 24A-25A) for the evening shift (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of 2/21/26, and there was no additional documentation reflecting staff regrouping to care for the residents in group 1 and group 2 after scheduled staff were unavailable. During a review of the facility policy titled Staffing, Sufficient and Competent Nursing, revised on 1/2026, the policy indicated the facility .provides sufficient numbers of nursing staff with he appropriate skills and competency necessary to provided nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. the policy further indicated that licensed nurses and certified nursing assistants are available .24 hours a day, seven (7) days a week to provide competent resident care services. including .responding to resident needs. and .assuring resident safety. The policy also stated that .staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment. and that staffing considerations include resident conditions, limitations and acuity.During a review of the facility's policy titled CALL LIGHT/BELL revised on 1/2026, the policy indicated the facility provides residents .a means of communication with nursing staff. the policy further indicated staff to .answer the call light within a reasonable time (3 - 5 minutes). and to .respond to the request.During a review of an undated facility's policy and procedure titled Registry / Agency Staff Utilization Policy, the policy indicated the facility ensures registry or agency personnel .utilized to supplement staffing meet federal, state, and facility regulatory requirements, possess appropriate qualifications, and adhere to the facility's standards of care, policies, and procedures. The policy further indicated that .registry personnel shall be used when necessary to maintain safe staffing levels and resident care standards. and that registry staff receive .orientation, supervision, and performance monitoring while working at the facility. The polity also indicated registry personnel must .follow all facility clinical protocols and documentation requirements. and are accountable for .accurate documentation.During a review of the facility's policy titled Resident Rights, revised on 1/2026, the policy indicated employees shall treat residents .with kindness, respect, and dignity. the policy further indicated residents have the right to .a dignified existence. and to .be treated with respect, kindness and dignity.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure medications were administered in accordance with professional standards of practice for one of four sampled residents (Resident 2), when a prescribed anticoagulant (medication used to prevent blood clots) was administered outside the facility's acceptable time frame due to staff's inability to locate the medication. This failure had the potential to result in adverse clinical outcomes, including blood clot formation for Resident 2. Findings: A review of Resident 2's admission Record, indicated Resident 2 had a history of venous thrombosis and embolism (a blood clot forms in a vein and can travel through the bloodstream). A review of Resident 2's Brief Interview for Mental Status (BIMS, a tool used to assess cognition) indicated a score of 14/15, reflecting intact cognition. During an interview on 3/4/26 at 9:56 AM with Resident 2, she stated that in the evening of 2/21/26, a registry nurse was assigned to her and was unable to find her Xarelto (a blood thinner medication), and it took some time before the medication was administered. During a review of Resident 2's electronic medication administration record (EMAR, a system used to document medication administration) dated 2/2026, the EMAR indicated, Xarelto 20 mg (milligram) ordered on 12/13/15, was scheduled for administration daily at 5:00 PM for a history of venous thrombosis and embolism. During a review of the facility's Medication Audit Report, dated 2/21/26, the report indicated Xarelto 20 mg was administered on 2/21/26 at 6:43 PM. During a review of the facility's Progress Notes from 2/19/26 to 2/24/26, no documentation was identified indicating the reason for the delayed administration of Xarelto on 2/21/26. During a concurrent phone interview and record review on 3/30/26 at 1:19 PM with the Director of Nursing (DON), the DON stated that the facility's acceptable time frame for medication administration relative to the scheduled time was one hour before and one hour after. The DON stated the administration of Xarelto at 6:43 PM was not acceptable, as it exceeded the acceptable time frame by 43 minutes based on the Medication Audit Report. The DON stated there was no documentation indicating the reason for the delayed administration of Xarelto. The DON further stated that because the nurse who administered the medication was from registry staff, it was possible the nurse did not know where to locate the medication. The DON stated that when a medication was administered outside the acceptable time frame, staff were expected to notify the physician or pharmacy. The DON stated the potential effect of delayed administration of an anticoagulant (medications used to prevent blood clot) was possible clotting. During a concurrent interview and record review on 3/30/26 at 2:59 PM with the Infection Preventionist (IP), the IP stated, based on the Medication Audit Report, Xarelto for Resident 2 was administered 43 minutes late. The IP stated medications should be administered within one hour of the scheduled time. The IP further stated that because the medication was administered by a registry nurse, the nurse likely did not know where to locate the medication. The IP stated the potential effect of delayed administration of Xarelto includes possible clot formation, particularly as Resident 2 was practically bedbound, and stated that Xarelto was very important. During a review of the facility's policy titled POLICY AND PROCEDURE IN MEDICATION ADMINSTRATION revised on 1/2026, the policy indicated medications must be administered in accordance with physician orders. The policy further indicated medications .must be administered within one hour before and after administration time per M.D. [Medical Doctor] order. The policy indicated medications must be administered following the scheduled administration time and documented immediately after administration. During a review of an undated facility's policy and procedure titled Registry/Agency Staff Utilization Policy, the policy indicted registry staff shall receive .appropriate verification, orientation, supervision, and performance monitoring while working in the facility. The policy further indicated registry staff .must demonstrate competency or training in. facility-specific practices. including medication administration procedures. The policy indicated registry staff was accountable for .following physician orders. and .accurate documentation. During a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/30/2026
NAME OF PROVIDER OR SUPPLIER Kit Carson Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility's policy titled Medication Error and Adverse Drug Reaction Report revised on 1/2025, the policy defined a medication error as .an incorrect medication prescribed, dispensed, or administered to a resident. and included omissions of vital medication due to administering errors. The policy indicated that in the event of a medication error, .immediate action is taken, as necessary, to protect the resident's safety and welfare. The policy further indicated the attending physician was to be .notified promptly. of any medication error, and that the incident must be documented in the resident's medical record, including a .factual description of the error. time notified. and .physician's subsequent orders. During a review of the facility's policy titled Storage of Medications revised on 1/2026, the policy indicated medications were to be .stored safely, securely, and properly. and were accessible only to licensed nursing personnel and authorized staff. The policy indicated medication carts and supplies were to be .locked or attended by persons with authorized access. The policy also indicated medication storage conditions were monitored on a regular basis, and corrective action was taken if problems were identified.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview, and record review the facility failed to ensure appropriate monitoring and safe administration of a blood pressure medication for one of four sampled resident (Resident1) when staff administered metoprolol (medication used to treat high blood pressure) despite low blood pressure readings, did not obtain physician parameters for when to hold the medication, and did not develop a care plan addressing hypertension(high blood pressure) and the risks associated with the medication.This failure placed Resident 1 at risk for symptomatic hypotension 9low blood pressure) and resulted in a change in condition requiring hospitalization due to very low blood pressure.Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses of, but not limited to diabetes mellitus (a condition where the body cannot control blood sugar levels), anemia (a condition where the body does not have enough healthy red blood cells), atrial fibrillation (an irregular and often fast heartbeat), acute respiratory failure with hypoxia (a sudden and serious problem where the lungs cannot get enough oxygen into the blood), and chronic kidney disease (long term damage to the kidneys that makes them not work properly).Review of Resident 1's clinical record titled, [Name of facility] - Progress Notes, dated 2/23/26, indicated, Nurses Notes . BP [blood pressure] 100/58 . appears deeply slept. Resident woke up lunch time but refused meds [medications] and refused to eat. Resident [Resident 1] went back to close eyes seems to sleep, . Endorsed to the following shift nurse.Review of Resident 1's clinical record titled, [Name of facility] - Progress Notes, dated 2/24/26, indicated, Nurses Notes . 86/58 [blood pressure] Resident lethargic [very tired, sluggish, or lacking energy], slow to respond. Resident appears pale. Not responding per baseline. Contacted [Name of Physician] via COC [Change of Condition] phone and updated on resident's condition with order to send to [Name of hospital] ER [emergency room] for further evaluation and treatment .Review of Resident 1's facility provided clinical record titled, [Name of hospital] - Hospitalist H&P - History and Physical examination], dated 2/24/26, indicated, History of Present Illness: . This morning patient's blood pressure was noted to be markedly low when paramedics reported that his systolic blood pressure was 70 over palp [sic - palpation: the provider could only feel the pulse return at 70 but could not hear or measure the bottom number, diastolic] . ED [emergency department] COURSE: Initial BP [blood pressure] on arrival was 47/38 .During an interview with concurrent record review on 3/5/26, at 11:52 AM, with licensed nurse (LN) 1, LN 1 reviewed the Medication Administration Record (MAR) for Resident 1. LN 1 confirmed that Resident 1 had a physician order for Metoprolol Tartrate 25 mg (milligram - a unit of measure) tablet, give 0.5 tablet (12.5 mg) by mouth twice daily for hypertension (high blood pressure). During the review of the January 2026 MAR, LN 1 confirmed that Resident 1 had a low blood pressure reading, including: 100/59 on 1/6/26 at 9:00 AM and 104/70 on 1/9/26 at 5:00 PM. LN 1 reviewed Resident1's February 2026 MAR and confirmed additional low blood pressure readings, including: 104/60 on 2/5/26 at 9:00 AM, 102/56 on 2/10/26 at 9:00 AM, and 106/56 on 2/13/26 at 5:00 PM. LN 1 confirmed that she administered the metoprolol on those days despite the low blood pressure readings. LN 1 stated that when blood pressure medication order did not include parameters (instructions on when to hold the medication), the nurse should assess the resident, review the blood pressure readings, notify the physician, and request clarification for safe parameters. LN 1 further stated that having clear parameters was important to prevent Resident 1's blood pressure from dropping too low. LN 1 stated if metoprolol had included parameters for holding the medication, the recent change in Resident 1's condition that resulted in hospitalization due to very low blood pressure might have been avoided.During an interview with concurrent record review on 3/5/26, at 1:52 PM, with the Director of Nursing (DON), the DON explained the facility's process for administering blood pressure medications. The DON stated that the facility followed holding parameters based on the resident's medical diagnosis. The DON stated residents who were treated for hypertension, nurses should hold their (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood pressure medication if the systolic blood pressure (top number) was less than 110. The DON stated residents who were treated for heart failure, nurses should hold their blood pressure medication if the systolic blood pressure was less than 100. The DON reviewed the electronic health record (EHR) and confirmed that Resident 1 was receiving metoprolol to treat hypertension. The DON reviewed Resident 1's January 2026 MAR and confirmed that Resident 1 received metoprolol despite having systolic blood pressure readings below 110, including: 9:00 AM administrations - 100/59 on 1/6/26, 107/58 on 1/7/26, 107/56 on 1/12/26, 103/59 on 1/19/26, 109/64 on 1/24/26 and for 5:00 PM administrations - 100/59 on 1/5/26, 104/70 on 1/9/26, 99/61 on 1/10/26 and 102/64 on 1/17/26. The DON reviewed Resident 1's February 2026 MAR and confirmed additional administrations of metoprolol when Resident 1's systolic blood pressure was below 110, including: 9:00 AM administrations - 104/60 on 2/5/26, 102/56 on 2/10/26 and for 5:00 PM administration - 106/56 on 2/13/26. The DON stated that administering metoprolol when the systolic blood pressure was below 110 was not consistent with the facility's process for residents treated for hypertension. The DON stated that she expected nurses to follow the facility's process, assess the resident, and contact the physician when the blood pressure readings were low. The DON further stated that clear medication parameters should have been in place, and without those parameters Resident 1's safety was at risk. The DON reviewed Resident 1's care plans and confirmed Resident 1 did not have a care plan addressing hypertension or the use of metoprolol, including monitoring for potential adverse effects related to the medication and its black box warning (BBW - the strongest safety warning for a medication about serious risks). The DON reviewed Resident 1's February Medication Regimen Review (MRR - a regular check of all a person's medications to make sure they are safe and appropriate) completed by the consultant pharmacist and confirmed that Resident 1 was included in the review, but the pharmacist did not make any recommendation regarding the lack of medication parameters or the low blood pressure readings.Review of facility policy and procedure (P&P) titled, Acute Condition Changes - Clinical Protocol, revised 1/25, indicated, Assessment and Recognition - The physician will help identify individuals with a significant risk for having acute changes of condition during their stay . someone with unstable vital signs . the nurse shall assess and document/report . Vital signs . All current medications . The physician will help identify medications . that are associated with adverse consequences that could cause significant changes in condition.Review of facility P&P titled, PHYSICIAN NOTIFICATION, revised 1/26, indicated, . It is the policy of this facility to notify the attending physician of any significant change in a resident's condition. Licensed nurse shall promptly notify primary physician of any significant change in resident's condition. adverse effects from medications, e.g. [for example] side effects noted .Review of facility P&P titled, POLICY AND PROCEDURE IN MEDICATION ADMINISTRATION, revised 1/26, indicated, Policy - Medications shall be administered in accordance with our established policies and procedures. Medication for hypertension that requires parameter before administration should be complied with.