

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 04/15/2026
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interview and record review, the facility failed to ensure professional standards of care for pharmacy services were met for one of four sampled Residents (Resident 1) when;Resident 1's anti-anxiety medication order administration times was not followed as written by the physician; andResident 1's medication was administered one hour and forty five minutes after the time it was scheduled.These failures caused Resident 1 psychosocial distress and had the potential to negatively affect her health and well-being.Findings:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included anxiety disorder (feelings of worry, anxiousness or fear that interfere with one's daily activities).During an interview on 4/15/26 at 10:45 AM with Resident 1, Resident 1 appeared visibly upset and stated on 4/10/26 the licensed nurse (LN) locked the keys inside the medication cart and could not access Resident 1's lorazepam (antianxiety medication) which was due at 3 PM. Resident 1 further stated she did not receive the medication until two and a half hours later. Resident 1 stated she needed the medication administered at a specific time to control her anxiety level.During a concurrent interview and record review on 4/15/26 at 1:39 PM with the Director of Nurses (DON), the DON confirmed the facility document titled, Medication Admin Audit Report, indicated Resident 1's lorazepam was scheduled to be administered at 3 PM and was not administered until 4:49 PM. The DON stated medications should be administered within 1 hour before or after their scheduled time. The DON further stated it was important to follow the scheduled administration times to ensure the therapeutic effect of the medication.During a review of Resident 1's Medication Administration Record (MAR) dated 4/1/2026-4/30/2026, the MAR indicated, .Lorazepam.Give 1 tablet by mouth every morning and at bedtime for M/B [manifested by] feeling anxious related to ANXIETY DISORDER. The MAR indicated the medication was to be administered at 3 AM and 3 PM.During a telephone interview on 4/16/26 at 11:31 AM with LN 1, LN 1 confirmed Resident 1's lorazepam order and the scheduled administration times did not match. LN 1 further stated the times written on the order should be followed to maintain accuracy. LN 1 stated the medication was scheduled to be administered at 3 PM per Resident 1's request even though the order indicated at bedtime.During a telephone interview on 4/17/26 at 11:41 AM with LN 2, LN 2 stated on 4/10/26 she accidentally locked the keys to the medication cart inside the cart. LN 2 confirmed Resident 1's lorazepam was administered late on 4/10/26. LN 2 stated Resident 1 was always upset when she did not receive her medication on time. LN 2 stated the lorazepam was scheduled to be given at 3 PM per Resident 1's request. LN 2 confirmed the lorazepam order indicated the medication was to be given at bedtime and should not be given at 3pm without a physician's order.During a telephone interview on 4/16/26 at 11:28 AM with the Director of Staff Development (DSD), the DSD stated medication orders included the resident's name, date of order, name of the medication, the dose, and frequency of the medication, and the physician's signature. The DSD further stated medications should be administered per the time frame ordered by the physician.A review of a facility policy and procedure (P&P) titled, POLICY AND PROCEDURE IN MEDICATION ADMINISTRATION, dated 1/26 indicated, .Medications shall be administered in accordance with our established policies and procedures.1. Drugs must be administered in accordance with the written orders of the attending (continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>physician.3. Medication .must be administered within one hour before or after administration time per M.D. [medical doctor] order.</p>		