

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 04/22/2026
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) was treated with dignity and respect when Resident 2 was observed in bed without a cover over the lower body and was visible from the hallway wearing only an incontinent brief (disposable undergarment designed to absorb urine and stool). This failure had the potential to negatively affect Resident 2's psychosocial well-being (overall emotional and social health). Findings: Review of Resident 2's admission RECORD indicated Resident 2 was admitted to the facility with diagnoses including congestive heart failure (a condition where the heart does not pump blood well), type 2 diabetes mellitus (high blood sugar), chronic pancreatitis (long-term inflammation of the pancreas), muscle weakness, pain, presence of a cardiac pacemaker (a device that helps control the heart rhythm), stage 3 chronic kidney disease (moderate kidney damage), and a personal history of transient ischemic attack (a temporary blockage of blood flow to the brain) and cerebral infarction (stroke) without residual deficits (no lasting weakness or problems). During a concurrent observation and interview on 4/22/26 at 1:51 PM with Licensed Nurse (LN) 2 and LN 3, upon entering Resident 2's room, Resident 2 was visible from the hallway through the entrance door to Resident 2's room. Resident 2 was in bed sleeping with no lower body clothing or lower body covering, which exposed the incontinent brief that Resident 2 was wearing. LN 2 and LN 3 acknowledged that Resident 2 was visible from the hallway through the entrance door to Resident 2's room without the lower lower body covered. Resident 2's bed was positioned next to a large glass window, and the blinds were raised, which allowed visibility from outside the room. LN 2 and LN 3 acknowledged that if someone stood outside near the window, Resident 2 could have been seen without the lower body covered. LN 2 stated that leaving the resident without the lower body covered was a dignity issue. LN 3 stated that Resident 2 should have been provided with lower body clothing to maintain dignity. Review of Resident 2's Minimum Data Set Assessment (MDS: an assessment tool) dated 2/1/26 in the section titled, Section C - Cognitive Patterns. Brief Interview for Mental Status [BIMS: to check a resident's thinking and memory], indicated that Resident 2 scored 7, which indicated Resident 2 had severely impaired cognition (the mental processes involved in acquiring, processing, and storing knowledge; 13 to 15 = Intact, 8 to 12 = Moderate, 0 to 7 = Severe). Review of Resident 2's [Facility Name] Documentation Survey Report v2 [version 2] Apr [April] 25, dated 4/1/26 through 4/22/26, in the section titled Dressing, indicated Resident 2 was totally dependent on staff with dressing 9 times in the AM shift, 7 times in the PM shift, and 14 times in the NOC shift, and it included dependence on staff for dressing during the AM shift of 4/22/26. During an interview on 4/22/26 at 1:55 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated that Resident 2 was forgetful and needed help with dressing. CNA 1 further stated it was important to provide Resident 2 with proper clothing to maintain Resident 2's dignity and self-respect. During an interview on 4/22/26 at 3:55 PM with the Director of Nursing (DON), the DON stated that residents were expected to be properly dressed to maintain residents' dignity and privacy. Review of facility's policy and procedure (P&P), titled Resident Rights revised in 1/26, the P&P indicated . Employees shall treat all residents with kindness, respect, and dignity. privacy and confidentiality. Review of facility's P&P, titled Dignity (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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>revised in 1/26, the P&P indicated .Each resident shall be cared in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.Resident are treated with dignity and respect at all times.encouraged to dress in clothing that they prefer.Staff promote, maintain and protect resident privacy, including bodily privacy.Demeaning practices and standards of car that compromise dignity are prohibited.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to accommodate the needs of one of three sampled residents (Resident 1) when Resident 1 activated the call light (a device used to request assistance) and staff did not respond in a timely manner. This failure placed Resident 1 at risk for unmet care needs, increased risk for accidents or injury, and had the potential to negatively affect Resident 1's psychosocial well-being (overall emotional and social health). Findings: Review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility with diagnoses including angina pectoris (chest pain from reduced blood flow to the heart), non-active primary progressive multiple sclerosis (a long-term condition affecting the brain and nerves causing weakness and disability), hypertensive heart disease with heart failure (heart problems caused by high blood pressure, where the heart does not pump well), osteoarthritis (joint pain and stiffness), muscle weakness, muscle spasm, headache, and chronic pain (long-lasting pain). During an observation on 4/22/26 at 1:15 PM in the hallway, the corridor call light above Resident 1's room door was illuminated. Resident 1's room was located approximately halfway down the hallway from the nurse's station, where two staff sat inside the nurse's station. During a concurrent observation and interview on 4/22/26 at 1:27 PM with Resident 1 in Resident 1's room, Resident 1 was in bed with a meal tray containing food that had already been eaten on an overbed table in front of him. Resident 1 stated his lunch was delivered at 12 PM, he finished eating at 12:15 PM, and staff had not yet removed the tray. Resident 1 further stated he activated the call light to request assistance with removing the meal tray and had been waiting approximately 10 minutes prior to the observation. During an observation on 4/22/26 at 1:33 PM in the hallway outside Resident 1's room, the call light above Resident 1's room door remained illuminated. Certified Nursing Assistant (CNA) 1 was in the hallway picking up a meal tray from a room across from Resident 1's room. During an interview on 4/22/26 at 1:38 PM with CNA 1, CNA 1 acknowledged that Resident 1's call light was activated above Resident 1's room door and stated that Resident 1 was not assigned to her care. During a concurrent observation and interview on 4/22/26 at 1:40 PM with CNA 2 in the hallway outside Resident 1's room, CNA 2 walked toward Resident 1's room and confirmed the light above Resident 1's room door was an activated call light. CNA 2 stated her assigned residents were on the opposite side of the hall and Resident 1 was the only resident on that side assigned to her. CNA 1 stated that all staff were expected to respond to call lights in a timely manner, regardless of assignment, and within five minutes. CNA 2 further stated that delays in responding to call lights could pose a safety risk, including falls. CNA 2 then entered Resident 1's room, and the call light was turned off. During a concurrent observation and interview on 4/22/26 at 1:45 PM with Licensed Nurse (LN) 1 at the nurse's station, one other staff member was sitting inside the nurse's station. LN 1 stated that staff were alerted when a resident activated a call light through the alarm system at the nurse's station and the light above the resident's door. LN 1 acknowledged that Resident 1's call light had been activated for more than 25 minutes and was not answered in a timely manner. LN 1 stated that any staff could respond to call lights and were expected to respond within a couple of minutes. LN 1 further stated that if call lights were not answered in a timely manner, resident needs could go unmet and residents could be at risk for injury. During an interview on 4/22/26 at 3:47 PM with the Director of Nursing (DON), the DON stated that staff were expected to respond to resident call lights as soon as possible, within three to five minutes, and that delays could pose safety risks to residents including falls and upset or anxious behavior. Review of facility's policy and procedure (P&P), titled CALL LIGHT/BELL, revised 1/26, the P&P indicated, .Answer the light within a reasonable time (3-5 minutes).</p>		