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	05/08/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a person-centered care plan related to antibiotic treatment and monitoring for one of three sampled residents (Resident 1) who was readmitted to the facility with a urinary tract infection (UTI).This deficient practice failed to provide staff with clear guidance regarding the resident's antibiotic therapy, monitoring for effectiveness and adverse reactions, infection management, notification requirements, and necessary interventions to address the resident's medical needs, which placed Resident 1 at risk for unresolved infection, worsening condition, complications, and decline. Findings:A review of Resident 1's clinical record titled, admission RECORD, indicated Resident 1 was admitted to the facility with diagnosis of, but not limited to chronic obstructive pulmonary disease (COPD - a long-term lung disease that makes it hard to breathe), unspecified cirrhosis of liver (severe scarring and damage of the liver), heart failure (the heart is not pumping blood well), hypertension (high blood pressure), and sepsis (a very serious infection that spreads through the body).During a review of Resident 1's clinical record titled, Order Summary Report, with an order date range from 12/1/25 to 12/31/25, there was a physician's order dated 12/17/25 which indicated, Bactrim DS Oral Tablet [antibiotic - a medicine used to treat bacterial infection] . Give 1 tablet by mouth . for Sepsis .During a review of Resident 1's clinical record titled, [Name of Hospital] HOSPITALIST DISCHARGE SUMMARY, dated 12/17/25, indicated, . admit date : [DATE] . discharge date : [DATE] . DISCHARGE DIAGNOSES: Principal Problem: Sepsis . Active Problems: Cellulitis [a skin infection], UTI [urinary tract infection].During a review of Resident 1s clinical record titled, Order Details, dated 9/7/25, indicated, . Order Summary: Cefpodoxime Proxetil Oral Tablet [antibiotic] . Give 1 tablet by mouth two times a day for UTI w/o [without] hematuria [blood in the urine] related to URINARY TRACT INFECTION .During a review of Resident 1's clinical record titled, [Name of Facility] Physician Progress Notes, dated 9/11/25, indicated, .[Resident 1] was sent out on 9/2/25 for further evaluation due to an elevated temperature. the patient returned to facility on 9/7/25 with a diagnosis of urinary tract infection. The patient [Resident 1] was prescribed antibiotic therapy including Cefpodoxime Proxetil 100 mg [milligram - unit of measurement] orally twice daily for 5 days and Metronidazole [antibiotic] 250 mg orally three times daily for 5 days.During a review of Resident 1's clinical record titled, [Name of Facility] Physician Progress Notes, dated 9/16/25, indicated, . ASSESSMENT: UTI . PLAN: #UTI Cefpodoxime Proxetil 100 mg PO BID x 5 days, Metronidazole 250 mg PO TID x 5 days, medication reviewed .During an interview on 5/8/26 at 9:29 AM with Resident 1, in her room, Resident 1 stated that she had been transferred to the hospital three times related to urinary tract infections (UTIs) that became worse. Resident 1 stated that during her most recent hospitalization, her condition became severe and she became septic at the hospital. Resident 1 further stated that before being transferred, she experienced chills, elevated temperature, and worsening condition, and described that her legs were ripping apart, referring to pain, redness, and skin problems involving her lower extremities. Resident 1 stated that the licensed nurse assessed her condition, checked her symptoms, and contacted the physician regarding the change in condition. Resident 1 stated that after the physician (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	was notified, emergency medical services (911 paramedics) transported her to the hospital for further evaluation and treatment.During an interview with concurrent record review on 5/8/26 at 11:45 AM with Licensed Nurse (LN) 1, LN 1 stated that Resident 1 was admitted to the facility on [DATE] and, based on review of the electronic health record (EHR), Resident 1 had three hospital transfers on 6/21/25, 9/2/25, and 12/8/25. LN 1 reviewed the documentation related to each hospitalization and confirmed that Resident 1 was readmitted to the facility on [DATE] with diagnoses including acute cystitis (a sudden bladder infection); on 9/7/25 with a diagnosis of urinary tract infection (UTI); and on 12/17/25 with diagnoses including sepsis, UTI, and cellulitis. LN 1 further confirmed that antibiotics were ordered by the physician following each readmission. LN 1 stated that it was important for residents with repeated infections and multiple hospitalizations to be properly assessed, monitored, and care planned in order to guide staff regarding the resident's condition, antibiotic treatment, monitoring for effectiveness and adverse reactions, signs and symptoms of worsening infection, hydration needs, physician notification, and interventions necessary to help prevent another rehospitalization or decline in condition.During an interview with concurrent record review on 5/8/26 at 1:10 PM with Licensed Nurse (LN) 2, LN 2 stated that care planning was part of the admission and readmission process every time a resident returned to the facility from the hospital. LN 2 explained that it was important for licensed nurses to review the hospital discharge summary, admission orders, physician documentation, diagnoses, and newly ordered medications, especially antibiotics, in order to determine the resident's current needs and develop an appropriate care plan. LN 2 stated that when a resident had a new diagnosis or was started on antibiotics, the care plan should include the identified focus or problem, measurable goals, and interventions to guide staff regarding monitoring and care. During review of Resident 1's electronic health record (EHR), including hospital discharge reports and physician progress notes related to previous hospitalizations, LN 2 confirmed that Resident 1 received antibiotic treatment following each hospital readmission related to infections. LN 2 further confirmed that the resident's infection-related condition, treatment, and monitoring should have been reflected in the care plan. LN 2 stated that the licensed nurse assigned during the resident's readmission or the Licensed Nurse Supervisor was responsible for initiating or updating the care plan. LN 2 added that the care plan was important because it served as the resident's plan of care and guided all members of the interdisciplinary healthcare team regarding how to properly care for the resident, monitor the resident's response to treatment, recognize changes in condition, and help prevent future infections, complications, or rehospitalization. LN 2 reviewed Resident 1's care plan during the interview and confirmed that there were no care plans addressing Resident 1's September 2025 readmission related to urinary tract infection (UTI) and December 2025 readmission related to sepsis, UTI, and cellulitis. LN 2 confirmed that these conditions, including the physician-ordered antibiotic treatments, monitoring requirements, and interventions related to the resident's recurrent infections and risk for rehospitalization, should have been reflected in the resident's care plan in order to guide staff in providing appropriate care and services.During an interview on 5/8/26 at 3:11 PM with the Infection Preventionist (IP), the IP stated that it was his expectation for licensed nurses to assess residents and update or develop care plans when there were significant changes in condition, including hospital readmissions related to infections. The IP stated that when a resident returned to the facility with diagnoses such as urinary tract infection (UTI), sepsis, cellulitis, and physician-ordered antibiotic treatment, those conditions and related interventions should be reflected in the resident's care plan to guide staff regarding monitoring, treatment, infection management, and prevention of further decline or rehospitalization. The IP reviewed Resident 1's care plan during the interview and confirmed that there were no care plans addressing Resident 1's September 2025 readmission related to UTI and December 2025 readmission related to sepsis, UTI, and cellulitis. The IP further stated that the care plan was important because it guided all staff involved in the resident's care and helped ensure consistent care delivery, resident safety, monitoring of the resident's condition, and prevention of complications or (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	additional hospitalizations.During an interview on 5/8/26 at 3:51 PM with the Director of Nursing (DON), the DON stated that she agreed with the Infection Preventionist (IP) and confirmed that it was also her expectation for a care plan to have been developed or revised following Resident 1's hospital readmissions related to urinary tract infection (UTI), sepsis, and cellulitis. The DON stated that when a resident experienced a significant change in condition, recurrent infections, hospitalization, or newly ordered treatments such as antibiotics, licensed nurses were expected to update the resident's care plan to reflect the resident's current medical condition, goals, monitoring needs, and interventions necessary to guide staff in providing appropriate care and services. The DON added that it was important for all healthcare staff, including licensed nurses and Certified Nursing Assistants (CNAs), to be on the same page regarding the resident's plan of care in order to help ensure consistent care delivery, prevention of further decline or rehospitalization, and most importantly resident safety.A review of a facility policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised 1/26, indicated, Policy Statement: 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. Policy Interpretation and Implementation: 1. The interdisciplinary team (IDT), in conjunction with the resident . develops and implements a comprehensive, person-centered care plan for each resident. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, . c. includes the resident's stated goals . and desired outcomes; . 9. Care plan interventions are chosen only after data gathering, . careful consideration of the relationship between the resident's problem areas and their causes, .