STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056198	A. BUILDING _____ B. WING _____	04/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) received care according to professional standards when Resident 1 was transferred into her wheelchair and then to bed, despite an injury from a fall. This failure placed Resident 1 at risk of increased pain and further injury caused by moving, and a delay in treatment. Findings: Resident 1 was admitted to the facility in 2018 with [DIAGNOSES REDACTED]. Review of the minimum data set (MDS-an assessment and care screening tool) dated 3/27/19, indicated Resident 1 had a brief interview for mental status (BIMS) score of 1. A score of 0-7 indicated severe cognitive impairment. Resident 1's assessment of, Moving from seated to standing position was marked, .Not steady, only able to stabilize with staff assistance . and .Walking . was marked, .Not steady, only able to stabilize with staff assistance . Review of Resident 1's clinical record, Pain assessment dated [DATE], indicated the evaluation was completed every three months. The assessment indicated Resident 1 had a history of [REDACTED].moaning, groaning, facial grimacing . Review of Resident 1's clinical record, Nurses Notes dated 6/12/19, at 10:09 a.m., indicated, I (License Nurse (LN) 3) was called to station 1 due to (Resident 1) laying on floor on right side in fetal position-unwitnessed .Resident examined-groans when right leg moved, slight rotation to leg without shortening .Resident helped to W/ch (wheelchair) then to bed . Review of Resident 1's clinical record titled, Fall Investigation Form dated 6/12/19, indicated, .Resident examined then put in W/ch then into bed. Complete exam done. Resident grimacing and groans when right leg moved. Right lower leg slightly larger than left lower leg .(physician) notified and ordered portable xray of right hip then order changed to Send to (hospital) ER (emergency room) Xray did not respond to call time in 1.5hr (one and hours) .resident (Resident 1) continues to groan and grimace with right hip pain . Review of Resident 1's care plan At risk for fall or injury . revision 4/9/19 indicated, Interventions . HIGH FALL RISK - Visual checks as often as needed .chair alarm as ordered.Assessment of resident. During a telephone interview on 3/24/20, at 12:20 p.m., with LN 3, LN 3 indicated if a resident fell and was suspected as having a hip, neck or back injury the resident should not be moved, and 911 was to be called for emergency transport to the hospital. LN 3 stated, I was pretty sure it (Resident 1's right hip) was fractured . When asked if Resident 1 should have been moved, LN 3 stated, Probably not. During a telephone interview on 3/24/20, at 2:52 p.m., the director of nursing (DON) 2 stated, I would rather keep them on the floor and call the (physician) and call 911. If on assessment there is no pain, then we proceed to move resident .if any sign and symptom of injury she (Resident 1) should have been left on the floor . Review of Resident 1's clinical record. Hospitalists H&P (history and physical) completed at the hospital on [DATE], indicated, .Patient has been complaining of right hip pain after the fall. In the emergency room patient was given .[MEDICATION NAME] (narcotic) for pain control .Patient will go for surgery today .
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) received adequate supervision to prevent a fall when: 1. Resident 1 was left in her wheelchair at the nurse's station to be supervised but no staff were present; 2. Staff was not able to meet the needs of Resident 1, on the day shift 6/12/19, when Resident 1 fell ; and 3. Resident 1's wheelchair alarm did not sound when she left her seat. These failures contributed to Resident 1's fall and a fracture of her right hip. Findings: Resident 1 was admitted to the facility in 2018 with [DIAGNOSES REDACTED]. Review of the minimum data set (MDS-an assessment and care screening tool) dated 3/27/19, indicated Resident 1 had a brief interview for mental status (BIMS) score of 1. A score of 0-7 indicated severe cognitive impairment. Resident 1's assessment of, Moving from seated to standing position was marked, .Not steady, only able to stabilize with staff assistance . and .Walking . was marked, .Not steady, only able to stabilize with staff assistance . Review of Resident 1's clinical record titled, FALL RISK assessment dated [DATE], indicated Resident 1 was at high risk for falling. 1. During an observation on 6/28/19, at 9:25 a.m., there were six residents seated in wheelchairs in the hall area near Station 1 of the facility. There were no staff members at Station 1 and none were visible from the area where the residents were sitting. During an interview on 6/28/19, at 9:50 a.m., with Certified Nurses Assistant (CNA) 2, CNA 2 stated, .She's (resident 1) supposed to lay down between meals. That day they left her up in her chair (wheelchair). We're supposed to put her back to bed after meals. No one was at the nurse's station. Breakfast ends around 9 (a.m.). She should have been toileted and taken to bed . Review of Resident 1's clinical record titled, Fall Investigation Form dated 6/12/19, indicated Resident 1's last meal was at 7:45 a.m. Review of Resident 1's clinical record titled, Neurological Evaluation Flow Sheet initiated on 6/12/19, indicated an initial assessment of Resident 1 was completed at 9:30 a.m. This form indicated Resident 1's initial assessment following the fall was completed at 9:30 a.m. During an interview on 6/28/19, at 12:40 p.m., with the director of nurses (DON) 1, DON 1 indicated Resident 1 was on the facility's star program, indicating high risk for falling. The DON stated, .They (residents on the star program) get more supervision checks. DON 1 indicated leaving residents unattended at the nursing station was not safe. The DON indicated Resident 1's fall was discovered at 9:30 a.m. on 6/12/19. Review of Resident 1's clinical record titled, Nurses Notes dated 6/12/19, at 9:30 a.m., indicated, .(CNA 4) informed me that a PT (patient) was laying on the floor in front of the nurses station .No witnesses as to what happened . During an interview on 8/14/19, at 4:35 p.m., Resident 1's family member (FM) stated, .She was found on the floor sleeping .There was nobody at the desk . During a telephone interview on 3/19/20, at 1:30 p.m., LN 2 stated, .The hall by the nurse's station (station 1) was a common place for residents to be placed. The staff thought it was safe there if someone was at the desk or on a cart nearby who could see them .It wasn't safe especially when we were short (not enough staff) . During a telephone interview on 3/19/20, at 1:47 p.m., CNA 4 indicated Resident 1 was assigned to her because another CNA did not come to work. CNA 4 stated, . I got there late. I overslept that day .She (Resident 1) was left at the nurse's station. We were very busy .Literally no one was around when I found her (Resident 1) . CNA 4 indicated she did not know how long Resident 1 was on the floor. During a telephone interview on 3/19/20, at 1:56 p.m., CNA 5 stated, .We were short staffed, and I had a hard time keeping an eye on patients. I got her (Resident 1) up and dressed because her CNA was late .She (Resident 1) ate breakfast and then she was left at the nursing station. I don't think anyone was there .We don't leave them (residents) there by themselves but we were short . 2. Review of the facility record, NURSING STAFFING ASSIGNMENT AND SIGN-IN SHEET dated 6/12/19, for the day shift indicated the CNA assigned to Resident 1 called in. She did not work on 6/12/19. During a telephone interview on 3/19/20, at 1:47 p.m., CNA 4 indicated Resident 1 was assigned to her because another CNA did not come to work. CNA 4 stated, .We were short that day. We (CNA's) each had 13 or 14 residents and I got there late. I overslept that day .She (Resident 1) was left at the nurse's station. We were very busy .I had to watch two hallways. Literally no one was around when I found her (Resident 1) .On a fully staffed day there might have been

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) enough (staff) around to watch out but not that day . During a telephone interview on 3/19/20, at 1:56 p.m., CNA 5 stated, .We were short staffed, and I had a hard time keeping an eye on patients. I got her (Resident 1) up and dressed because her CNA was late .She (Resident 1) ate breakfast and then she was left at the nursing station .We don't leave them (residents) there by themselves but we were short . Review of Resident 1's clinical record, Nurses Notes dated 6/12/19, at 10:09 a.m., indicated, I was called to station 1 due to (Resident 1) laying on floor on right side in fetal position-unwitnessed .Resident examined-groans when right leg moved, slight rotation to leg without shortening .Resident helped to W/ch (wheelchair) then to bed . 3. Review of physician orders [REDACTED]. dated 3/27/19. During an interview on 6/28/19, at 9:35 a.m., with Licensed Nurse (LN) 1, LN 1 indicated Resident 1 was at risk for falls and required a chair alarm to alert staff if she got up from her wheelchair and a bed alarm to alert staff of an attempt to get out of bed. LN 1 indicated Resident 1's alarm sound was delayed on 6/12/19, when Resident 1 left her wheelchair. Review of the facility document, 5 Day Conclusion (completed to follow up on result of a fall investigation) dated 6/18/19, indicated, .Multiple staff reported that the chair alarm (Resident 1's) did not sound . During a telephone interview on 3/19/20, at 1:47 p.m., CNA 4 stated, .Literally no one was around when I found her (Resident 1). Her alarm (wheelchair alarm) was not going off. It was on though, a light, but it didn't go off . CNA 4 indicated it was possible the alarm delayed ringing but was not ringing when she was there. CNA indicated she did not know how long Resident 1 was on the floor. Review of Resident 1's clinical record titled, Nurses Notes dated 6/12/19, at 9:30 a.m., indicated, .(CNA 4) informed me that a PT (patient) was laying on the floor in front of the nurses station .No witnesses as to what happened . Review of Resident 1's clinical record, History and Physical dated 6/21/19, completed by her facility physician indicated, .fell [DATE], sent to (hospital) .R (right) hip fx (fracture) .R (right) hip hemiarthroplasty (hip replacement surgery) . Review of Resident 1's nursing care plan, At risk for fall or injury . revised 4/9/19, indicated, .Chair Alarm as ordered .Constant safety reminders-Daily and PRN (as needed) .Provide safe environment .Encourage to call for assist provide call light within easy reach-Answer promptly .