STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056416	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayers Memorial Hospital	43563 Hwy 299 E Fall River Mills, CA 96028

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review the facility failed to ensure their abuse reporting policy was followed for six of 14 residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6) sampled for abuse when: 1. Resident 1 had an altercation with Resident 6 and the follow-up investigation was not sent to California Department of Health (CDPH) as per facility policy. 2. Resident 4 was accused of an altercation with Resident 3 and Resident 5 and the follow-up investigation was not sent to the CDPH as per facility policy. 3. Resident 2's family member (FM) was accused of verbally abusing Resident 2 and the facility did not report the alleged abuse to the CDPH withing 24 hours per facility policy. This failure had the potential to subject residents to mistreatment, neglect or abuse. Findings: 1.A review of the facility's policy and procedure (P&P) titled Abuse, Resident revised 3/2/23, indicated Results of investigation are reported to, with documentation of dates and times, as appropriate . State Survey, Certification Agency and any other agency according to state law. DHS (Department of Health Services or CDPH) Licensing and Certification. A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included vascular dementia with other behavioral disturbance (a type of dementia [memory, thinking and cognitive abilities are affected] caused from a lack of blood flow to the brain, leading to damage and eventual loss of brain cells with mood changes, agitation, and aggression.) Resident 1 made her own health care decisions. A review of Resident 6's Admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses which included dementia, major depressive disorder, and chronic pain. A review of an Entity Reported Incident (a federally required report sent to CDPH concerning an alleged abuse) dated 9/13/24, indicated Resident 1 abused Resident 6. No other details were provided. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's document titled Investigation Tool dated 9/16/24, indicated Resident 1 threw a cheese and crackers plate at Resident 6 on 9/13/24. During a concurrent interview with the Director of Nursing (DON) A and document review on 3/28/25 at 2:01 pm, the Investigation Tool for the altercation between Resident 1 and Resident 6 was reviewed. The DON confirmed that the result of the investigation should have been sent to the CDPH, but the DON was unable to provide proof that the results were sent. 2. A review of Resident 4's Admission Record indicated Resident 4 was admitted on [DATE] with diagnoses that included dementia, stroke (blood supply is blocked to the brain leading to brain damage) and dysphagia (difficulty swallowing). A review of Resident 3's Admission Record indicated Resident 3 was admitted on [DATE] with diagnoses that included weakness, pain, depression and heart failure. A review of Resident 5's Admission Record indicated Resident 5 was admitted on [DATE] with diagnoses that included lung disease, depression, and chronic pain. A review of the facility's Entity Reported Incident dated 11/18/24, indicated Resident 4 slapped Resident 3 on the wrist on 11/17/24. A review of the facility's document titled Investigation Tool dated 11/19/25, indicated an investigation was conducted for the altercation between Resident 4 and Resident 3 but there was no documentation that the report was sent to the CDPH. A review of the facility's Entity Reported Incident dated 1/13/25, indicated Resident 4 yelled at Resident 5 on 1/12/25. A review of the facility's Investigation Tool dated 11/13/25, indicated an investigation was conducted for the altercation between Resident 4 and Resident 5 but there was no documentation that the report was sent to the CDPH. During a concurrent interview with the DON A and document review on 4/1/25 at 11:29 am, Investigation Tool for the altercations between Resident 4 and Resident 3, and between Resident 4 and Resident 5 were reviewed. The DON A confirmed that there was no record that the investigations for these incidents were reported to the CDPH, and they should have been. 3.A review of the facility's policy and procedure (P&P) titled Abuse, Resident revised 3/2/23, indicated Call Department of Health Services (DHS) Licensing and Certification [CDPH] no later than 2 hours after allegation is made, if the events that cause the allegations involves abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. A review of Resident 2 Admission Record indicated Resident 2 was admitted to the facility on [DATE] with the diagnoses that included dementia, mood disturbance and anxiety. A review of Resident 2's progress note dated 9/22/24 at 12:12 pm, by Registered Nurse (RN) C, indicated resident had distressing visit with [Family Member, FM] today. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A written review of the interaction with Resident 2 and her FM by RN C dated 9/22/24 (Sunday) at 12:00 pm, indicated Today at lunch time [Resident 2's FM name] came for a visit. I was notified by a CNA [Certified Nursing Assistant] that they were concerned about conversations heard in room. I went and stood outside room since door was open a little along with a CNA. We overheard [FM] cussing at patient letting her know how much of a [NAME] she was and the fact that no one knew she would live this long. [FM] said F* about every other word and continued to belittle resident for quite some time. A review of the facility's Entity Reported Incident received by the CDPH on 9/24/24 at 9:44 am (Tuesday), indicated that on 9/22/24 at 12:00 pm .Resident 2's (FM) visited, and the CNA and Nurse overheard him verbally abusing her about living so long and used profanity. During a concurrent interview with the Assistant Director of Nursing (ADON) and review of the Entity Reported Incident on 3/28/25 at 3:20 pm, the interaction between Resident 2 and FM was reviewed. The ADON indicated the incident was reported 46 hours after the incident and should have been reported to CDPH withing 24 hours but was not.