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	05/27/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent physical and verbal abuse for two of six sampled residents (Resident 3 and Resident 4) when Certified Nursing Assistant (CNA) A was rough with Resident 3 and CNA H cursed and threw personal care items toward Resident 4. These failures violated Resident's 3 and 4's right to be free from abuse and caused Resident 4 to fear CNA H. These failures and had the potential to subject residents to physical harm, mistreatment and negatively impact their emotional and psychosocial well-being. Findings: Review of the facility ' s policy and procedure titled, Abuse, Resident dated 3/2/2023 indicated that the facility, .ensure that each patient has the right to be free from abuse (verbal, sexual, physical and mental) and The facility prohibits mistreatment . Review of admission records for Resident 3 indicated Resident 3 was admitted to the facility on [DATE], with diagnoses including dementia (loss of memory and ability to make sound decisions), chronic pain (pain that lasts longer than three months), and weakness. Review of Resident 3 ' s Annual Minimum Data Set (MDS an assessment tool), dated 1/30/25, indicated Resident 3 had a Brief Interview for Mental Status (BIMS, an assessment of a resident's memory and decision-making skills with a score from 0 to 15), score of 3 out of 15 which is a severe impairment. Review of a nursing note by Licensed Nurse (LN) C dated 10/30/24 at 2:20 PM, indicated that Resident 3 was, .emotional and distraught during conversation . after the abuse by CNA A. During an interview on 4/25/25 at 12:32 PM, with Resident 2, who was Resident 3 ' s roommate, Resident 2 indicated that she saw CNA A push at and be rough with Resident 3. Review of admission records for Resident 4 indicated Resident 4 was admitted to the facility on [DATE], with diagnoses that included dementia. Review of Resident 4 ' s Quarterly BIMS, dated 4/6/25, indicated Resident 4 scored 3 out of 15, a severe impairment. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/25 at 1:48 PM, with CNA I, CNA I stated that she was in the room when CNA H pushed Resident 4 and said, [F***] it, I ' m done and threw a clean brief (adult diaper) and a container of wet wipes on Resident 4 ' s chest and left the room. CNA I indicated that after CNA H left Resident 4's room, and that Resident 4 said he didn ' t like CNA H taking care of him because she can get aggressive, and it scared him. During an interview on 4/24/25 at 3:48 PM, with CNA H, CNA H stated that she tossed the brief and wipes to CNA I, not Resident 4, and left the room. During an interview on 5/27/25 at 12:56 PM, with the Director of Nursing (DON), the DON confirmed that both CNA A and CNA H were terminated and and stated that her expectations for staff were that they, need to treat the residents with respect, dignity, and care as if they are in their own home.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure a thorough investigation of an allegation of staff to resident abuse was conducted for one of six sampled residents (Resident 3). This failure had the potential to put all residents of the facility at risk for staff to resident abuse. Findings: Review of a facility policy titled, Abuse, Resident dated 3/2/2023 indicated that, 5. a) The facility will investigate all suspected incidents .i) Obtain written statements by all persons involved while facts are fresh in their minds. Review of a facility policy titled, Guidelines for Conducting Investigation Accidents/Incidents dated 10/8/2019, indicated that, 1. The Licensed Nurse on duty at the time an accident or incident occurs will .a. i. Conduct staff/resident interviews. Review of Resident 3 ' s Annual Minimum Data Set (MDS an assessment tool) dated 1/30/25, reflected that Resident 3 scored 3 out of 15 possible points on a Brief Interview for Mental Status (BIMS, an assessment of memory and decision-making skills), which indicated severely impaired cognition. During an interview on 4/25/25 at 12:32 PM, with Resident 2, who was Resident 3 ' s roommate, Resident 2 indicated that she saw Certified Nursing Assistant (CNA) A push at and be rough with Resident 3, and confirmed that the facility had not interviewed her about the incident. During a review of the facility ' s investigation of alleged abuse of Resident 3, no records were found of an interview with Resident 3 ' s roommate, Resident 2. During an interview on 5/27/25 at 12:56 PM, the Director of Nursing (DON), the DON confirmed that there was no interview conducted with Resident 2 regarding Resident 3 ' s abuse allegation, and there should have been since Resident 2 witnessed the incident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure Resident 4 was monitored specifically for any problems resulting from the abuse he experienced when Certified Nursing Assistant (CNA) H was rough with Resident 4 and threw personal care items at him on 1/10/25, when they did not complete change in condition charting (documentation done just after an unexpected incident occurs that had a negative effect on a resident to communicate the resident's condition to other healthcare providers), and alert charting (ongoing documentation of monitoring for 72 hours after an accident, injury, or incident to reassess if any problems occurred over time resulting from the accident, injury, incident), was initiated late. These failures had the potential for staff to not be fully informed and intervene if Resident 4's mental and medical status declined which could result in delays in care and a decline in Resident 4's physical and emotional well-being. Findings: Review of a facility policy titled, Charting and Documentation dated 3/5/2025, indicated that, All skilled and unskilled services will be recorded .Any significant change in condition and Narrative entries are required for all changes in condition .abuse/unusual occurrences. Review of a facility policy titled, Abuse, Resident dated 3/2/2023, indicated that the facility will, (7) Monitor patient and assess if abusive behavior could be repeated and (10) Chart the occurrence in nurse ' s notes. Review of admission records for Resident 4 indicated Resident 4 was admitted to the facility on [DATE], with diagnoses including dementia (loss of memory and ability to make sound decisions). During a review of Resident 4's progress notes after the reporting of abuse of Resident 4 by staff on 1/10/25, no Change in Condition charting was found. During a review of Resident 4's progress note by Licensed Nurse (LN) D, dated 1/12/25 at 12:42 PM, indicated that alert charting was added for Resident 4 two days after he experienced abuse by CNA H. During a concurrent interview and record review on 4/24/25 at 2:49 PM, the Assistant Director of Nursing (ADON) confirmed Resident 4's documentation was missing Change in Condition documentation and that alert charting documentation should have been started on Resident 4 right away after he experienced abuse by CNA H on 1/10/25.