STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555115	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Mountain Care Center	40131 Highway 49 Oakhurst, CA 93644

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation, interview and record review the facility failed to ensure resident rights were implemented according to the facility's policy and procedure (P&P) for call lights and Resident rights for three of four sampled residents (Resident 1, Resident 2, and Resident 3) when Resident 1, Resident 2, and Resident 3's call lights were ignored while CNAs were observed by staff and residents to be using personal cellphones and not providing requested assistance. This failure resulted in Resident 1, Resident 2 and Resident 3 to have feelings of being ignored, loss of dignity and respect from the facility staff and had the potential to cause skin breakdown and falls when requested assistance to use the restroom or changing of soiled briefs was not honored. Findings: During a concurrent observation and interview on 5/15/24 at 10:52 a.m. with Resident 1, Resident 1 was observed crying while recalling events that transpired in the facility. Resident 1 stated the facility staff were not answering her call lights when she needed assistance with activities of daily living (ADL) that included changing soiled bed sheets. Resident 1 stated she was sitting in bed for two to three hours with the call light on, but no staff went to assist. Resident 1 stated when she requested assistance with changing soiled linen on her bed, the staff informed her they were not able to assist her if the meal trays were out in the hallway and proceeded to exit her room without providing assistance or returning after meals. Resident 1 stated, I felt degraded and demeaned , when staff would not answer her call light and refused to provide assistance. During a review of Resident 1's Admission Record (AR-a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), indicated Resident 1 was admitted to the facility on [DATE] with diagnosis, difficulty in walking, pressure ulcer (injury to the skin resulting from prolonged pressure on the skin) of the right buttock (healed), morbid obesity, abnormalities of gait (manner of walking) and mobility. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Minimum Data Set [MDS - a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 4/18/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 13 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8 12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact. During a review of Resident 1's Mobility Care Plan (CP) , dated 3/18/24, the CP indicated, . needs assistance with transfers, bed mobility and ambulation . need extensive assistance (requires hands on assistance more than half of the time or is totally dependent) of 2 staff with bed mobility, transfers and ambulation . During a review of Resident 1's Physical functioning Care Plan , dated 2/24/24, the CP indicated, . Has physical functioning deficit related to Morbid Obesity . bed mobility assistance of 1-2 . call bell within reach . During a review of Resident 1's Braden Scale for predicting pressure injury risk , dated 2/24/24, the Braden scale indicated Resident 1 had a score of 13-14 (15-18 at risk, 13-14 moderate risk, 10-12 high risk, 9 or below very high risk). Which indicated Resident 1 was moderate risk. During an interview on 5/15/24 at 11:20 a.m. with Resident 2, Resident 2 stated he felt the facility staff ignored his call light when it was turned on to request assistance with going to the restroom. Resident 2 stated the staff will answer the call light, turn it off and exit the room without returning. Resident 2 stated he was continent (ability to control bowel and bladder) and used the bathroom but had requested to use briefs due to feeling unsafe when going to the bathroom alone without assistance when he was waiting for the call light to be answered. Resident 2 stated the facility staff was observed standing in the hallways, using their cellphones, and talking instead of answering the call lights. Resident 2 stated he felt ignored and felt some of the staff did not see me as a human being . During a review of Resident 2's AR, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis, Parkinson's disease (disorder that affects movement causing shaking, stiffness or difficulty with balance), muscle weakness, abnormalities of gait and mobility, history of falling, orthostatic hypotension (sudden drop in blood pressure upon standing), syncope (fainting) and collapse, other age-related cataract (clouding of the eye), chronic kidney disease (kidneys are damaged over a long period of time), difficulty walking. During a review of Resident 2's MDS dated [DATE], the MDS indicated, Resident 2's BIMS score was 12 out of 15 (8-12 moderate cognitive impairment), which indicated Resident 2 was moderately cognitively impaired. During a review of Resident 2's, Braden Scale for predicting pressure injury risk , dated 4/21/24, the Braden Scale indicated Resident 2 had a score of 16 , (15-18 at risk, 13-14 moderate risk, 10-12 high risk, 9 or below very high risk). Which indicated Resident 2 was at risk for skin breakdown. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/15/24 at 12:42 p.m. with the social services director (SSD), Resident 2's, Progress Note (PN) , dated 5/16/2024, was reviewed. The PN indicated, . interdisciplinary team (IDT- consisting of various members including nurses, therapists, administration) met and discussed regarding resident concern expressed to social services department (SSD) on 5/15/24 regarding resident was not being changed timely . The SSD stated Resident 2 complained about his call light not being answered for assistance to go to the restroom to change his soiled brief. During a review of Resident 2's, Bladder & Bowel Management (B&B) , dated May 2024, the B&B indicated Resident 2 was continent of bowel and bladder. During an interview on 5/15/24 at 11:35 a.m. with Resident 3, Resident 3 stated the facility staff would take a long time to answer the call light when requiring assistance with changing his soiled brief. Resident 3 stated he had waited 2 hours for staff to answer the call light and provide assistance. Resident 3 stated he had observed the facility staff standing outside his room using their cellphones and talking, while his call light was on for assistance with brief changes. Resident 3 stated the facility staff would not provide brief changes until after the meal trays were served and would, at times, not return. Resident 3 stated he felt mad, ignored, and asked himself, . why bother . During a review of Resident 3's AR, AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of unspecified dementia (group of symptoms affecting memory, thinking, and social abilities), chronic pain, osteoarthritis (disease in which the tissues in the joint break down over time), acute kidney failure (condition in which the kidneys suddenly cannot filter waste from the blood), repeated falls, major osseus defect (extensive bone loss), muscle weakness. During a review of Resident 3's MDS dated [DATE], the MDS indicated, Resident 3's BIMS score was 3 out of 15 (0 7 indicated severe cognitive impairment [memory loss, poor decision-making skills) which indicated Resident 2 was cognitively impaired. During a review of Resident 3's Toileting Care Plan , dated 5/1/24, the CP indicated, . use of brief/pads for incontinence (lack of control over urination or defecation) protection . During a review of Resident 3's Skin Care Plan , dated 5/3/14, the CP indicated, . at risk for impairment to skin integrity related to decrease mobility with high risk for friction . During a review of Resident 3's Weekly assessment (WA) , dated, the WA indicated, toilet use self-performance total dependance . toilet use support provided one person physical assist . bed mobility self-performance extensive assistance . bed mobility support provided one person physical assist . During an interview on 5/15/24 at 11:45 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated during mealtimes the residents in the facility could not be changed if they were soiled. CNA 1 stated it was the facility process that the residents were asked politely to wait until mealtimes were completed and all the meal trays were taken back to the kitchen. CNA 1 stated the residents who required assistance were changed if needed only if the meal trays were not present in the residents' room. CNA 1 stated all call lights should have been answered right away and residents should have been assisted as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/24 at 11:50 a.m. with CNA 2, CNA 2 stated if the resident requested assistance with brief changes during mealtimes it should have been completed by the facility staff. CNA 2 stated when a resident was soiled, they should not have been left in that condition because it was uncomfortable to eat and could have caused skin damage. CNA 2 stated when a resident uses their call light, it was the expectation for all staff who are available, to answer the call light immediately and assist the resident. During an interview on 5/15/24 at 11:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the CNAs had a problem with cell phone usage during resident care times. LVN 1 stated the CNAs were observed ignoring resident call lights and walking past them in the hallways on several occasions. LVN 1 stated the CNAs had been observed using cellphones in resident rooms during resident care. LVN 1 stated the use of cellphones was reported to the facility administration with no results of disciplinary action taken. During an interview on 5/15/24 at 12:29 p.m. with CNA 3, CNA 3 stated residents have the right to have assistance with ADLs as needed. CNA 3 stated it was not acceptable to leave a resident soiled during meals because of the risk of skin breakdown. CNA 3 stated it was not an acceptable practice to use cellphones in resident care areas. During an interview at 5/15/24 at 12:58 p.m. with the Director of nurses (DON), the DON stated it was the facility process for the staff to wait to assist residents until after the mealtimes were completed. The DON stated it was the expectation for the facility staff to ask the residents to wait if they were soiled, to be changed until after the mealtimes due to the inconvenience of the smell for other residents in the room. The DON stated all call lights should have been answered immediately by any staff member who observed the call light. The DON stated it was not acceptable to ignore a resident's call light. The DON stated all facility CNAs should not have been using their cellphones during resident care times. The DON stated the facility nurses were allowed to use their cellphones only if the physician was called. During an interview on 5/15/24 at 12:59 p.m. with CNA 4, CNA 4 stated the facility had issues with staff not answering call lights and CNAs cell phone usage. CNA 4 stated there were complaints from Resident 1 regarding other staff not assisting with brief changes during mealtimes and staff ignoring the call light when it was turned on. CNA 4 stated it was not acceptable practice for staff to walk by residents' rooms, ignore the call light and refuse to change the resident when soiled. CNA 4 stated it was not acceptable to make the resident wait to be changed because they had a right to feel comfortable. CNA 4 stated the CNAs were taking time from the residents' care when they were using the cell phones and not responding to residents' requests for assistance. During an interview on 5/15/24 at 1:14 p.m. with LVN 2, LVN 2 stated it was the facility process for all staff to answer resident call lights immediately when they required assistance. LVN 2 stated it was not an acceptable practice for staff to leave a resident soiled during mealtimes as there was a potential for skin breakdown. LVN 1 stated it was the facility expectation that no staff use cellphones during resident care, as it took time away from the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/24 at 1:23 p.m. with LVN 3, LVN 3 stated it was the facility expectation that if a call light was turned on by a resident, it should have been immediately answered by facility staff. LVN 3 stated if the resident was using their call light to ask for assistance with changing a soiled brief during mealtimes, it was the expectation for the staff to assist the resident due to the potential for skin breakdown. LVN 3 stated the CNAs had a problem with cellphone usage during resident care times. LVN 3 stated the cellphone usage was a concern that had been reported to the administration, but no disciplinary action was taken. LVN 3 stated she had observed the CNAs standing, talking and using their cellphones by Resident 1's room ignoring the call light while it was turned on. LVN 3 stated staff will ignore Resident 1's call light at times for more than 30 minutes to an hour prompting LVN 3 to answer the call light while the CNAs were outside Resident 1's room. LVN 3 stated Resident 1 had the right to use the call light to requests assistance. During a concurrent interview and record review on 5/15/24 at 1:40 p.m. with the Director of Staff Development (DSD), the facility in-service titled, Call lights , dated 1/31/24-2/7/24 was reviewed. The in-service indicated the facility CNAs had been educated on the importance of answering all resident call lights. The DSD stated the facility expectation was for all staff to answer all the call lights immediately if the staff were available. The DSD stated it was not an acceptable practice for the facility staff to ignore residents' call lights and neglecting their requests for assistance. The DSD stated the CNAs should not have been using their cellphones during working hours because it took time away from the resident's care. The DSD stated there was no in-service provided for CNAs to address the cell phone usage. The DSD stated changing the residents while the meal trays were out in the hallway, could have been an infection control issue because there was food possibly going into the residents' room. The DSD stated it was the facility process to ask the resident to wait until after mealtimes, but believed it was not acceptable to ask the resident to wait when needing a soiled brief change because that was demeaning and a dignity issue. During an interview on 5/15/24 at 2:11 p.m. with the administrator (ADM), the ADM stated it was the facility expectation for the staff to assist the resident during mealtimes when the residents were requesting to be changed or assisted with soiled brief changes. The ADM stated it was not an acceptable practice to leave any resident in that environment and expected to consume their meals. The ADM stated it was not acceptable to leave a resident soiled for more than two hours because it was a dignity issue and there was a potential for skin breakdown. The ADM stated CNAs should not have been using cellphones during resident care times and should have been answering resident call lights timely to assist with all care needs. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light , dated March 2021, the P&P indicated, . The purpose of this procedure is to ensure timely responses to the resident's requests and needs . if the resident needs assistance, indicate the approximate time it will take for you to respond. If the resident's request requires another staff member, notify the individual. If the resident's request is something you can fulfill, complete the task within five minutes if possible. If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance. If assistance is needed when you enter the room, summon help by using the call signal. Document any significant requests or complaints made by the resident and how the request or complaint was addressed . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Activities of Daily Living (ADL) , dated March 2018, the P&P indicated, .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, and oral care), mobility (transfer and ambulation, including walking), elimination (toileting) . interventions to improve or minimize a resident's functional abilities will be in accordance with the residents assessed needs, preferences, stated goals and recognized standards of practice . During a review of the facility's P&P titled, Resident Rights for all Nursing Procedures , dated October 2010, the P&P indicated, . To provide general guidelines for resident rights while caring for the resident . resident rights, including . resident dignity and respect . resident freedom of choice .