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	08/15/2024

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 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** 48713 Based on observation, interview, and record review the facility failed to meet professional standards of quality for one of five sampled residents (Resident 1), when Resident 1 had an unwitnessed fall on 8/6/24 and the facility staff did not complete a change of condition assessment, skin assessment and post fall assessment. This failure resulted in incomplete documentation for Resident 1 and put Resident 1 at risk for falls and potential delay in care. Findings: During an observation on 8/16/24 at 9:58 a.m., Resident 1 was observed lying in bed with eyes closed. Resident was dressed, clean and groomed. 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), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (disorder of the brain that slowly destroys memory and thinking skills), muscle weakness, altered mental status (changes in behavior, consciousness, mood or appearance) and unspecified dementia (loss of memory, language, problem solving skills and other thinking abilities). 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 7/24/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 0 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 severely cognitively impaired. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/16/24 at 12:48 p.m. with LVN 1, Resident 1's Risk Management Assessment (RMA) dated 8/6/24, was reviewed. The RMA indicated, Resident 1 had an unwitnessed fall with no injuries and was found by facility staff lying on the floor outside the therapy room. LVN 1 stated there was no change of condition (COC) assessment, post fall assessment and skin assessment completed for Resident 1's fall. LVN 1 stated the facility process was for an unwitnessed fall to complete the COC assessment, post fall assessment and skin assessment to effectively monitor Resident 1. LVN 1 stated the proper documentation was important to recognize delayed injury and properly initiate Resident 1's plan of care. LVN 1 stated the documentation was the charge nurse's responsibility to complete after a resident fall. During a concurrent interview and record review on 8/16/24 at 12:56 p.m. with LVN 1, the facility's Post Fall Checklist Binder undated, was reviewed. The Post fall checklist indicated, . post fall checklist . Situation, Background, Assessment, and Recommendation (SBAR) Post fall & Change of Condition . LVN 1 stated the post fall binder provided a list of documentation to be completed by the charge nurse when there was a witnessed or unwitnessed fall. LVN 1 stated the post fall process binder was available to all nurses and always located at the nurse's station for reference. During an interview on 8/16/24 at 1:28 p.m. with LVN 2, LVN 2 stated the facility process for an unwitnessed fall was for the charge nurse to complete a change of condition assessment, skin assessment and all documentation listed in the post fall process binder. LVN 2 stated if the documentation was not completed after a fall, it places the resident at risk for unknown conditions and delays in care. During a concurrent interview and record review on 8/16/24 at 1:34 p.m. with the DON, Resident 1's Risk Management Assessment (RMA) dated 8/6/24, was reviewed. The RMA indicated Resident 1 had an unwitnessed fall with no injuries and was found by facility staff lying on the floor outside the therapy room. The DON stated there was no change of condition assessment completed for Resident 1's unwitnessed fall. The DON stated it was the expectation that the charge nurse on shift to have completed the COC assessment for Resident 1. The DON stated it was important for the COC to have been completed to know the root cause of Resident 1's fall and gather as much information for proper assessment and implementation to prevent further falls. During an interview on 8/16/24 at 2:06 p.m. with the administrator (ADM), the ADM stated it was the facility expectation for the nurses to follow the facility process for falls and complete a COC assessment. The ADM stated it was important to have all documentation completed to know what happened to Resident 1. During a review of the facility's policy and procedure (P&P) titled, Falls-Clinical Protocol dated 03/2018, the P&P indicated, . the nurse shall assess and document/report the following . change of condition or level of consciousness, precipitating factors, details on how fall occurred . the staff will evaluate and document falls that occur while the individual is in the facility, for example, when and where they happen, any observations of the events . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a professional reference review titled, Lippincott Manual of Nursing Practice 11th Edition dated 2020, pages 15 indicated, . Standards of Practice . General Principles . These standards describe what nursing is, what nurses do, and the responsibilities for which nurses are accountable . A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events . Common Departures from the Standards of Nursing Care . Legal claims most commonly made against professional nurses include the following departures from appropriate care: .follow physician orders, follow appropriate nursing measures, communicate information about the patient . document appropriate information in the medical record . and follow physician's orders that should have been questioned or not followed . Common Legal Claims for Departure from Standards of Care . Failure to implement a physician's . order properly .