

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/12/2025
NAME OF PROVIDER OR SUPPLIER  Majestic Mountain Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713</b></p> <p>Based on interview and record review the facility failed to report allegations of abuse according to the facility's policy and procedure (P&amp;P) titled, Abuse, Neglect and Exploitation, for one of three sampled Residents (Resident 1), when Resident 1 reported a resident-to-resident verbal altercation to licensed vocational nurse (LVN) 1 on 2/9/25 and LVN 1 failed to report the incident .</p> <p>This failure resulted in the incident of abuse being reported three days later causing Resident 1 distress when Resident 1 continued to encounter Resident 2 during smoking breaks and was not monitored or separated by the facility staff. This failure exposed Resident 1 to further verbal altercations and emotional distress.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR- a summary of information regarding a resident 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 diagnosis for cerebral infarction (blood flow to the brain is blocked), attention deficit hyperactivity disorder (attention difficulty and impulsiveness), bipolar disorder (mood changes from sad to manic), anxiety (intense worry and fear), adult failure to thrive and history of suicidal behavior.</p> <p>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 1/23/2025, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 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.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 12:17 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 2/9/25 Resident 1 had attempted to enter the dining room to watch television and was denied access from Resident 2. LVN 1 stated Resident 1 had reported on 2/9/25 that Resident 2 was yelling profanity and kicked Resident 1 out of the dining room. LVN 1 stated Resident 1 was upset and crying at the time of the incident. LVN 1 stated the incident was considered a resident-to-resident altercation and a form of abuse but was not reported. LVN 1 stated it was the facility process to document and report all resident altercations for their safety, monitoring and protection. LVN 1 stated the failure to report the incident resulted in Resident 1 being exposed to further altercations with Resident 2 and lack of monitoring from the facility staff. LVN 1 stated there was a potential for further distress for Resident 1.</p> <p>During an interview on 2/12/25 at 12:41 p.m. with Resident 1, Resident 1 recalled incident that occurred on 2/9/25 with Resident 2. Resident 1 stated he had entered the dining room to watch television with group of residents. Resident 1 stated Resident 2 began to yell at Resident 1 stating he could not be in there and needed to leave. Resident 1 stated Resident 2 was yelling out profanity and calling him a piece of shit while also insulting Resident 1's wife. Resident 1 stated he exited the dining room following the incident and reported the altercation to LVN 1. Resident 1 stated the incident made him feel like shit and he became angry with tears the day of the incident. Resident 1 stated since the incident occurred, he felt bothered by Resident 2's attempts to continue to get under my skin. Resident 1 stated he was around Resident 2 following the incident and felt uncomfortable every time Resident 1 saw Resident 2. Resident 1 stated he had to share a smoking break with Resident 2 today which made him feel uncomfortable. Resident 1 stated he attempted to separate himself from Resident 2 during the smoking break and proceeded to immediately leave the area once he was done smoking. Resident 1 stated when Resident 2 was around him anywhere in the facility, Resident 1 would leave and go back to his room or another area away from Resident 2.</p> <p>During an interview on 2/12/25 at 1:46 p.m. with the assistant director of nurses (ADON), the ADON stated the facility process was to document, report and monitor resident to resident altercations that occurred in the facility. The ADON stated the facility was not made aware that an incident had occurred on 2/9/25 between Resident 1 and Resident 2 in the dining room. The ADON stated LVN 1 had not reported the incident to the facility administration and had not completed required documentation. The ADON stated when the incident was not reported and documented, Resident 1 and Resident 2 had not received monitoring to prevent further altercations. The ADON stated the failure to report placed Resident 1 at risk for further verbal altercations with Resident 2.</p> <p>During a record review of Resident 1's Progress Note (PN), dated 2/12/25, the PN indicated, . Resident came to my office and stated another resident had verbally assaulted him and that the resident had called him names using foul language and that he was kicking him out of the dining hall and that he was saying things about his wife and at the time of the interview resident became tearful and started to cry, resident stated he is not a good person he always talks bad to staff and to other residents and he wished to not be around him any longer and he sated I don't like mean people and [Resident 2] is rude and disrespectful .</p> <p>During a record review of Resident 1's Progress Note, dated 2/13/25, the PN indicated, . resident to resident verbal altercation . residents continue to be separated in the facility and during scheduled smoke times .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Progress Note, dated 2/13/25, the PN indicated, . [Resident 1] went on saying that [Resident 2] is often verbally mean and uses foul language at him. I asked [Resident 1] if he starts talking to [Resident 2] first, he responded no, that he tries to ignore him . [Resident 1] responded he will not allow someone to verbally abuse him or talk ill about his wife. [Resident 1] stated that [Resident 2] initiates the conversation every time . no episodes of tears or crying noted but [Resident 1] did seem emotionally upset while talking .</p> <p>During a telephone interview on 2/26/25 at 4:17 p.m. with certified nursing assistant (CNA) 2, CNA 2 stated that on 2/9/25, Resident 1 entered the dining room to attend a resident gathering. CNA 2 stated when Resident 1 entered the dining room, Resident 2 began yelling profanity and telling Resident 1 to leave the dining room. CNA 2 stated Resident 1 began to cry and left the dining room to head back to his room. CNA 2 stated Resident 1 was upset and refused to attend the resident gathering any further following the altercation. CNA 2 stated LVN 1 was present in the dining room when the incident happened.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Abuse, Neglect and Exploitation, dated 12/19/2022, the P&amp;P indicated, .it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations . instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse . willful means the individual must have acted deliberately . verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age, ability to comprehend, or disability . the facility will develop and implement written policies and procedures that . establish policies and procedures to investigate any such allegation and include training for new and existing staff on activities that constitute abuse . employee training . training topics . identifying what constitutes as abuse . recognizing signs of abuse . reporting process for abuse . the identification, ongoing assessment, care planning, for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect . the facility will make efforts to ensure all residents are protected from physical and psychosocial harm . responding immediately to protect the alleged victim and integrity of the investigation . examining the alleged victim for any injury . increased supervision of alleged victim and residents . protection from retaliation . providing emotional support and counseling to the resident during and after the investigation . the facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies within specified timeframes . immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result 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 .</p>		