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	06/05/2025

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** Based on interview and record review the facility failed to ensure medications were administered according to professional standards of practice for one of six sampled residents (Resident 1), when Resident 1 was not administered medication metformin (medication used for the treatment of diabetes a condition in which there is too much sugar in the blood), enoxaparin (medication used as a blood thinner to prevent blood clots), and nystatin powder (medication used to treat a fungal infection) according to physician orders due to medication unavailability in the facility. This failure had the potential to result in medication ineffectiveness resulting in blood clots that could have led to stroke (interruption in blood supply to the brain) or death, high blood sugar or uncontrolled blood sugar, and worsening of active fungal infection for Resident 1. Findings: 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 (condition in which blood flow to the brain is blocked, causing brain tissue to die), diabetes (elevated blood sugar), seizures (uncontrolled jerking, loss of consciousness, blank stares caused by abnormal electrical activity in the brain), aphasia (disorder that affects a persons ability to communicate). 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 4/23/2025, 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 cognitively intact. During a telephone interview on 6/5/25 at 11:49 a.m. with family member (FM) 1, FM 1 stated the facility did not have enough medication enoxaparin to administer to Resident 1. FM 1 stated she did not have specific dates but recalled the incident occurred in May 2025. FM 1 stated she recalled an incident when the facility placed Resident 1 medication Enoxaparin on hold because they did not have enough of a supply to administer. FM 1 stated there were other incidents with other medications not being administered by the facility because of the lack of supply. (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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(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	During a review of Resident 1's Medication Administration Record (MAR), dated May 2025, the MAR indicated, . Enoxaparin Sodium Injection . inject 1 syringe subcutaneously (under the skin) every 12 hours for Deep Vein Thrombosis (blood clot in a deep vein) . Nystatin Powder 100000 unit/gm (unit of measure) apply to bilateral (both) groin, scrotum, topically every 2 hours for fungal infection . During a concurrent interview and record review on 6/5/25 at 12:12 p.m. with registered nurse (RN) 1, Resident 1's Medication Administration Record (MAR), dated May 2025, the MAR indicated, . Enoxaparin Sodium Injection . inject 1 syringe subcutaneously (under the skin) every 12 hours for Deep Vein Thrombosis (blood clot in a deep vein) . Nystatin Powder 100000 unit/gm (unit of measure) apply to bilateral (both) groin, scrotum, topically every 2 hours for fungal infection . The MAR indicated Resident 1 did not receive medication enoxaparin on 5/28/25 and 5/31/25 per physician order. The MAR also indicated, Resident 1 did not receive treatment order for medication nystatin powder, on 5/13/25 due to medication unavailability. RN 1 stated medication enoxaparin was not administered on 5/28/25 & 5/31/25 because medication was not available in the facility. RN 1 stated the medication nystatin powder was not administered on 5/13/25 due to the medication not being available in the facility. RN 1 stated the reason for the medication unavailability could have been due to staff not reordering medications in a timely manner to avoid disruption of medication administration. During an interview on 6/5/25 at 1:12 p.m. with the director of nurses (DON), the DON stated the facility process for reordering medications from the pharmacy was for the facility nurses to identify when the medication had at least three days worth of doses and reorder medication at that point. The DON stated it was not an acceptable practice to wait and order medications when there were no doses left to administer. The DON stated the expectation was for the nurses to submit the pharmacy request and follow up with the pharmacy to ensure request was received. During a telephone interview on 6/6/25 at 1:37 p.m. with licensed vocational nurse (LVN) 1, LVN 1 stated the facility process for reordering medications was for the nurse in charge of resident, to reorder medications when there were two or three days worth of doses left. LVN 1 stated it was not acceptable to wait to reorder medications when there were no doses left and then not administer medication to residents. LVN 1 stated the importance of reordering medications and having enough to administer was to avoid disruption of medication regimen and to ensure effectiveness of treatment. During a review of Resident 1 ' s, MAR, dated 1/2025, the MAR indicated, Metformin oral tablet . give 1000 mg by mouth two times a day for [Diabetes Mellitus] give with meals . The MAR indicated two doses of medication metformin were not administered on 1/19/25 at 8:00 a.m. and at 6:00 p.m. The MAR was coded as medication was not available. During a review of the facility ' s policy and procedure (P&P) titled, Medication Administration, dated 9/2/2022, the P&P indicated, . Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . keep medication cart . stocked with adequate supplies .compare medication source . with MAR to verify resident name, medication name, form, dose, route and time . administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician . (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 review of a professional reference (PR) titled, National Library of Medicine, dated 2025, the PR indicated, . Right Time - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. A guiding principle of this right is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents at risk for elopement received adequate supervision and monitoring to prevent accidents for one of six sampled residents (Resident 2), when on 6/1/25 Resident 2 left the facility through the front door and walked half a mile to a grocery store. This failure had the potential for Resident 2 to result in injury caused by falls due to areas of uneven terrain (land that is not flat, varies in height, may have bumps or holes making it difficult to walk)), motor vehicle accident due to a busy highway located next to the facility, and heat exhaustion due to rise in temperature of over 90 degrees Fahrenheit (unit of measurment) for Resident 2. Findings: During a review of Resident 2'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 Dementia (decline in menatal ability that interferes with daily life), cerebrovascular disease (condition that affects blood flow to the brain), Diabetes (high blood sugar due to lack of insulin production) and osteoporosis (condition in which bones become weak and brittle). During a review of Resident 2's Minimum Data Set (MDS a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/21/2025, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 2 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 had severe cognitive impairment. During a review of Resident 2 ' s report titled, Elopement-Off Premises, dated 6/1/25, the report indicated, . at [2:00 p.m.] the facility received a phone call from [Law Enforcement-LE] this [LE] stated that he was at [grocery store name] approximately 0.1 miles from the facility and that he was with a woman matching the description of [Resident 2]. [Resident 2] was last seen by writer at approximately [1:30 p.m.] near the dining room at the facility . [LE] denied release of resident back to the facility stating he did not deem the facility fit to care for resident . this writer spoke with [LE] and he stated that he would be placing resident on a gravely disabled hold . During a review of Resident 2's Elopement Care Plan (CP), dated 4/18/25, the CP indicated, . Is at risk for wandering and/or Elopement . the residents safety will be maintained through the review date . interventions, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books . identify pattern of wandering, intervene as appropriate . During a review of Resident 2's, admission Initial Evaluation- Elopement Risk, dated 4/17/25, the evaluation indicated, . Score: 18 . If total score is 10 or greater, Resident is considered an elopement risk . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/25 at 10:43 a.m. with certified nursing assistant (CNA) 1, CNA 1 stated Resident 2 had previous attempts of elopement from the facility. CNA 1 stated there was concern for Resident 2 due to the unavailability of a facility monitoring system for residents at risk for elopement. CNA 1 stated the facility used to have a [Brand name] system in which residents at risk for elopement, were given a bracelet that would trigger an alarm if residents were too close or walked through doors that led outside. CNA 1 stated the facility had implemented a 1 to 1 (CNA assigned to a specific Resident) for Resident 2 only and felt other at-risk for elopement residents were not being monitored enough. During an interview on 6/5/25 at 10:55 a.m. with licensed vocational nurse (LVN) 1, LVN 1 stated the facility process for monitoring Residents at risk for elopement was to observe residents every 15 minutes and complete a head count every six hours. LVN 1 stated Resident 2 was the only resident who was assigned a 1 on 1 staff for monitoring. LVN 1 stated the facility would have benefited from other interventions to effectively monitor residents as there were multiple residents in the facility at risk for elopement. During a concurrent observation and interview on 6/5/25 at 11:10 a.m. with the activity assistant (AA), the AA stated the back door of the dining room was observed unlocked and without an alarm when opened. The AA stated the back door of the dining room led to the back patio and did not sound an alarm unless the alarm system was set up. During an interview on 6/5/25 at 12:12 p.m. with registered nurse (RN) 1, RN 1 stated the facility doors leading outside had alarms, except the front entrance door. RN 1 stated the facility entrance door had an alarm in place that only sounded between the hours of 6:00 p.m. to 6:00 a.m. when opened. RN 1 stated the entrance door would not sound an alarm when opened during the hours of 6:00 a.m. to 6:00 p.m. unless the alarm system was initiated during those times. During an interview on 6/5/25 at 12:35 p.m. with the receptionist (RST), the RST stated part of the receptionist job duties was to monitor the front entrance door. The RST stated if a resident was attempting to go outside, she would alert the nursing staff to ensure the residents had adequate supervision. The RST stated the facility entrance door had a functioning alarm that would sound between the hours of 6 p.m. and 6 a.m. when opened. The RST stated the facility had an available receptionist Monday through Friday. The RST stated the facility entrance door was monitored by the facility staff present on the weekends. During an interview on 6/5/25 at 12:44 p.m. with CNA 2, CNA 2 stated there was a lack of monitoring in the facility for residents at risk for elopement. CNA 2 stated the facility used to have a system in place for [brand name] to detect residents at risk for elopement when they were either exiting the facility or getting close to exit doors, but the system had been removed. CNA 2 stated, when Resident 2 eloped from the facility on 6/1/25, none of the facility door alarms sounded to alert staff that Resident 2 was leaving the facility and due to the lack of monitoring of the front entrance door, staff had not detected Resident 2 left the facility. CNA 2 stated there was concern for all residents at risk for elopement due to the lack of monitoring of the doors, especially the entrance door and the back door of the dining room. CNA 2 stated if a resident wanted to elope from the facility, they could have left without being detected. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/25 at 1:12 p.m. with the director of nurses (DON), the DON stated the facility had implemented 15-minute monitoring of all residents at risk for elopement. The DON stated, Resident 2 had eloped through the facility entrance door undetected by the facility staff on 6/1/25. The DON stated the front entrance door was supposed to be monitored by the facility staff. The DON stated all doors leading outside the facility had alarms in place that sounded when opened. When asked about the dining room back door, the DON stated she was not aware of the back door in dining room and was not aware it did not have a working alarm when opened. During an interview on 6/5/25 at 1:52 p.m. with the facility assistant administrator (AADM), the AADM stated Resident 2 eloped from the facility through the facility entrance door undetected by facility staff. The AADM stated Resident 2 was located by LE 0.1 miles away from the facility at a grocery store. the AADM stated All doors leading outside the facility had an alarm in place to sound when opened. The AADM stated the only door that did not have an alarm, was the facility entrance door from 6 a.m. to 6 p.m. in which staff would be monitoring the door. The AADM stated he was not aware the dining room back door leading to the back of the facility did not have an active alarm in place. The AADM stated the facility was in the process of obtaining a new system that would detect residents at risk for elopement when they attempted to exit the facility. During a telephone interview on 6/6/25 at 1:13 p.m. with medical records (MR), MR stated she was assigned the manager of the day role on 6/1/25. MR stated she had received a call from LE who had asked if the facility had a missing resident, in which MR responded yes. MR stated LE requested MR go to scene and identify Resident 2. MR stated when she arrived at the scene, Resident 2 was sitting in the back of the LE vehicle while waiting to be transported to the acute hospital. MR stated Resident 2 was last seen walking freely throughout the facility and required supervision only when walking. MR stated the facility entrance alarm did not sound when Resident 2 eloped from the facility because there was no system in place to trigger an alarm and no one was monitoring the entrance door at that time . During a telephone interview on 6/6/25 at 1:20 p.m. with CNA 3, CNA 3 stated on 6/1/25, Resident 2 was observed walking around the facility freely. CNA 3 stated she was informed by LVN 2 that Resident 2 had eloped from the facility. CNA 3 stated the facility entrance door, and the back door of the dining room were the only doors in the facility that did not have an alarm system when opened. CNA 3 stated Resident 2 ' s elopement could have been prevented if the facility had an effective monitoring system in place that would have alerted staff that Resident 2 was exiting the facility. CNA 3 stated when Resident 2 eloped from the facility, there was a potential for heat exhaustion due to increased temperatures, potential for falls and injury due to the busy road. During a telephone interview on 6/6/25 at 1:37 p.m. with LVN 2, LVN 2 stated that on 6/1/25, LE contacted the facility to inform them Resident 2 had been located at a grocery store parking lot approximately half a mile (walking) from the facility. LVN 3 stated, Resident 2 was ambulatory (ability to walk independently) and had previous attempts of elopement. LVN 3 stated she had accompanied MR to identify Resident 1 at the scene. LVN 3 stated LE would not release Resident 2 back to the facility and transferred Resident 2 to the acute care hospital. LVN 3 stated when Resident 2 returned to the facility, she was placed on a 1 on 1, which was not implemented prior to the incident. LVN 3 stated Resident 2 required constant redirection, was a fast walker and would walk around the facility freely. LVN 3 stated if Resident 2 had specific monitoring interventions in place prior to 6/1/25, the elopement from the facility could have been prevented. LVN 3 stated Resident 2 was at risk for falls, injury heat exhaustion and being hit by a car when she eloped from the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of reference titled, Map, the map indicated the distance from the facility to the grocery store was approximately half a mile walking distance that lasted approximately 11 minutes. During a review of the facility ' s policy and procedure (P&P) titled, Elopements and Wandering Residents, dated 12/19/2022, the P&P indicated, . This facility ensures that residents who exhibit wandering behaviors and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . wandering is random or repetitive locomotion that may be goal-directed . elopement occurs when a resident leaves the premises or a safe area without authorization . the facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner .