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	09/12/2025

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow its policy and procedure (P&P) titled Charting and Documentation in accordance with professional standards of practice for one of five sampled residents (Resident 1), when the facility staff did not complete documentation of Resident 1's fall or possible injuries and did not follow up with cervical (neck) x-ray results for three weeks following Resident 1's fall on 7/25/25.This failure resulted in delay in assessment and treatment for Resident 1 due to a potential injury following the fall on 7/25/25.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 fusion of spine cervical region (surgical procedure that joins two or more bones in the neck to create a stable structure), functional quadriplegia (not able to move all four limbs but no damage to the brain or spinal cord), inflammatory spondylopathy (disease that causes pain, stiffness and inflammation to areas that attach to bones), chronic pain syndrome, spinal stenosis cervical region (condition in which the spinal canal puts pressure on the spinal cord and nerves).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 6/17/25, 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.During a concurrent observation and interview on 8/15/25 at 11:03 a.m. with Resident 1, Resident 1 was observed sitting up in wheelchair and appeared to limit movements with arms and neck. Resident 1 stated that on 7/25/254, staff were wheeling him out to the courtyard using the backdoor. Resident 1 stated that for the wheelchair to go through the door, the staff member had to tilt the chair backwards. Resident 1 stated he fell backwards instantly when the chair was tilted. Resident 1 stated he felt as if he had fallen forcefully onto the ground because he hit the back of his head and neck on the floor. Resident 1 stated the staff assisted him off the floor and offered to transfer him to the acute care hospital, but Resident 1 stated he refused. Resident 1 stated the pain was lingering following the fall but was informed by the facility staff that the x-rays taken were negative for injury or fracture. Resident 1 stated the pain did not go away due to a previous medical procedure but stated the pain had been felt at all times since the fall.During a review of Resident1's, Situation, Background, Assessment and Recommendation (SBAR) Post Fall, dated 7/25/25, the SBAR indicated, . I am contacting you about a fall the above resident experienced. Prior to fall resident was in wheelchair/chair resident fell in hallway. assessment. injury, witnessed fall, fall details, other wheelchair tilted back. primary care clinician notified. recommendations.During a review of Resident 1's, Progress Note, dated 7/25/25 at 9:50 a.m., the note indicated, . Resident had a fall and refused vitals, just wanted smoke his cigarette.During a review of Resident 1's, Progress Note, dated 7/25/25 10:25 a.m., the note indicated, . X-rays STAT (immediately) ordered. wrist, forearm, cervical, skull.During a review of Resident 1's, Radiology Results Report, dated 7/25/25, the report indicated, . Cervical spine 4 or 5 view, results to follow. The report indicated there were no results following Resident 1's cervical x-ray.During a concurrent interview and record review on 8/15/25 at 11:24 a.m. with licensed vocational nurse (LVN) 1, Resident1's, SBAR Post Fall, dated 7/25/25, Resident 1's, Progress Note, dated 7/25/25 at 9:50 a.m. and Resident 1's, Radiology Results Report, dated 7/25/25, were reviewed. The SBAR indicated, . I am contacting you about a fall the above resident experienced. Prior to fall resident was in wheelchair/chair resident fell in hallway. assessment. injury, witnessed fall, fall details, other wheelchair tilted back. primary care clinician notified. recommendations. The progress note indicated, . Resident had a fall and refused vitals, just wanted smoke his cigarette. The radiology result report indicated, . Cervical spine 4 or 5 view, results to follow. LVN 1 stated that after review of the SBAR and progress note, the documentation was not complete regarding Resident 1's fall. LVN 1 stated the facility process was to create a detailed progress note following a fall that would detail what happened and which interventions were completed. LVN 1 stated the radiology report was incomplete and after reviewing the x-ray results in the electronic medical record (EMR), there was no indication that the facility staff followed up with obtaining the final results for the cervical x-ray. LVN 1 stated it was important to follow up with reports and complete all documentation to ensure there was no delayed

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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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident environment remained free from accident hazards and that residents received assistance devices to prevent accidents for one of seven sampled residents (Resident 1) when nursing staff were aware Certified Nursing Assistant (CNA)s used a regular wheelchair to transport Resident 1 over an elevated threshold (a strip of wood, metal, or stone forming the bottom of a doorway) to the smoking area, CNA 5 wheeled Resident 1's wheelchair pulling him backwards in order to get Resident 1 over the threshold and tilted, causing Resident 1 to fall back. Nursing staff did not evaluate the hazardous nature of the path of travel or the unsafe technique to tilt the wheelchair. Nursing staff did not consider a physical therapy evaluation for a new wheelchair with anti-tilt bars.These failures resulted in the unsafe practice of transporting Resident 1 which caused an avoidable accident on 7/25/25, Resident 1 struck the back of his head onto the concrete floor, suffering avoidable pain and injury to his neck.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 fusion of spine cervical region (surgical procedure that joins two or more bones in the neck to create a stable structure), functional quadriplegia (not able to move all four limbs but no damage to the brain or spinal cord), inflammatory spondylopathy (disease that causes pain, stiffness and inflammation to areas that attach to bones), chronic pain syndrome, spinal stenosis cervical region (condition in which the spinal canal puts pressure on the spinal cord and nerves).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 6/17/25, 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.During a concurrent observation and interview on 8/15/25 at 11:03 a.m. with Resident 1, Resident 1 was observed sitting up in wheelchair and observed to limit movements with arms and neck. Resident 1 stated on 7/25/25, staff were wheeling him out to the courtyard using the fire escape door. Resident 1 stated for the wheelchair to go through the door, the staff member had to tilt the chair backwards. Resident 1 stated the wheelchair went backwards instantly when the chair was tilted. Resident 1 stated he felt as if he had fallen forcefully onto the ground because he hit the back of his head and neck on the floor. Resident 1 stated the staff assisted him off the floor. Resident 1 stated the pain was lingering following the fall but was informed by the facility staff that the x-rays taken were negative for injury or fracture. Resident 1 stated that prior to the fall, he had preexisting pain due to a previous medical procedure but stated since the fall the pain had increased and was now consistent to the neck area and back.During a review of Resident1's, Situation, Background, Assessment and Recommendation (SBAR) Post Fall, dated 7/25/25, the SBAR indicated, . Prior to fall resident was in wheelchair/chair resident fell in hallway. assessment. injury, witnessed fall, fall details, other wheelchair tilted back. primary care clinician notified. recommendations. The documentation indicated Resident 1 fell in the hallway, but findings indicated Resident 1 experienced a fall going through the fire escape door.During a review of Resident 1's, Progress Note, dated 7/25/25 at 9:50 a.m., the note indicated, . Resident had a fall and refused vitals (indicators that reflect a person's basic body functions and overall health), just wanted smoke his cigarette.During a review of Resident 1's, Progress Note, dated 7/25/25 10:25 a.m., the note indicated, . X-rays STAT (immediately) ordered. wrist, forearm, cervical, skull.During a review of Resident 1's, Radiology Results Report, dated 7/25/25, the report indicated, . Cervical spine 4 or 5 view, results to follow. The report indicated there were no results available to rule out an injury following Resident 1's cervical x-ray.During a concurrent interview and record review on 8/15/25 at 11:24 a.m. with licensed vocational nurse (LVN) 1, Resident 1's, SBAR Post Fall, dated 7/25/25, Progress Note (PN), dated 7/25/25 at 9:50 a.m., SBAR dated 7/25/25 and Radiology Results Report, dated 7/25/25, were reviewed. The SBAR indicated, .Prior to fall resident was in wheelchair/chair resident fell in hallway. assessment. injury, witnessed fall, fall details, other wheelchair tilted back. primary care clinician notified. recommendations. The Progress Note indicated, . Resident had a fall and refused vitals, just wanted smoke his cigarette. The Radiology Result Report indicated, . Cervical spine 4 or 5 view, results to follow. LVN 1 stated after review of the SBAR

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure pain management was provided to residents for one of five sampled residents, (Resident 1), when Resident 1 suffered a head and neck injury on 7/25/25, nursing staff did not assess Resident 1's pain, administer medications to effectively address the pain in accordance with professional standards of practice and the facility's policy and procedure Pain Management. On 7/25/25, staff tilted Resident 1's wheelchair backward in order to transport Resident 1 to the smoking area and Resident 1 fell backward, striking his head onto the concrete ground. Afterwards, Resident 1 complained of head and neck pain that radiated to the right side and nurses did not effectively treat the pain.These failures resulted in Resident 1 feeling unheard of, experiencing avoidable uncontrolled and unmanaged pain due to delay in assessment and treatment following the fall on 7/25/25.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 fusion of spine cervical region (surgical procedure that joins two or more bones in the neck to create a stable structure), functional quadriplegia (not able to move all four limbs but no damage to the brain or spinal cord), inflammatory spondylopathy (disease that causes pain, stiffness and inflammation to areas that attach to bones), chronic pain syndrome, spinal stenosis cervical region (condition in which the spinal canal puts pressure on the spinal cord and nerves).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 6/17/25, the MDS indicated, Resident 1's Brief Interview for Mental Status [BIMS screening tool used to assess resident cognitive (understanding through thought, experience and senses) 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.During a concurrent observation and interview on 8/15/25 at 11:03 a.m. with Resident 1 in Resident 1's room, Resident 1 was observed sitting up in wheelchair and observed to limit movements with arms and neck. Resident 1 stated on 7/25/25, staff were wheeling him out to the courtyard using the back door. Resident 1 stated for the wheelchair to go through the door, the staff member had to tilt the chair backwards. Resident 1 stated he fell backwards instantly when the chair was tilted. Resident 1 stated he felt as if he had fallen forcefully onto the ground because he hit the back of his head and neck on the floor. Resident 1 stated the staff assisted him off the floor and offered to transfer him to the acute care hospital, but Resident 1 stated he refused. Resident 1 stated the pain was lingering following the fall but was informed by the facility staff that the x-rays taken were negative for injury or fracture (break in a bone). Resident 1 stated that prior to the fall, he had preexisting pain due to a previous medical procedure but stated since the fall the pain had increased and was now consistent to the neck area and back.During a review of Resident 1's, Progress Note, dated 7/25/25 10:25 a.m., the note indicated, . X-rays STAT (immediately) ordered. wrist, forearm, cervical, skull. During a review of Resident 1's, Radiology Results Report, dated 7/25/25, the report indicated, . Cervical spine 4 or 5 view, results to follow. The report indicated there were no results available to rule out an injury following Resident 1's cervical x-ray.During a concurrent interview and record review on 8/15/25 at 11:24 a.m. with licensed vocational nurse (LVN) 1, Resident1's, Radiology Results Report, dated 7/25/25, was reviewed. The report indicated, . Cervical spine 4 or 5 view, results to follow. LVN 1 stated the radiology report was incomplete and after reviewing the x-ray results in the electronic medical record (EMR), there was no indication that the facility staff followed up with obtaining the results for the cervical x-ray. LVN 1 stated it was important to follow up with reports and complete all documentation to ensure there was no delayed trauma, to address all aspects of the situation, to find a root cause and to properly address any injury. LVN 1 stated the lack of follow up placed Resident 1 at risk for delayed diagnosis and treatment if there was a possible injury.During a review of Resident 1's, Progress Note, dated 7/26/25, the note indicated, . This evening writer went over x-ray results with resident, which were negative. earlier this evening, resident stated he is in much more pain related to fall, I reminded him he has a as needed (PRN) order for [Acetaminophen] (pain medication used for mild pain).During a concurrent interview and record review on 8/15/25 at 1:29 p.m. with director of nursing (DON), Resident 1's, Radiology Results Report, dated 7/25/25, was reviewed. The report indicated, . Cervical spine 4 or 5 view, results to follow. The DON stated she was not aware the x-ray