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	01/28/2026

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 meet professional standards of practice and follow the policy and procedure titled, Nursing Assessment and Management of Residents Following a Fall, for one of three sampled residents (Resident 1), when LVN 1, CNA 1 and CNA 2 observed Resident 1 on 1/16/26 exhibit restless and anxious behavior, exit seeking behavior and wheeling herself into other resident rooms trying to get into their beds. LVN 1 did not assess the situation, did not assess Resident 1 at the time of the behaviors and did not notify the physician to provide instructions on how to address Resident 1. Instead, LVN 1 instructed CNA 1 and CNA 2 to put Resident 1 to bed and Resident 1 was found on the hallway floor outside her room [ROOM NUMBER] minutes later. LVN 1 did not assess Resident 1 following the unwitnessed fall on 1/16/26 and instead instructed CNA 1 and CNA 2 to transfer Resident 1 back to bed. Once Resident 1 was in bed, LVN 1 did not complete a full head to toe assessment following the fall. These failures resulted in not recognizing and acting appropriately on a change of condition, not taking the opportunity to conduct a physical assessment of Resident 1, not obtaining physician input on how to address the change of condition. These failures led to Resident 1 falling from her bed, a delay in assessing possible injuries from the fall. On 1/17/26 X-rays of the hand indicated there was a fracture to the left 5th metacarpal bone (the long bone in the hand located on the pinky finger side, forming part of the palm and connecting the wrist). Subsequently, Resident 1 was transported to the acute care hospital.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 history of falling Anxiety Disorder, Dementia (a condition with persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), cognitive communication deficit (an impairment in communication).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 12/18/2025, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 5 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 an interview on 1/28/26 at 11:38 a.m. with CNA 1, CNA 1 stated that on 1/16/26, she was assigned to care for Resident 1. CNA 1 stated Resident 1 was observed restless and anxious wheeling herself in her wheelchair around the facility, which had been out of her normal behavior. CNA 1 stated LVN 1 requested Resident 1 be taken to Resident 1's room and assisted to bed. CNA 1 stated she felt it was unsafe to lay Resident 1 on her bed due to the anxious and restless behavior that could have caused Resident 1 to fall. CNA 1 stated Resident 1 was assisted back to bed where she remained (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	awake and observed fidgeting with the bed remote and call light. CNA 1 stated that Resident 1 was found sitting on the hallway floor outside her room between fifteen to twenty minutes after she had been assisted back to bed. CNA 1 stated LVN 1 instructed CNA 1 and CNA 2 to transfer Resident 1 from the hallway floor to the bed prior to LVN 1 completing an initial assessment of Resident 1 following her fall. CNA 1 stated the facility process was for the nurse to assess and check residents for any injuries prior to residents being moved or transferred.During an interview on 1/28/26 at 11:54 a.m. with CNA 2, CNA 2 stated that on 1/16/26, Resident 1 was observed restless and anxious, which had been out of her normal behavior. CNA 2 stated LVN 1 told CNA 1 to assist Resident 1 to bed even though she was restless. CNA 2 stated she had informed LVN 1 that Resident 1 had the potential to fall if she was assisted back to bed. CNA 2 stated LVN 1 had insisted CNA 1 and CNA 2 assist Resident 1 to bed. CNA 2 stated CNA 1 assisted Resident 1 back to bed as requested by LVN 1. CNA 2 stated she assisted CNA 1 with another resident for approximately 20 to 30 minutes before both CNA 1 and CNA 2 found Resident 1 sitting on the floor in the hallway outside Resident 1's room. CNA 2 stated LVN 1 was standing in the hallway and ordered CNA 1 and CNA 2 to pick up Resident 1 from the floor and assist her to bed. CNA 2 stated LVN 1 did not assess Resident 1 prior to Resident 1 being moved and assisted back to bed following the fall. CNA 2 stated that once Resident 1 was in bed, LVN 1 went into the room and assessed Resident 1 for a few seconds then left the room. CNA 2 stated the facility process when there was a resident fall was to report the incident immediately to the nurse, then the nurse was supposed to assess the resident. Then the LVN would instruct the CNA's present when to move and transfer the resident safely. CNA 2 stated there was a risk for injury or further injury when Resident 1 was moved without LVN 1's assessment following the incident on 1/16/26.During a review of Resident 1's document titled, Progress Note, dated 1/16/26, the progress note indicated, . At 4:30 p.m. writer was notified that resident was on the ground in resident's room. Upon entering resident's room, resident was observed to be sitting upright on her bottom near the foot of her bed. Resident noted to be self-propelling through halls during the day and was attempting to lay in residents' beds that were not her own. Resident was laid down in her own bed approximately 30 minutes prior to being observed on the ground. The progress note indicated Resident 1 was exhibiting unsafe behaviors while attempting to self-transfer to other resident's beds. During a review of Resident 1's, Cognitive Impairment Care Plan, the care plan indicated, [Resident 1] exhibits cognitive impairments as evidenced by periods of poor recall. Goal. [Resident 1] will be able to be redirected/reoriented to situation daily. Interventions. Explain cares to [Resident 1] before and during, involve family as needed, keep daily routine as consistent as possible, reassure [Resident 1] as needed if confused, reorient [Resident 1] to situation as needed.During a review of Resident 1's document titled, Situation, Background, Assessment & Review/Recommendation (SBAR), dated 1/16/26, the SBAR indicated, . The change in condition reported on this change in condition evaluation are/were: falls. outcomes of physical assessment. mental status evaluation, no changes observed. skin status evaluation, no changes observed. nursing observations, evaluation, and recommendations are, Resident had unwitnessed fall in room, no injuries noted. Bed was in lowest position; resident was displaying anxious behaviors throughout shift and redirected multiple times. The SBAR indicated Resident 1 was exhibiting anxious behaviors that required staff interventions and redirection throughout the day on 1/16/26.During a review of Resident 1's document titled, SBAR Post Fall, dated 1/16/26 6:58 p.m., the SBAR indicated, . Situation, I am contacting you [Physician]about a fall the above resident experienced. Prior to fall resident was, Attempt to self-transfer. Fall risk factors: Impaired safety awareness/judgment. Risk for falls. total score greater than 10 resident is considered at risk for falls: 10, at risk for falls: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Yes. The SBAR indicated, LVN 1 had notified the physician of the fall that occurred on 1/16/26, when Resident 1 was observed sitting in the hallway outside of her room. The SBAR indicated, Resident 1 was exhibiting behaviors of self-transferring self and was at risk for falls.During an interview on 1/28/26 at 12:15 p.m. director of staff development (DSD), the DSD stated the facility expectation when there was a fall or incident was for the nurse to assess the resident for injury prior to the CNAs moving or transferring the resident. The DSD stated it was important for the nurse to complete a thorough assessment of the residents immediately following a fall to identify any injuries and prevent further injury.During a telephone interview on 2/3/26 at 3:30 p.m. with LVN 1, LVN 1 stated that on 1/16/26, she was assigned to Resident 1. LVN 1 stated Resident 1 was found sitting on the hallway floor outside Resident 1's room on 1/16/26. LVN 1 stated that on this day, Resident 1 was observed with restless behaviors and appeared anxious as Resident 1 was exit seeking, propelling self, down the hallways in her wheelchair and not wanting to lie down as she normally would do after meals. LVN 1 stated Resident was also seen going into other resident rooms and attempting to self-transfer onto other resident beds. LVN 1 stated she asked CNA 1 and CNA 2 to assist Resident 1 back to bed as LVN 1 assumed Resident 1 was tired when she was attempting to self-transfer. LVN 1 stated Resident 1's behavior was different on 1/16/26, but no assessment was completed to attempt to identify cause. LVN 1 stated that approximately 20 to 30 minutes after LVN 1 had requested CNA 1 and CNA 2 assist Resident 1 back to bed, CNA 1 and CNA 2 were walking down the hall when they informed LVN 1 that Resident 1 was sitting on the hallway floor. LVN 1 stated when she arrived in Resident 1's room, CNA 1 and CNA 2 had transferred Resident 1 from the hallway floor to bed. LVN 1 stated due to CNA 1 and CNA 2 transferring Resident 1 back to bed following the fall, LVN 1 did not complete an assessment of Resident 1 or assessed Resident 1 for injuries. LVN 1 stated, once Resident 1 was assisted back to bed, LVN 1 completed a quick objective assessment that included visible skin, vitals and observation of Resident 1 moving extremities. LVN 1 stated a thorough complete assessment was not completed following the fall because LVN 1 had to attend to other obligations. LVN 1 stated she should have completed the assessment immediately after Resident 1 was observed on the hallway floor, but felt from what was observed, Resident 1 did not have any changes. LVN 1 stated the assessment was quick and was in and out of Resident 1's room. LVN 1 stated the facility process was for the nurse to assess the resident first before the resident was moved or transferred and to complete an accurate assessment of Resident 1 to ensure no injuries were missed. LVN 1 stated her lack of assessment to identify the changes in behavior could have contributed to Resident 1's fall on 1/16/26. LVN 1 stated it was important to follow the facility process because there was a potential for injury or further injury to Resident 1.During a review of Resident 1's document titled, Progress Note, dated 1/17/26 at 6:37 a.m., the progress note indicated, . Resident is up in wheelchair and sitting in lobby, writer notices bruise to top of left outer palm and top of left hand. Resident able to move all digits of left hand without grimacing or stating pain. The Progress note indicated that Resident 1 had an injury to the left hand that was not identified by LVN 1 on 1/16/26.During a review of Resident 1's document titled, Progress Note, dated 1/17/26 at 11:11 a.m., the progress note indicated, . [Physician] notified, order received for x-ray to left hand and wrist.During a review of Resident 1's document titled, Order Summary Report, dated 1/17/26, the order summary indicated, . May have x-ray to left hand and wrist related to unwitnessed fall.During a review of Resident 1's document titled, Radiology Report, dated 1/17/26, the report indicated, . Hand two views, left, Results: there is a fracture involving the 5th metacarpal shaft with minimal displacement. There is associated soft tissue swelling. Wrist two view left. Conclusion: no fracture seen. The progress note indicated that Resident 1 had a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fracture/injury to the left hand that was not identified on the day of the fall on 1/16/26.During a review of Resident 1's document titled, SBAR, dated 1/17/26, the SBAR indicated, . The change in condition reported on this change in condition evaluation are/were: other changes in condition. nursing observations, evaluation, and recommendations are [Radiology company name] reported fracture to left wrist, resident had unwitnessed fall on 1/16/26 delayed injury noted to left wrist. Writer notified [Physician], [Physician] gave an order to send resident out to acute care for further evaluation and left-hand fracture. The SBAR indicated that Resident 1's physician was notified of Resident 1's injury to the left hand and the physician gave new order to transfer Resident 1 to the acute hospital for further evaluation.During a review of Resident 1's hospital record titled, Emergency Department (ED) Notes, dated 1/17/26, the record indicated, . [Resident 1] with bruising with purple discoloration to left hand, per staff, patient had ground level fall yesterday without complaint (around noon yesterday), but today she had discoloration, [physician] for facility called for x-ray and per staff, x-ray showed a broken hand.During an interview on 2/4/26 at 8:57 a.m. with the director of nursing (DON), the DON stated the facility expectation was for the nurse to assess residents when there was a change in behavior or a fall. The DON stated LVN 1 should have assessed Resident 1 prior to the fall when Resident 1 was exhibiting changes in behaviors. The DON stated LVN 1 should have been more aggressive with the assessment process and should have assessed Resident 1 before the fall and immediately following the incident on 1/16/26. The DON stated LVN 1 should have identified Resident 1's change in behavior, should have called the physician and put interventions in place according to the assessment findings to keep Resident 1safe. The DON stated LVN 1 should have assessed Resident 1 while Resident 1 was still on the floor prior to being transferred by CNA 1 and CNA 2 back to bed following the fall, but LVN 1 did not.During a record review of the facility's policy and procedure (P&P) titled, Nursing Assessment and Management of Residents Following a Fall, undated, the P&P indicated, . Purpose: To ensure timely, thorough, and consistent nursing assessment and intervention following a resident fall in the Skilled Nursing Facility (SNF) to identify injuries, prevent complications, and maintain resident safety. This policy applies to all licensed nursing staff providing direct resident care within the Skilled Nursing Facility. Fall: An unplanned descent to the floor, ground, or extension of the floor, with or without injury. Post-Fall Assessment: A systematic nursing evaluation performed immediately after a fall to identify actual or potential injury and contributing factors. All resident falls, whether witnessed or unwitnessed and whether or not injury is apparent, require an immediate nursing assessment. The nurse is responsible for completing a comprehensive post-fall assessment, initiating appropriate interventions. Immediate Response, Ensure the resident's safety and do not move the resident until assessed, unless remaining in place presents immediate risk. Initial Nursing Assessment. Head-to-toe physical assessment with focus on: Head, neck, and spine, Extremities for deformity, swelling, bruising, or limited range of motion, Neurological assessment, including: Level of consciousness, Orientation, Speech, Pupil size and reactivity, Motor strength and sensation, Skin assessment for lacerations, abrasions, bruising, or pressure injuries. Documentation. The nurse shall document in the medical record. Resident response to interventions and ongoing monitoring. Nursing Staff: Perform assessments, initiate interventions, communicate changes in condition, and document care. Charge Nurse/Designee: Ensure appropriate follow-up and monitoring.During a review of a professional reference (PR) titled, National Library of Medicine-Nursing Process, dated 2024, the PR indicated,. The nursing process is a critical thinking model based on a systematic approach to client-centered care. Nurses use the nursing process to perform clinical reasoning and make clinical judgments when providing client care. the nursing process: Assessment, Diagnosis, Outcomes (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Identification, Planning, Implementation, and Evaluation. Assessment, The Assessment Standard of Practice is defined as, The registered nurse collects pertinent data and information relative to the health care consumer's health or the situation.10 A registered nurse uses a systematic method to collect and analyze client data. Assessment includes physiological data, as well as psychological, sociocultural, spiritual, economic, and lifestyle data. Licensed practical/vocational nurses (LPN/VNs) assist with gathering data. Subjective data is information obtained from the client and/or family members and offers important cues from their perspectives. When documenting subjective data stated by a client, it should be in quotation marks. Objective data is anything that you can observe through your sense of hearing, sight, smell, and touch while assessing the client. There are three sources of assessment data: interview, physical examination, and review of laboratory or diagnostic test results. A physical examination is a systematic data collection method of the body that uses the techniques of inspection, auscultation, palpation, and percussion. Inspection is the observation of a client's anatomical structures. Auscultation is listening to sounds, such as heart, lung, and bowel sounds, created by organs using a stethoscope. Palpation is the use of touch to evaluate organs for size, location, or tenderness. Percussion is an advanced physical examination technique typically performed by providers where body parts are tapped with fingers to determine their size and if fluid or air are present. After nurses collect assessment data from a client, they use their nursing knowledge to analyze that data to determine if it is expected or unexpected or normal or abnormal for that client according to their age, development, and baseline status. From there, nurses determine what data is clinically relevant as they prioritize their nursing care.