| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555115 | A. Building<br>B. Wing | 03/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Majestic Mountain Care Center | 40131 Highway 49<br>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) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**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 Abuse Prevention and Response Policy to ensure residents were free from abuse and neglect for two of six sampled residents (Resident 1 and Resident 3) when:1.Social services was made aware of Resident 1's allegation of sexual abuse and did not investigate or document the incident.This failure placed Resident 1 at risk for further abuse, neglect and emotional harm.2. Licensed Vocational Nurse (LVN) 3 left Resident 3 unsupervised outside the facility front door for 15-20 minutes and Resident 3 left the facility.This failure placed Resident 3 at risk for harm due to the facility being located on a busy highway, at risk for falls and injury.Findings:1. 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].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 11/26/2025, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 12 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 moderate cognitive impairment.During a telephone interview on 3/24/26 at 8:50 a.m. with the administrator (ADM), the ADM stated that on 3/12/26, he was informed by facility staff that Resident 1 had reported an incident involving Resident 2 inappropriately touching Resident 1's breast. The ADM stated that on 3/12/26, an investigation was initiated to gather more information regarding the incident. The ADM stated that during the investigation Resident 1 had requested the incident not be reported to any authorities. The ADM stated that based on Resident 1's request the incident was not reported per facility policy and instead was only reported to law enforcement.During a review of Resident 2's admission Record, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnosis for Alzheimer's disease.During a review of Resident 2's Minimum Data Set, dated [DATE], the MDS indicated, Resident 2's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 4 out of 15, which indicated Resident 2 had severe cognitive impairment.During an interview on 3/24/26 at 11:20 a.m. with CNA 1, CNA 1 stated it was the facility process to report and investigate sexual abuse or any forms of abuse allegation immediately to ensure all residents were safe. CNA 1 stated Resident 1 had reported feeling uncomfortable with Resident 2 and Resident 1 would request staff keep her away from Resident 2. CNA 1 stated it was important to report and investigate sexual abuse allegations to prevent further abuse and to protect Resident 1 from any distress.During a concurrent observation and interview on 3/2/26 at 11:41 a.m. with Resident 2 in Resident 2's room, Resident 2 was observed sitting on his wheelchair not moving right hand, arm and right leg. Resident 2 denied any incident involving any residents in the facility. Resident 2 stated he did not recall any inappropriate touching toward another resident in the facility.During a concurrent interview and record review on 3/24/26 at<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 12:13 p.m. with LVN 1, Resident 1's Electronic Medical Record (EMR) were reviewed. The LVN 1 stated, no documentation or investigation was found for Resident 1's report of sexual abuse incident on 3/12/26 in Resident 1's EMR. Resident 2's document titled, Inappropriate Behavior- Care Plan (CP), dated 9/1/2025, was reviewed. The CP indicated, . Inappropriate behavior towards a female resident. Was witnessed grabbing a female resident's breast in the social dining room. Goal: my behavior will stop with staff interventions. Interventions: 15 minute checks. offer me something I like as a diversion. Resident to be monitored during mealtimes at the social dining room to ensure he is not to be by female residents. LVN 1 stated Resident 1 had reported, that during a mutual hug with Resident 2, Resident 2 touched both of Resident 1's breast without consent. Resident 1's report of alleged sexual abuse should have been reported immediately to ensure Resident 1 was separated from Resident 2 and safe from any potential abuse. LVN 1 stated Resident 2 should have been kept away or separated from female residents. During an interview on 3/24/26 at 12:55 p.m. with Resident 1, Resident 1 stated she recalled an incident that involved Resident 2 inappropriately touching both her breast. Resident 1 stated she could not recall the date of the incident but did recall Resident 2 requesting a hug from Resident 1 as she was attempting to walk away in the hallway. Resident continued to state, Resident 2 would not allow her to walk through the hallway therefore Resident 1 agreed to give Resident 2 a hug. Resident 1 stated that as she pulled away from Resident 2, Resident 2 slid his hand over both of Resident 1's breast. Resident 1 stated she immediately yelled at Resident 2 and informed him that the action was inappropriate. Resident 1 stated she felt violated as the action from Resident 2 touching her breast felt intentional. Resident 1 stated she felt safe in the facility only after she informed the staff herself of the situation.During an interview on 3/24/26 at 1:22 p.m. with social services (SS), the SS stated that on 3/12/26 Resident 1 reported that Resident 2 had been harassing and following Resident 1 in the facility. SS stated Resident 1 reported that there was an incident in which Resident 2 had inappropriately touched her breast while engaging in a mutual hug. SS stated the incident was not reported per Resident 1's request to not report it. SS stated there was nothing that was done for the allegation other than a call to local law enforcement, who had concluded there was nothing they could do. SS stated following the local law enforcement visit, no further interventions were made from the facility. SS stated the facility process was to conduct an investigation, ensure resident safety and implement new interventions to ensure the incident would not happen again. SS stated the process was to monitor Resident 1 for psychosocial harm or changes in behavior. SS stated since the incident was reported there were no SS visits with Resident 1 due to a lot going on and forgot to do it. SS stated Resident 1 was kept safe and interventions were initiated but could not answer how facility staff was made aware of the allegation or where the allegation was documented.During an interview on 3/24/26 at 1:37 p.m. with the clinical coach (CC), the CC stated the facility had made her aware of the allegation on 3/24/26. The CC stated the facility process for an allegation of abuse was for staff to ensure safety, separate the residents, and report it immediately. The CC stated it was important to report and document allegations of abuse to ensure the residents were safe and to prevent further abuse. During a concurrent interview and record reviewed on 3/24/26 at 2:05 p.m. with LVN 2, Resident 1's EMR were reviewed. The LVN 2 stated, no documentation or investigation was found for Resident 1's report of sexual abuse incident on 3/12/26 in Resident 1's EMR. LVN 2 stated she was made aware of Resident 1's allegation toward Resident 2, when Resident allegedly touched Resident 1's breast. LVN 2 stated Resident 2 had a history of inappropriate behavior toward female residents and staff. LVN 2 stated she was unaware of new interventions for Resident 1 following the incident. LVN 2 stated all staff would monitor Resident 2 when he was up in the wheelchair due to the past inappropriate behaviors. LVN 2 stated the facility process was to ensure resident safety following an allegation of abuse, documenting the incident, ensuring all residents involved were closely monitored for behavioral changes and implementing new interventions. LVN 2 stated the facility process was to report and document the allegations to ensure the incident was investigated and to monitor Resident 1 for emotional distress, withdrawing from<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | normal activities or feeling scared. The LVN stated, no documentation or investigation was found for Resident 1's report of sexual abuse incident on 3/12/26 in Resident 1's EMR. 2. During a review of Resident 3's admission Record, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnosis for Dementia, Schizophrenia, muscle weakness.During a review of Resident 3's Minimum Data Set, dated [DATE], the MDS indicated, Resident 3's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 14 out of 15, which indicated Resident 2 cognitively intact.During an interview on 3/24/26 at 11:48 a.m. with Resident 3, Resident 3 stated he had left the facility through the front door during a smoke break. Resident 3 stated he had hitchhiked a ride to an unfamiliar female's home where Resident 3 was given money to travel. Resident 3 stated the unfamiliar female drove Resident 3 to a local casino 12.4 miles away from the facility where Resident 3 remained until local law enforcement arrived. Resident 3 stated he felt safe in the facility but when Resident 3 was given an opportunity to leave the facility, Resident 3 would leave again.During a concurrent interview and record review on 3/24/26 at 11:55 a.m. with the activities director (AD), the facility's Elopement Binder, undated, was reviewed. The AD stated the elopement binder was used to identify the residents who were at risk for elopement. The AD stated Resident 3 was listed on the Elopement binder as at risk with a total elopement assessment score of 20. The AD stated a score of 10 or above represented a high risk for elopement. The AD stated the purpose of identifying the residents at risk for elopement was to ensure all facility staff were closely monitoring the residents identified to prevent residents from eloping.During a review of Resident 3's, Elopement Risk, dated 1/10/2026, the document indicated Resident 3 had a score of 20 indicating a total score 10 or above represented high risk.During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1, the facility's Elopement Binder, undated, was reviewed. The Elopement binder indicated Resident 3 had an elopement risk score of 20. LVN 1 stated the elopement binder was the first tool used by the facility staff to identify the residents at risk for elopement. LVN 1 stated the elopement binder consisted of the residents' admission record, elopement risk assessment, elopement care plan and the residents physician orders. LVN 1 stated that Resident 3 had left the faciity on 3/21/26 when Resident 3 was left outside by LVN 3 during a smoking break without staff supervision. LVN 1 stated the facility process was for all residents to have staff supervision when going outside, especially residents who were at risk for elopement. LVN 1 stated the facility process was to monitor residents who were outside to avoid falls, injuries and elopement.During a review of Resident 3's Progress Note, dated 3/21/26 at 6:30 p.m., the note indicated, .Nurse on shift heard front door alarm going off and approached to turn off alarm and found [Resident 3] sitting on bench outside of front door smoking a cigarette. Alarm on door was shut off and staff reminded [Resident 3] to come inside building once done smoking, resident agreed. [LVN 3] went back to north hall to finish completing admission. after approximately 10-15 minutes [LVN 3] went to check on [Resident 3] in front sitting area and [Resident 3] was not there. [LVN 3] walked out to front parking lot with certified nursing assistant (CNA) and saw nothing signaling [Resident 3] was outside. [LVN 3] and CNA returned into the building and checked [Resident 3] room and bathroom. When [Resident 3] was not found in room/bathroom CNA and [LVN 3] alerted staff to start searching building for client. Parking lot around building, inside building searched and [Resident 3] was not found.During an interview on 3/24/26 at 1:09 p.m. with social services (SS), SS stated that on 3/21/26, Resident 3 had eloped from the facility. SS stated that Resident 1 was left alone and unsupervised during a smoke break by LVN 3. SS stated the facility process was for the assigned staff to remain outside with residents during an outing or during smoke breaks. SS stated the residents should not be left alone when being outside. SS stated Resident 3 should not have been left outside unsupervised due to the potential for elopement that could have led to injury or accidents.During an interview on 3/34/26 at 1:37 p.m. with the Clinical Coach (CC) the CC stated Resident 3 had eloped from the facility on 3/21/26. The CC stated Resident 3 was left outside without supervision during a smoke break. The CC stated that according to the facility's investigation, (continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 3 was left outside without supervision for approximately 10-15 minutes. The CC stated the facility process was for the staff to monitor and remain with residents when residents were outside, especially during smoking breaks to ensure resident safety.During an interview on 3/24/26 at 1:51 p.m. with the AD, the AD stated it was the facility process for all residents to be monitored during outings and smoking breaks. The AD stated on 3/21/26, Resident 3 was left outside by LVN 3 unsupervised during a smoking break. The AD stated Resident 3 should not have been left outside unsupervised due to the high risk for elopement and for safety. The AD stated the facility had a designated smoking area with designated smoking times that should have been followed on 3/21/26. The AD stated the front of the facility where Resident 3 was left was not a designated smoking area. The AD stated it was important to follow the facility's process to ensure all residents were safe and monitored.During an interview on 3/24/26 at 2:05 p.m. with LVN 2, LVN 2 stated that on 3/21/26, Resident 3 was left unsupervised outside the front door by LVN 3 during a smoking break. LVN 2 stated the front door area was not a designated smoking area and Resident 3 should have been redirected by LVN 3. LVN 2 stated the facility staff should monitor all residents that were outside especially the residents who were a high risk for falls an elopement. LVN 2 stated residents should not have been left unattended and unsupervised at any moment during an outing or smoking break. LVN 2 stated there was a safety concern for residents left unattended due to the potential for falls, injury or elopement.During an interview on 3/24/26 at 2:50 p.m. with the administrator (ADM), the ADM stated the expectation was for the facility staff to follow all policy and procedures which included monitoring of residents during smoke breaks. The ADM stated that no residents should have been left alone during smoking breaks due to the safety concerns. During an attempted telephone interview on 3/24/26 at 4:30 p.m. with LVN 3, LVN 3 was called with several attempts for interview, messages were left requesting call back but were unsuccessful.During a record review of the facility's policy and procedure (P&P) titled, .Abuse Prevention and Response Policy, undated, the P&P indicated, Purpose: To ensure the safety, dignity, and well-being of all residents by preventing, identifying, reporting, and responding to all forms of abuse, neglect, mistreatment, and exploitation within the facility. Policy Statement: This facility maintains a zero-tolerance policy for abuse, neglect, exploitation, or mistreatment of residents. All staff, contractors, volunteers, and visitors are required to uphold this policy and report any suspected or alleged incidents immediately. Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or emotional distress. Reporting Requirements. staff must not delay reporting to conduct their own investigation. Response and Investigation, Ensure immediate protection of the resident, including medical care if needed. All allegations, observations, and actions taken must be documented promptly and accurately. Records must include dates, times, individuals involved, and actions taken. Residents have the right to be free from abuse, neglect, exploitation, and mistreatment. Residents and families will be informed of these rights upon admission and throughout their stay. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure violations involving abuse were reported for one of three sampled residents (Resident 1) when facility staff did not report an allegation of abuse for Resident 1's report of sexual abuse involving Resident 2 touching her breast without consent.This failure placed Resident 1 safety at risk and there was potential for further abuse.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].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 11/26/2025, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 12 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 moderate cognitive impairment.During a review of Resident 2's admission Record, the AR indicated, Resident 2 was admitted to the facility on [DATE].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 2/5/26, the MDS indicated, Resident 2's Brief Interview for Mental Status score was 4 out of 15 which indicated Resident 2. During a telephone interview on 3/24/26 at 8:50 a.m. with the administrator (ADM), the ADM stated that on 3/12/26, he was informed by facility staff that Resident 1 had reported an incident involving Resident 2 inappropriately touching Resident 1's breast. The ADM stated that on 3/12/26, an investigation was initiated to gather more information regarding the incident. The ADM stated that during the investigation Resident 1 had requested the incident not be reported to any authorities. The ADM stated that based on Resident 1's request the incident was not reported to state agency and instead was only reported to law enforcement.During an interview on 3/24/26 at 11:20 a.m. with CNA 1, CNA 1 stated it was the facility process to report and investigate sexual abuse or any forms of abuse allegation immediately to ensure all residents were safe. CNA 1 stated it was important to report and investigate sexual abuse allegations to prevent further abuse and to protect Resident 1 from any distress.During a concurrent interview and record review on 3/24/26 at 12:13 p.m. with licensed vocational nurse (LVN) 1, the facility document titled, Report of Suspected Dependent Adult/Elder Abuse, undated, was reviewed. The facility document indicated, . This form documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult. Abuse means any treatment with resulting physical harm, pain, or mental suffering or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect has occurred, shall complete this form for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult immediately or as soon as practicably possible. LVN 1 stated the facility process for an allegation of abuse was for the allegation to have been reported immediately using the Report of Suspected Dependent Adult/Elder Abuse document. LVN 1 stated Resident 1 had reported that during a mutual hug with Resident 2, Resident 2 touched both of Resident 1's breast without consent. Resident 1's report of alleged sexual abuse should have been reported immediately to ensure Resident 1 was separated from Resident 2 and safe from any potential<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | abuse.During an interview on 3/24/26 at 12:55 p.m. with Resident 1, Resident 1 stated she recalled an incident that involved Resident 2 inappropriately touching both her breast. Resident 1 stated she could not recall the date of the incident but did recall Resident 2 requesting a hug from Resident 1 as she was attempting to walk away. Resident continued to state, Resident 2 would not allow her to walk through the hallway therefore Resident 1 agreed to give Resident 2 a hug. Resident 1 stated that as she pulled away from Resident 2, Resident 2 slid his hand over both of Resident 1's breast. Resident 1 stated she immediately yelled at Resident 2 and informed him that the action was inappropriate. Resident 1 stated she felt violated as the action from Resident 2 touching her breast felt intentional. Resident 1 stated she felt safe in the facility only after she informed the staff herself of the situation.During an interview on 3/24/26 at 1:22 p.m. with the social services director (SSD) the SSD stated that on 3/12/26, Resident 1 reported that Resident 2 had touched her breast without consent. The SSD stated that Resident 1 requested the SSD to not report the incident outside of the facility. The SSD stated the incident was not reported as per facility policy. The SSD stated all staff in the facility were mandated reporters and the allegation of sexual abuse that Resident 1 had reported should have been reported immediately.During an interview on 3/24/26 at 1:37 p.m. with the clinical coach (CC), the CC stated the facility process for an allegation of abuse was for staff to ensure safety, separate the residents, and report it immediately. The CC stated it was important to report allegations of abuse to ensure the residents were safe and to prevent further abuse.During an interview on 3/24/26 at 2:50 p.m. with the ADM, the ADM stated the facility process was for an abuse allegation included reporting the incident immediately. The ADM stated the expectation was for staff to follow all policies.During a record review of the facility's policy and procedure (P&P) titled, Unusual Occurrence Reporting, dated 12/2007, the P&P indicated, . Our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. Our facility will report the following events to appropriate agencies. allegations of abuse, neglect. unusual occurrences shall be reported via telephone to appropriate agencies as required as required. |