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	04/28/2026

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 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 adequate supervision to prevent accidents for one of three sampled residents (Resident 1) when Resident 1, was left unattended in bed lying on his right side by Licensed Vocational Nurse (LVN) during wound-care treatment (specialized medical management of skin injuries to promote healing and prevent infection) on [DATE], while the right side of his bed had no bedrail in place.This failure resulted in Resident 1 falling from his bed onto the floor causing an avoidable left hip fracture (broken bone) and mild pain.During a concurrent observation and interview on [DATE] at 9:17 a.m. with Resident 1, in Resident 1's room, Resident 1 was lying in bed. Resident 1 was covered with a blanket that notably outlined his bilateral (left and right) above the knee amputations (removal of limbs). Resident 1 stated he had a fall at the facility. Resident 1 stated on the day of the fall, he was receiving care from the LVN and a wound doctor, and during the care they left the room. Resident 1 stated he had fallen asleep, rolled on to his back and off the bed. Resident 1 stated staff had to get a machine to help get him back in bed. Resident 1 stated x-rays (medical test that produces pictures of the inside of the body) were taken and he was told he had a fracture.During an interview on [DATE] at 9:30 a.m. with Resident 2 (Resident 1's roommate), Resident 2 stated Resident 1 fell two weeks ago in their room. Resident 2 stated he did not witness the fall. Resident 2 stated on the day of the fall, a woman was with Resident 1 and then she left the room. Resident 2 stated he heard a shaking motion coming from Resident 1's bed and then Resident 1 fell onto the floor, on the right side of Resident 1's bed. Resident 2 stated four or five people came to help get Resident 1 off the floor and into bed. Resident 2 stated Resident 1 was bedridden because he had no legs.During an interview on [DATE] at 10:02 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on the day of Resident 1's fall, CNA 1 was caring for another resident who was across the hall from Resident 1's room. CNA 1 stated he heard a faint cry for help. CNA 1 stated he entered Resident 1's room and noticed Resident 1 was not in his bed. CNA 1 stated it was not normal for Resident 1 to be out of his bed due to his condition. CNA 1 stated he found Resident 1 on the floor. CNA 1 stated Resident 1 had no visible injuries and was not complaining of any pain. CNA 1 stated he called a Registered Nurse (RN) for help. CNA 1 stated a large team of staff needed to get Resident 1 into bed but could not recall who was specifically there. CNA 1 stated Resident 1 was a one-person assist prior to his fall at the facility.During an interview on [DATE] at 10:15 a.m. with the LVN, the LVN stated she was the wound treatment nurse caring for Resident 1 on the day of his fall. The LVN stated she and the wound doctor were performing wound care on Resident 1 when she noticed blood on Resident 1's brief (a single use absorbent garment like underwear). The LVN stated she asked a CNA to get her a new brief for Resident 1. The LVN stated she then left Resident 1's room with Resident 1 lying on his side without placing a new brief. The LVN stated she assumed a CNA would put a brief on Resident 1. The LVN stated she went into another resident's room and heard Resident 1 fell. The LVN stated she did not return to Resident 1's room after the fall but was made aware he sustained a left hip fracture. The LVN stated Resident 1 used Acetaminophen (medication used for mild pain) as needed for pain control after the fall. The LVN (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she should have made sure a brief was placed on Resident 1 before she left the room. The LVN stated she felt it was her fault that Resident 1 fell.During an interview on [DATE] at 10:30 a.m. with CNA 2, CNA 2 stated he did not witness Resident 1 fall, but he was at the facility at the time it happened. CNA 2 stated he was caring for another resident when CNA 1 asked him to help get Resident 1 back into bed. CNA 2 stated he grabbed a sling (hammock-like support system attaches to a mechanical lift) and the mechanical lift (a device used to transfer someone from one place to another) to lift Resident 1 back into bed. CNA 2 stated this was the first time Resident 1 had fallen at the facility.During an interview on [DATE] at 12:53 p.m. with CNA 3, CNA 3 stated CNA 1 informed her of Resident 1's fall. CNA 3 stated she asked Resident 1 what happened. CNA 3 stated Resident 1 reported he was waiting for the LVN who was doing his wound care to get a brief and he fell. CNA 3 stated Resident 1 complained of pain in his left hip. CNA 3 stated this was Resident 1's first fall in the facility. CNA 3 stated Resident 1 must have been left in a vulnerable position to have fallen.During an interview on [DATE] at 11:18 a.m. with the Director of Nursing (DON), the DON stated she was not familiar with Resident 1 because she had only been the DON at the facility for two weeks. The DON stated she heard of Resident 1's fall from the Assistant Director of Nursing (ADON). The DON stated Resident 1 had an unwitnessed fall off the right side of the bed. The DON stated prior to the fall Resident 1 had a side rail for mobility on the left side of his bed only. The DON stated Resident 1 initially did not complain of pain but later reported left side pain. The DON stated Resident 1 refused to be transferred to the hospital for further evaluation.During a concurrent interview and record review on [DATE] at 11:41 a.m. with the ADON, Resident 1's Care Plan Report (CPR) dated [DATE] was reviewed. The CPR indicated, prior to Resident 1's fall, Resident 1 .Requires Assist of 1-2 person Assist to Start and Complete Most ADL [activities of daily living - basic routine self-care tasks such as bathing, dressing, and eating] Task. The ADON stated she was familiar with Resident 1's recent fall. The ADON stated she had been informed Resident 1 had a fall, complained of left side pain but refused to go to the hospital. The ADON stated Resident 1 reported he was leaning on his right side waiting for help and it felt like gravity pulled him down. The ADON stated Resident 1 fell off the right side of his bed. The ADON stated Resident 1 was a two-person assist prior to fall. The ADON stated she was shocked to hear Resident 1 was a one-person assist. The ADON stated had two caregivers been present, the fall could have been avoided. The ADON stated the LVN should never had left Resident 1 in the middle of providing care. The ADON stated it was standard practice (written guidelines that define the minimum, acceptable level of performance, skill and care expected of a professional) to not leave any resident by themselves during care. The ADON stated if Resident 1 had his care completed before the LVN left the room, the fall could have been avoided.During an interview on [DATE] at 12:04 p.m. with the Administrator (ADM), the ADM stated he was not in the facility at the time of Resident 1's fall. The ADM stated he was not a part of the Interdisciplinary Team (IDT- a collaborative routine gathering of professionals from various specialties like nurses, doctors, therapists and social workers) for Resident 1's fall investigation. The ADM stated he was the Abuse Coordinator and should have probably been a part of the IDT investigation into Resident 1's fall. The ADM stated the results of the IDT investigation showed the LVN left Resident 1 unattended during wound care. The ADM stated during wound care two people should be present, the nurse and the wound care doctor. The ADM stated Resident 1's fall was potentially avoidable.During a record review of Resident 1's admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE] with the diagnosis of .Acquired Absence of Right Leg Above the Knee, Acquired Absence of Left Leg Above the Knee.During a record review of Resident 1's Order Summary Report (OSR) dated [DATE] the OSR indicated, Resident 1 had an order to assess for pain every shift and chart intensity of pain 0 equals no pain, 1-4 equals mild pain, 5-7 equals moderate pain, 8-10 equals severe to excruciating pain. The OSR indicated, he had an order for left side 1/4 rail for functional bed mobility assist. The OSR indicated, an order for .Acetaminophen Tablet 325 MG [milligrams- unit of measurement]. 2 tablet by mouth every 6 hours as needed for pain . The OSR indicated, an order for (continued on next page)

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