

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2026
NAME OF PROVIDER OR SUPPLIER Majestic Mountain Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 interview and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for one of three sampled residents (Resident 1) when facility staff did not provide supervision for Resident 1 when Resident 1 exited the facility through the back patio door, wandered off the facility perimeter that did not have a fence or barrier dividing the front and back of the facility and was located in a rough terrain area with tall grass, tall bushes, long tree branches, mud and a water hole. This failure had the potential to cause falls and injuries to Resident 1 and other Residents in the facility. 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, muscle weakness, anxiety disorder (disorder causing excessive, persistent fear or worry that interferes with daily life), insomnia (sleep disorder characterized by difficulty falling or staying asleep), abnormalities of gait and mobility. 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 12/29/25, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 14 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 5/6/26 at 10:13 a.m. with certified nursing assistant (CNA) 1, the back patio and trail leading to the front of the facility was observed. The back patio and trail were observed with no barrier or fence separating the front and back of the facility. CNA 1 stated that on 5/2/26, Resident 1 went outside to the back patio, walked around the trail leading to the front of the facility and walked outside the facility perimeter without supervision or staff knowledge that Resident 1 had left the facility grounds. CNA 1 stated the area where Resident 1 was found had rough terrain with tall grass, long bushes and tree branches and a water hole with a narrow trail. CNA 1 stated she was unsure if Resident 1 required supervision while being outside as he had been seen sitting alone outside in the past. During a telephone interview on 5/6/26 at 10:43 a.m. with licensed vocational nurse (LVN) 1, LVN 1 stated on 5/2/26, Resident 1 was observed by Activity Assistant (AA) 1 going outside alone without staff. LVN 1 stated she was alerted via staff communication that Resident 1 could not be found in the facility and immediately initiated a search. LVN 1 stated that Resident 1 was found lying outside the facility perimeter located between a wire fence, bushes, and tall grass. LVN 1 stated it was the facility process to monitor and supervise residents when they went outside for safety. During a telephone interview on 5/6/26 at 10:54 a.m. with AA 1, AA 1 stated that on 5/2/26, Resident 1 was observed walking outside to the back patio through the dining room door. AA 1 stated that Resident 1 had stated he would be going outside for fresh air and would be returning shortly. AA 1 stated Resident 1 walked outside with his walker alone. AA 1 stated Resident 1 was observed by the dining room window as AA 1 continued to assist other residents in the dining room activities. AA 1 stated, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555115	Facility ID: 555115
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During a telephone interview on 5/6/26 at 11:30 a.m. with LVN 3, LVN 3 stated that on 5/2/26 Resident 1 had left the facility through the back door and was located outside the facility perimeter lying on the ground surrounded by thick bushes, tall grass, and a water hole. LVN 3 stated the facility process was for all residents to have been monitored by staff when going outside or going into the back patio. During a concurrent observation on 5/6/26 at 12:00 p.m. with the MDS nurse and the director of nursing (DON), the facility's video surveillance dated 5/2/26 was reviewed. The video surveillance showed Resident 1 walking outside with a walker to the back patio area through the dining room back door. Resident 1 was observed to be walking alone with no staff or other visitors or residents present. Resident 1 was observed walking with his walker to the end of the cemented pathway and onto the grass area leading to the front of the facility parking lot and driveway. Resident 1 was observed walking toward the driveway until the end of the wire fence was reached, then proceeded to walk into the tall grass area with heavy terrain and bushes outside the facility perimeter. During an interview on 5/6/26 12:10 p.m. with Registered Nurse (RN) 1, RN 1 stated the facility process was for staff to monitor all residents when they were outside. RN 1 stated the facility had a back patio area where residents sat for smoking breaks or outings when doing activities. RN 1 stated the lack of fencing to the back patio area could have been a safety concern due to residents' access to the parking lot and driveway. During an interview on 5/6/26 at 2:18 p.m. with the activities director (AD), the AD stated the facility process was for all residents to have supervision when going outside by themselves. The AD stated the AAs were trained to alert staff when a resident was requesting to go outside and when the AA was unable to assist with monitoring the resident. During an interview on 5/6/26 at 2:39 p.m. with CNA 2, CNA 2 stated the facility process was for the staff to monitor all residents including residents who were independent and ambulatory when they were in the facility or going outside. CNA 2 stated it was important to monitor residents to ensure they are safe from falls or injuries and to ensure the residents do not wander away from the facility. CNA 2 stated the lack of fencing and barriers causing an open landscape around the facility was not safe for the residents, especially the residents who wander around the facility. During an interview on 5/6/26 at 2:51 p.m. with social services (SSD). The SSD stated on 5/2/26, Resident 1 left the facility through the back door in the dining room and was located outside the facility perimeter. The SSD stated the facility process was for all residents to be monitored when the residents were able to go outside independently or required assistance. The SSD stated the assumption was that if a resident in the facility used a walker or wheelchair and they were able to go outside, the facility staff should have monitored the residents. During an interview on 5/6/26 at 3:28 p.m. with the MDS, the MDS stated that on 5/2/26, Resident 1 had exited the facility through the back patio and walked around to the front of the facility where he exited the facility perimeter into a rough terrain area where he was found. The MDS stated the facility's lack of fencing or barriers dividing the back patio from the parking lot and front of the facility driveway was unsafe for the residents. During an interview on 5/6/26 12:30 p.m. with the administrator (ADM), the ADM stated the facility expectation was to ensure resident safety within the facility. The ADM stated the back patio area was not enclosed, fenced or had a barrier dividing the back patio to the front of the facility driveway and parking lot. The ADM stated all residents in the facility should be supervised or monitored when going outside to ensure residents were safe and that they did not leave the facility without staff knowledge. During a record review of the facility's policy and procedure (P&P) titled, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safety and Supervision of Residents, dated 2001, the P&P indicated, .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Our facility-oriented approach to safety addresses risks for groups of residents. Safety risks and environmental hazards are identified on an ongoing basis. Our individualized resident-centered approach to safety addresses safety and accident hazards for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. The facility oriented and resident oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors and then adjust interventions accordingly. Resident supervision is a core component of the system's approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment .		