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	08/07/2024

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. 28193 Based on interview, record review, and facility policy review, the facility failed to provide a response and resolution for resident grievances in a timely manner. This deficiency had the potential to affect all residents that resided in the facility. Findings included: An undated facility policy titled, Theft/Loss/Complaint/Grievance Policy, indicated, Policy Statement: [Facility name] will promptly resolve all grievances and will provide a copy of this policy to the resident upon request. The policy indicated, A resident or representative will be notified of: A reasonable expected time frame for completing the review of the grievance and The right to obtain a written decision regarding his or her grievance. The policy indicated, A Grievance Official will: Notify resident or representative's RP [responsible party] of results of investigation and corrective action within 7 days of the completion of the investigation. The policy indicated, Written grievance decisions will include: Date the grievance was received; A summary statement of the resident's grievance; A summary of the pertinent findings or conclusions regarding the resident's concern(s); A statement as to whether the grievance was confirmed or not confirmed; Any corrective action taken by the care center as result of the grievance; The date the written decision was issued. The facility's Grievance/Complaint Investigation Reports, for the timeframe from 01/01/2024 through 07/28/2024 revealed nine of 11 reports provided had no documented investigation initiated or follow-up information provided on the form. The Resident Council Minutes for the timeframe from 01/04/2024 through 07/05/2024, revealed the following patterns of repeat grievances: call light response time was noted all seven months without a documented resolution; meal set up assistance was noted five months (01/04/2024, 02/01/2024, 03/07/2024, 04/04/2024, and 07/05/2024) without a documented resolution; noisy staff in the hallways was noted two months (04/04/2024 and 05/02/2024) without a documented resolution; and call lights needing clipped within reach was noted two months (05/02/2024 and 07/05/2024) without a documented resolution. An Admission Record revealed the facility admitted Resident #5 on 12/20/2018. According to the Admission Record, the resident had a medical history that included diagnoses of multiple sclerosis, epilepsy, atrial flutter, and major depressive disorder. (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

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	08/07/2024

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/09/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. During an interview on 08/01/2024 at 1:10 PM, Resident #5, who had attended the Resident Council Meetings, stated they had voiced complaints to staff; however, the staff did not come back and tell them what happened regarding any resolutions. Resident #5 stated they had expressed complaints regarding staff shutting off the call light and not returning for a long period of time. Resident #5 stated they had also expressed concerns with the staff being very loud at night, laughing and yelling down the hallway. During an interview on 08/04/2024 at 12:57 PM, the Social Services Director (SSD), who was also the Grievance Officer, stated that when she received a complaint from a resident or family member, the team would try to solve it in a timely manner. The SSD stated if the concern was taken care of immediately a form was not filled out. The SSD stated the Activities Director (AD) had a different form for grievances. The SSD stated, if the AD received the grievance, then the AD would see the process through to the end and the AD would make Social Services aware of the issue. She stated the form would be brought to the morning meeting and given to the appropriate department head to address. During an interview on 08/05/2024 at 12:40 PM, the AD stated she wrote down grievances in the Resident Council Meeting every month, and she would then pass them out to the appropriate department heads at the next morning meeting. The AD stated she would sometimes receive the forms back, or the department head would address the situation verbally with her and she would make follow-up notes on the form. The AD stated she had never gone back to the resident to give an answer for the concern. The AD stated she was not aware she was responsible for the concerns she received during the meetings. The AD agreed the same concerns were written down month after month and the residents did not receive a resolution to their concerns. The AD stated she knew it looked bad on paper, and it was very frustrating to her and the residents that items were mentioned month after month and not fixed. During an interview on 08/06/2024 at 10:16 AM, the Interim Director of Nursing (IDON) stated the expectation was for the staff member who took the grievance to fill out the grievance form and give it to Social Services. The IDON stated Social Services responsibility was to interview and understand what the grievance was addressing and to find a resolution in a timely manner. The IDON stated a copy of the grievance was to go to the appropriate department head to ensure resolution. The IDON further stated the facility staff should be following up with residents and, if they were not, then that was an issue. During an interview on 08/06/2024 at 11:30 AM, the Administrator stated the expectation was to assign the SSD as the one responsible for the grievance and to ensure every grievance was followed through. The Administrator stated he expected grievances to be followed through timely and given to him after resolution for his signature.

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	08/07/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45555 Based on interview, record review, and facility policy review, the facility failed to notify the physician when new pressure ulcers were identified and when nursing staff noted increased wound measurements or a decline in the condition of pressure ulcers for 2 (Resident #15 and Resident #46) of 4 sampled residents reviewed for pressure ulcers. Findings included: A facility policy titled, Change in a Resident's Condition or Status, revised in 02/2021, indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g. [for example], changes in level of care, billing/payments, resident rights, etc. [et cetera]). The policy also indicated the nurse was to notify the resident's attending physician or physician on call when there was a, d. significant change in the resident's physical/emotional/mental condition. e. need to alter the resident's medical treatment significantly. 1. An Admission Record indicated the facility admitted Resident #15 on 07/28/2022. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus, obesity, and bilateral above the knee amputations. The Admission Record revealed diagnoses of Stage III pressure ulcers to the left and right buttocks were added to the resident's list of diagnoses on 07/19/2024. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/08/2024, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had two Stage III pressure ulcers, one of which was present upon admission. The MDS also revealed Resident #15 had moisture-associated skin damage. Per the MDS, the resident had treatments for pressure ulcers that included a pressure reducing device for the bed, a nutrition or hydration intervention to manage skin problems, and pressure ulcer/injury care. Resident #15's care plan included a focus area, initiated on 03/18/2023 and revised on 08/16/2023, that indicated the resident had a recurring Stage III pressure ulcer to the left buttock. A care plan focused area, initiated on 08/03/2024, indicated the resident also had a Stage III pressure ulcer to the right buttock. Resident #15's Order Recap [recapitulation] Report revealed physician orders started on 04/18/2024 to clean the left superior buttock recurrent Stage III pressure ulcer and the right buttock recurring Stage III pressure ulcer with normal saline, pat the areas dry, apply Calmoseptine (a moisture barrier/skin protectant) and Vaseline/A&D Ointment (treats and prevents skin irritations) to the wound beds, and cover the areas with a non-adherent dressing every shift for 21 days. Per the Order Recap Report, these orders were discontinued on 04/25/2024, and the same treatments were ordered again on 04/25/2024 and remained in effect until 05/16/2024. (continued on next page)

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	08/07/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Weekly Wound Reviews for April 2024 revealed the following regarding the pressure ulcer to Resident #15's left buttock: - A Weekly Wound Review, dated 04/04/2024, indicated Resident #15's left buttock pressure ulcer was a Stage III wound measuring 6.3 cm in length x 0.6 cm in width x 0.1 cm in depth. The review indicated the wound base was comprised of 90% epithelial tissue and 10% red granulation tissue. - A Weekly Wound Review, dated 04/18/2024, indicated Resident #15's left buttock pressure ulcer was a Stage III wound. The length had decreased to 3.2 cm; however, the width had increased to 1.7 cm. The depth remained 0.1 cm. The review indicated the wound base was comprised of 50% pink epithelial tissue (decreased from 90%) and 50% red granulation tissue (increased from 10%). There was no documentation the physician was notified of the 40% loss of epithelialization. - A Weekly Wound Review dated 04/25/2024 indicated Resident #15's left buttock pressure ulcer was a Stage III wound that measured 3.0 cm in length. The width of the wound had increased to 2.4 cm. The depth remained 0.1 cm. The review revealed the wound base was comprised of 75% pink epithelial tissue and 25% red granulation tissue. The review indicated Calmoseptine cream was unavailable for three weeks and the pressure ulcer declined in that time. The section of the Weekly Wound Review form designated for information regarding physician notification was not completed to indicate the physician was informed of the Calmoseptine being unavailable or of a decline in the resident's wound. The review was signed as completed by Licensed Vocational Nurse (LVN) #17. Weekly Wound Reviews for April 2024 revealed the following regarding the pressure ulcer to Resident #15's right buttock: - A Weekly Wound Review dated 04/04/2024 indicated the right buttock pressure ulcer was a Stage III wound that measured 1.7 cm in length x 0.5 cm in width x 0.1 cm in depth. The review indicated the wound bed was comprised of 100% granulation tissue. - A Weekly Wound Review dated 04/25/2024 indicated the right buttock pressure ulcer was a Stage III wound that measured 6.1 cm in length x 2.5 cm in width x 0.2 cm in depth. The review revealed the wound base was comprised of 75% epithelial tissue and 25% granulation tissue. The review also indicated the Calmoseptine cream was unavailable for three weeks and that the pressure ulcer had declined in that time. The section of the review form designated for information regarding physician notification was not completed to indicate the physician was informed of the Calmoseptine being unavailable or of a decline in the resident's wound. The review was signed as completed by LVN #17. Resident #15's April 2024 Treatment Administration Record (TAR) revealed nursing staff documented the wound treatments to the left and right buttock pressure ulcers, which included application of Calmoseptine, were provided as scheduled, with the exception of eight occasions during the month of April 2024. There was no documentation the Calmoseptine was not available. The surveyor attempted to contact LVN #17 for a telephone interview to clarify the discrepancy regarding the availability of Calmoseptine on 08/03/2024 at 11:18 AM and 08/05/2024 at 3:21 PM. The surveyor left two voice mail messages requesting a return call. LVN #17 did not return the surveyor's call as of the survey exit date (08/07/2024). (continued on next page)

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	08/07/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Weekly Pressure Injury/Ulcer Progress Report, dated 05/23/2024, indicated Resident #15 had developed a new a Stage III pressure ulcer to the left inferior buttock that measured 1 cm in length x 1 cm in width. The report revealed the physician notification portion of the form was not completed and there was no documented evidence the facility notified the physician of a new pressure ulcer to the left inferior buttock. A Weekly Pressure Injury/Ulcer Progress Report, dated 05/23/2024, indicated the Stage III pressure ulcer to the left superior buttock measured 5.5 cm in length x 2.9 cm in width, with no depth measurement provided. The wound had increased in length and width since the most recent documented assessment on 04/25/2024. The report revealed the physician notification portion of the form was not completed and there was no documented evidence the resident's physician was notified of the increase in size of the pressure ulcer to the left superior buttock. A Weekly Pressure Injury/Ulcer Progress Report, dated 06/06/2024, indicated Resident #15 had developed a new pressure ulcer to the left sub-inferior buttock that measured 0.4 cm in length x 0.5 cm in width, with no depth measurement provided. The physician notification portion of the form was not completed, and Resident #15's health record revealed no documented evidence the resident's physician was notified the resident had developed a new pressure ulcer to the left sub-inferior buttock. A Weekly Pressure Injury/Ulcer Progress Report, dated 06/20/2024, indicated Resident #15 had multiple wounds to the left buttock with a total measurement of 9.3 cm in length x 2.2 cm in width, with no depth measurement provided. The physician notification portion of the report was not completed, and there was no documented evidence the physician was notified that the left buttock now had multiple wounds with an overall increase in size. Weekly Pressure Injury/Ulcer Progress Reports, dated 06/20/2024, indicated Resident #15 had a pressure ulcer to the right outer buttock that measured 0.6 cm in length by 0.5 cm in width (no depth measurement provided) and a pressure ulcer to the right inner buttock that measured 1 cm in length x 0.4 cm in width (no depth measurement provided). The physician notification sections of the reports were not completed, and there was no documented evidence the physician was notified of the development of an additional pressure ulcer to the right buttock. A Weekly Pressure Injury/Ulcer Progress Report, dated 06/27/2024, indicated Resident #15 now had multiple wounds to the right buttock; however, the report did not include individual measurements for each wound. The report indicated a measurement of 2.5 cm length by 1.9 cm width, with no depth measurement provided. A Weekly Pressure Injury/Ulcer Progress Report, dated 07/11/2024, indicated Resident #15 had a pressure wound to the right buttock that measured 3 cm length by 2 cm width, with no depth measurement provided. (This indicated the size had increased from the 06/27/2024 measurements of 2.5 cm length by 1.9 cm width). The physician notification portion of the report was left blank, and there was no documented evidence the physician was notified that the pressure ulcer size had increased. The report was signed as completed by LVN #11. A Weekly Pressure Injury/Ulcer Progress Report, dated 07/11/2024, indicated the site of the pressure ulcer was L [left] buttock. No specific location on the buttock was noted. The measurements indicated the pressure ulcer was 12.5 cm length x 7 cm width. No depth measurement was provided. The section of the form designated for documentation of physician notification was left blank, and there was no documentation the physician was consulted regarding the increased size of the wound to determine if a change in treatment was needed. The report was signed as completed by LVN #11. (continued on next page)

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	08/07/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Weekly Pressure Injury/Ulcer Progress Reports dated 08/01/2024 indicated Resident #15 continued to have pressure ulcers requiring treatment to the left and right buttocks. During an interview on 08/06/2024 at 8:36 AM, LVN #11 stated if a resident's pressure ulcer worsened, she notified a Registered Nurse (RN) or continued the same treatment. She stated she occasionally contacted the physician to get treatment orders but did not contact the physician every time a wound changed. LVN #11 stated she was not aware of whether Resident #15's physician had ever been seen the resident's pressure ulcers and was not sure the physician was ever notified of the pressure ulcers. During a telephone interview on 08/07/2024 at 3:31 PM, Physician #15 stated he knew that Resident #15 had a history of pressure ulcers but thought they were healed. He stated he was not aware that the resident currently had wounds and was not notified when the wounds were worsening. Physician #15 also stated that he had not seen the resident's pressure ulcers during the last three to four visits. He stated he thought that the facility had a wound team, including a wound physician that was visiting the facility weekly to manage residents' wounds and was not aware that they had stopped coming in February 2024. During an interview on 08/06/2024 at 10:16 AM, the Interim Director of Nursing (IDON) stated the physician should be notified of any change in a pressure ulcer and the notification should be documented in a progress note in the resident's medical record. During an interview on 08/06/2024 at 11:37 AM, the Administrator stated the physician should be notified any time there was a change to a pressure ulcer, and the notification should be documented in the resident's electronic health record. 2. An Admission Record indicated the facility admitted Resident #46 on 08/28/2023 and readmitted the resident on 07/18/2024 after a hospital stay from 07/10/2024 to 07/16/2024. According to the Admission Record, the resident had a medical history that included diagnoses of a fracture of the second cervical vertebra, type 2 diabetes, intervertebral disc displacement of the thoracic region, Stage II pressure ulcer of the right buttock, anterior spinal artery compression syndrome of the lumbar region, paraplegia, central cord syndrome of the cervical spinal cord, acute myelomonocytic leukemia, dementia, and cervical region spinal stenosis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/03/2024, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. The MDS indicated the resident was not at risk for developing pressure ulcers and did not have an unhealed pressure ulcer. A Weekly Wound Review dated 04/04/2024 indicated Resident #46 had a Stage III pressure ulcer to the coccyx that measured 1.5 centimeters (cm) in length by (x) 3.9 cm in width x 0.1 cm in depth. The review revealed the wound base was comprised of 75% red epithelial (newly healed) tissue and 25% red granulation (healing) tissue. (continued on next page)

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	08/07/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Weekly Wound Review dated 04/18/2024 indicated the Stage III pressure ulcer to Resident #46's coccyx measured 1.0 cm in length x 0.7 cm in width x 0.1 cm in depth. The wound measurements had decreased, but the review indicated the wound bed no longer had any epithelial tissue and was now comprised of 100% granulation tissue, which represented a deterioration in the wound status. The physician notification section of the review form was left blank, and there was no evidence the physician was notified of the change in wound status. The review was signed as completed by Licensed Vocational Nurse (LVN) #17. During an interview on 08/06/2024 at 8:36 AM, LVN #11 stated she had been doing the wound measurements since May 2024. She stated she was not trained to do this and, I do not know what I am doing with staging or documenting wounds. She stated if a wound got worse, she would let the Registered Nurse (RN) know or just continue the same treatment. She stated that occasionally, she would contact the physician to get treatment orders. She stated she did not contact the physician with changes every time, just once in a while. During an interview on 08/06/2024 at 10:16 AM, the Interim Director of Nursing (IDON) stated the physician should be notified of any change to a wound for treatment changes and nutritional support. She stated the notification should be documented in a progress note in the medical record. During an interview on 08/06/2024 at 11:37 AM, the Administrator stated the physician should be notified any time there was a change to a wound, and this should be documented in the resident's electronic health record.

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	08/07/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 28193 Based on interview, record review, and facility policy review, the facility failed to provide a means for residents to file an anonymous grievance. This deficiency had the potential to affect all residents that resided in the facility. Findings included: An undated facility policy titled, Theft/Loss/Complaint/Grievance Policy indicated, A resident or representative will be notified of: The right to file grievances orally (meaning spoken) or in writing; The right to file grievances anonymously; The contact information of the grievance official with whom a grievance can be filed. The policy also indicated, Anonymous grievances will have written decisions completed as related to a resident and if needed. 1. An Admission Record revealed the facility admitted Resident #5 on 12/20/2018. According to the Admission Record, the resident had a medical history that included diagnoses of multiple sclerosis, epilepsy, atrial flutter, and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/09/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. During an interview on 08/01/2024 at 1:10 PM, Resident #5 stated they did not know how to file a complaint other than to tell a staff member and were not aware of how to file an anonymous complaint. 2. An Admission Record revealed the facility admitted Resident #40 on 05/16/2022. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified dementia, type 2 diabetes mellitus, and hypertension. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/28/2024, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. During an interview on 08/01/2024 at 1:17 PM, Resident #40 stated they did not know how to file an anonymous complaint or that there was a form to complete to submit one. 3. An Admission Record revealed the facility admitted Resident #59 on 04/24/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's with late onset, hypothyroidism, anxiety, and hypertension. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2024, revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. (continued on next page)

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	08/07/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/01/2024 at 2:11 PM, Resident #59 stated they did not know how to file a grievance outside the resident council meetings. During an interview on 08/04/2024 at 12:57 PM, the Social Services Director (SSD), who was the Grievance Officer, stated there were hard copy grievance forms located at the nurses' station for anonymous grievances. She stated that if a staff member had to hand the form to a resident, it was not anonymous, so she guessed facility staff needed to put the forms somewhere else in the building where residents could get the forms themselves. She further stated most of the residents came to her directly or requested she go to their room, so residents may not know how to file an anonymous grievance. She stated that the residents were directed to come to her. During an interview on 08/05/2024 at 12:40 PM, the Activities Director stated there were forms at the nurses' station the residents could ask for if she was not available; however, that was not an anonymous system because someone would have to get the form for the resident. She further stated, No, we do not have a way for residents to make an anonymous complaint at this time. During an interview on 08/06/2024 at 10:16 AM, the Interim Director of Nursing (IDON) stated the facility had a grievance process, however, they did not currently have a place for a resident to file an anonymous grievance as they had to ask staff for a grievance form to fill out. During an interview on 08/06/2024 at 11:30 AM, the Administrator stated he expected residents to be able to file an anonymous grievance, and if they could not, that was an issue.

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	08/07/2024

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. 46194 Based on interview, record review, and review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete Minimum Data Set (MDS) assessments timely for 1 (Resident #21) of 20 sampled residents' whose electronic medical records were reviewed. Findings included: On 08/06/2024 at 12:32 PM, the Director of Clinical Operations (DCO) stated the facility used the RAI manual as their policy for MDS assessments. The CMS Long-Term Care Facility RAI 3.0 User's Manual, dated 10/2023, revealed, The Quarterly assessment is an OBRA [Omnibus Budget Reconciliation Act] non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. Per the manual The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type. The manual specified, -The ARD must be within 92 days after the ARD of the previous OBRA assessment (Quarterly, Admission, SCSA [Significant Change in Status Assessment], SCPA [Significant Correction to Prior Comprehensive Assessment], SCQA [Significant Correction to Prior Quarterly Assessment), or Annual assessment + 92 calendar days). -The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). An Admission Record indicated the facility admitted Resident #21 on 01/13/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Parkinson's disease, muscle weakness, and abdominal aortic aneurysm. Resident #21's most recent Minimum Data Set (MDS) was a quarterly assessment with an ARD of 04/21/2024, indicating their next assessment was to have an ARD no later than 07/22/2024. Resident #21's electronic medical record (EMR) revealed a quarterly MDS, with an ARD of 07/22/2024, was In Progress. The EMR flagged this MDS as 1 [one] day overdue. On 08/06/2024 at 10:52 AM, the MDS Director stated Resident #21's MDS was not completed on time. She stated she was new to the position and was learning. She also stated time management was another reason it was not completed. On 08/06/2024 at 11:08 AM, the Interim Director of Nursing (IDON) stated MDS assessments should be completed according to the allotted timeframes, and they should be submitted timely. On 08/06/2024 at 11:57 AM, the Administrator stated the MDS Consultant was supposed to monitor for the completion of the MDS assessments.

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	08/07/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45555 Based on interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected the presence of a serious mental illness per the state Level II Preadmission Screening and Resident Review (PASRR) process for 1 (Resident #15) of 4 residents reviewed for PASRR requirements. Findings included: On 08/06/2024 at 12:32 PM, the Director of Clinical Operations (DCO) stated the facility used the RAI manual as their policy for MDS assessments. The CMS Long-Term Care Facility RAI 3.0 User's Manual, dated 10/2023, indicated A1500: Preadmission Screening and Resident Review (PASRR) included Coding Instructions that specified, -Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD [intellectual disability/developmental disability] or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. An Admission Record indicated the facility admitted Resident #15 on 07/28/2022. According to the Admission Record, the resident had a medical history that included diagnoses of paranoid schizophrenia and anxiety disorder. Resident #15's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 07/28/2022, indicated the Level I screening was positive due to suspected mental illness, and a Level II was required. Resident #15's Preadmission Screening and Resident Review (PASRR) Individualized Determination Report, dated 08/16/2022, indicated the resident required nursing facility services due to a medical or mental health condition, and specialized services were recommended. An annual MDS, with an Assessment Reference Date (ARD) of 08/10/2023, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had an active diagnosis of schizophrenia; however, A1500 was coded as 0, which indicated the resident was not considered by the state Level II PASRR process to have as serious mental illness and/or intellectual disability or related condition. During an interview on 08/05/2024 at 3:24 PM, the MDS Director stated MDS assessments needed to be accurate to ensure they captured the proper care for the resident and for billing purposes. She stated she was responsible for ensuring the MDS assessments were accurate. She stated she utilized information obtained through record review and through interviews to code the MDS assessments. The MDS Director stated if a resident had a Level II PASRR, it should be coded on the MDS. The MDS Director stated Resident #15 did have a Level II PASRR and confirmed it was not coded correctly on their annual MDS. (continued on next page)

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	08/07/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/2024 at 10:16 AM, the Interim Director of Nursing (IDON) stated MDS assessments needed to be accurate because it was a document that reflected the residents' status and should be correct. She stated the accuracy of MDS assessments was the responsibility of MDS staff. The IDON stated if a resident had a Level II PASRR, then it should be coded on the MDS. She stated Resident #15 did have a Level II PASRR and confirmed that it was not coded correctly on their MDS. During an interview on 08/06/2024 at 11:37 AM, the Administrator stated the MDS Consultant and the MDS staff were responsible for ensuring MDS assessments were accurate. The Administrator stated Resident #15's MDS should have been coded to reflect their Level II PASRR findings.

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	08/07/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 28193 Based on interview, record review, and facility document review, the facility failed to complete a Level I Preadmission Screening and Resident Review (PASRR) assessment for 1 (Resident #40) of 2 residents reviewed for PASRR. Findings included: A California Department of Health Care Services PASRR Information Notice titled, When to initiate a Preadmission Screening and Resident Review (PASRR) Reconsideration Request or Resident Review, dated 04/02/2024, indicated, If the Level I Screening indicates suspected SMI [Serious Mental Illness] and/or ID [Intellectual Disabilities]/DD [Developmental Disabilities]/RC [Related Conditions], the individual must be referred for further evaluation (Level II Evaluation). The goal of the Level II Evaluation and subsequent Determination process is to ensure appropriate placement of individuals in the least restrictive setting that best meets their needs and identify the need for specialized services (PASRR Determination). The notice also indicated, SNFs [skilled nursing facilities] must initiate a Resident Review by completing a Level I Screening when the following occurs: Within 72 hours of identifying a significant change in condition relating to the individual's SMI and/or ID/DD/RC. An Admission Record revealed the facility admitted Resident #40 on 11/29/2021. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified dementia and mixed anxiety disorders. A Psychologist Consultation/Follow Up form, dated 09/14/2022, revealed Resident #40 had initial complaints or symptoms of delusions, agitation or inappropriate behaviors, and treatment and compliance issues. The form revealed Resident #40 was given diagnoses of Dementia with Bx [behaviors], and Schizoaffective D/O [disorder]. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/28/2024, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had diagnoses of anxiety disorder and schizophrenia. Resident #40's medical record revealed an additional Level I PASRR had not been resubmitted after receiving the new diagnosis of schizoaffective disorder. During an interview on 08/01/2024 at 1:40 PM, the Social Services Director (SSD) stated she was unaware she was supposed to do a new PASRR with a new qualifying diagnosis. The SSD stated the prior company that owned the facility had not required her to do a new PASRR for new diagnoses. The SSD stated she had been doing two jobs, medical records and social services, and things had started to fall behind during that time span and were not completed like they should have been. During an interview on 08/06/2024 at 10:29 AM, the Interim Director of Nursing (IDON) stated it was her expectation, for the PASRR process, that the assessments were to be filled out correctly and submitted timely. (continued on next page)

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	08/07/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/2024 at 11:31 AM, the Administrator stated his expectation was for the PASRR to be followed through with and completed as they were needed.

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	08/07/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 45555 Based on interview, record review, facility document review, and review of a memorandum from the California Department of Health Care Services, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Level I screening was resubmitted for 1 (Resident #39) of 4 residents reviewed for PASRR. Specifically, the facility failed to resubmit a Level I screening to re-open their case when a Level II evaluation could not be completed due to the resident being hospitalized . Findings included: A memorandum from the California Department of Health Care Services, dated 04/02/2024, revealed, Subject: When to initiate a Preadmission Screening and Resident Review (PASRR) Reconsideration Request or Resident Review. The memorandum specified, PASRR cases closed as 'Attempt' or 'Unavailable' due to the SNF [skilled nursing facility] not providing the required documentation to the Level II Contractor timely (within 24 hours of a positive Level I Screening) or the unavailability of an individual during the scheduled Level II Evaluation are not considered completed. 'Attempt' and 'Unavailable' Letters issued in the PASRR Online System due to reasons stated above are not valid documentation for TAR [Treatment Authorization Request] approval because the PASRR process was not completed. Therefore, for cases closed as 'Attempt' or 'Unavailable' due to such reasons, the SNFs are required to submit a new Level I Screening to commence the PASRR process again and ensure successful completion. An Admission Record indicated the facility admitted Resident #39 on 04/17/2024. According to the Admission Record, the resident had a medical history that included diagnoses of schizophrenia and unspecified psychosis. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2024, revealed Resident #39 re-entered the facility in 04/29/2024 from a short-term general hospital. Resident #39's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 04/24/2024, indicated the resident had a serious diagnosed mental disorder, specifically schizophrenia, and received psychotropic medications for mental illness. Resident #39's PASRR Level I Screening was positive due to suspected mental illness. A letter from the Department of Health Care Services, Special Programs Branch, PASRR Section, dated 04/24/2024, indicated a Level II mental health evaluation was required. A letter from the Department of Health Care Services, Special Programs Branch, PASRR Section, dated 04/25/2024, indicated a Level II Mental Health Evaluation was not scheduled due to Resident #39 being transferred temporarily to an acute care hospital for treatment. The letter indicated the case was closed and a new Level I screening would need to be submitted to reopen the case. During an interview on 08/04/2024 at 12:50 PM, the Social Service Director (SSD) stated when a resident was readmitted from the hospital, a new PASRR needed to be done. She stated Resident #39's Level I screening should have been completed when the resident was readmitted from the hospital. (continued on next page)

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	08/07/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/2024 at 10:16 AM, the Interim Director of Nursing (IDON) stated Resident #39's Level I screening should have been resubmitted when the resident was readmitted to the facility. During an interview on 08/06/2024 at 11:31 AM, the Administrator stated he expected the facility to follow through with PASRRs as needed.

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	08/07/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45555 Based on interview, record review, and facility policy review, the facility failed to ensure the care plan was updated with fall interventions for 1 (Resident #39) of 4 residents reviewed for accidents. Findings included: A facility policy titled, Care Plans, Comprehensive Person-Centered, revised in 03/2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy indicated, 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met. An Admission Record indicated the facility admitted Resident #39 on 04/17/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Parkinson's disease, rheumatoid arthritis, muscle weakness, and a history of falling. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2024, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had one fall without injury and one fall with major injury since the previous assessment. Resident #39's care plan included a focus area initiated 04/21/2024 and revised 07/19/2024, that indicated the resident was at risk for falls related to generalized weakness, gait/balance problems, being unaware of safety needs, severe cognitive impairment, confusion, history of falling, history of non-compliance with using the call light or asking for help to get in and out of bed without assistance, a history of dangling their feet off the bed, and indicated that the resident strived for independence. Interventions directed staff to anticipate and meet the resident's needs (initiated 04/21/2021), keep the call light within reach at all times (initiated 04/21/2024), follow the facility fall protocol (initiated 04/21/2024), and provide therapy intervention as needed (initiated 07/19/2024). (continued on next page)

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	08/07/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39's care plan included a focus area initiated 04/23/2024, that indicated the resident was at risk for injuries due to a recent fall incident related to balance problems and poor safety awareness. Interventions directed staff to have a certified nurse aide (CNA) complete visual checks of the resident every 15 minutes (initiated 04/23/2024 and revised 05/01/2024), when the resident becomes restless, assist to wheelchair and encourage to go out to the lobby area to watch television (initiated 04/23/2024 and revised 05/01/2024), invite to daily in house activities of preference and encourage participation (initiated 04/23/2024), and monitor for side effects from medications, labs, and appetite as cause for falls (initiated 04/23/2024). Resident #39's Progress Notes revealed an IDT [Interdisciplinary Team] Event Review note, dated 05/13/2024 at 4:11 PM, that indicated Resident #39 had a witnessed fall on 05/12/2024 at 4:00 PM. The review indicated the resident's roommate called for assistance because the resident was on the floor next to the bed. The note indicated that per interview with the roommate, Resident #39 was trying to get up multiple times without assistance and was trying to self-transfer to a wheelchair without assistance and fell . The review indicated the Root Cause Analysis for event revealed the resident had impulsive behavior, non-compliance with asking for help, and had a history of falls and restlessness. The review indicated the IDT recommended to check the resident every two hours, place the resident in the wheelchair in the morning after breakfast and place in front of the nursing station, continue the bed in the lowest position when in bed, and re-educate the resident on the importance of asking for assistance. Resident #39's care plan revealed it was not updated with the 05/12/2024 fall or interventions that were to be put into place. Resident #39's Progress Notes revealed an Event Initial Note, dated 06/29/2024 at 9:00 PM, that indicated Resident #39 had a witnessed fall on 06/29/2024 at 7:15 PM. Per the note, the resident had a fall out of bed on their head that was witnessed by a CNA, who was assisting another resident. The note indicated the CNA emphasized that the resident's head had a hard impact with the ground. Per the note, the resident sustained a 2 centimeter (cm) long by 2 cm wide raised area to the left front side of the forehead and a 10.5 cm long by 0.5 cm wide abrasion/bruising to the mid to lower back. The note indicated interventions to prevent the event from happening again were to complete frequent rounding, encourage the resident to use their call light and keep the bed in the lowest position. Resident #39's Progress Notes revealed an IDT note, dated 07/01/2024 at 10:40 AM that indicated the IDT met to discuss Resident #39's witnessed fall on 06/29/2024. The note indicated the CNA was doing their room rounds and found the resident in their bed trying to get out of the bed, and the resident fell on the floor. The note indicated the resident sustained a skin tear and skin discoloration and was sent out to the hospital for further evaluation. The note indicated the resident was sent back to the facility with no new orders. The note indicated the resident was a high risk for falls due to a history of falls, impulsive behavior, and forgetfulness. The note indicated the IDT recommended staff make sure the resident was in the lowest position when in bed. Resident #39's care plan revealed it was not updated with the 06/29/2024 fall or interventions that were to be put into place following the fall. During an interview on 08/05/2024 at 3:24 PM, the MDS Director stated she was responsible for updating the care plan with any changes, including new fall interventions. She stated she was unsure why the interventions were not added to Resident #39's care plan after their falls. (continued on next page)

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	08/07/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/2024 at 10:16 AM, the Interim Director of Nursing (IDON) stated the DON and MDS Director were responsible for putting fall interventions on the care plan. She stated if she was not the person that updated the care plan, then she would review the care plan to ensure that the interventions were on the care plan. The IDON stated the interventions mentioned in the IDT notes after Resident #39's falls should have been put on the care plan and the care plan should have been updated to reflect the actual interventions being used. During an interview on 08/06/2024 at 11:37 AM, the Administrator stated the care plan should be updated with fall interventions during the IDT review by the MDS nurse.

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	08/07/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45555 Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure residents with pressure ulcers received treatment and services in accordance with professional standards of practice, to promote healing and prevent deterioration for 3 (Residents #15, #5, and #46) of 3 sampled residents reviewed for pressure ulcers. Specifically, the facility failed to: - Accurately and consistently assess and document the appearance, stage, and complete measurements of pressure ulcers at least weekly to facilitate the ability to promptly identify deterioration or track healing progress of pressure ulcers for Residents #15, #46, and #5. - Consult with the physician to obtain appropriate pressure ulcer treatment orders when nursing staff noted a decline or deterioration in Resident #15's pressure ulcers and when a new Stage III pressure ulcer was identified for Resident #15. - Obtain pressure ulcer treatment orders to cover all dates when pressure ulcer treatments were needed for Resident #5. - Ensure wound treatments were consistently provided and documented for Residents #15, #46, and #5. - Notify the Registered Dietitian (RD) to obtain nutritional recommendations to facilitate wound healing for Resident #15 and Resident #46. The failures resulted in delayed healing and deterioration of Resident #15's Stage III pressure ulcers to the right and left buttocks and had the likelihood to cause delayed healing, deterioration, or infection of pressure ulcers for Resident #46 and Resident #5. It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 Pressure Ulcers at a scope and severity of K. The IJ began on 04/25/2024 when nursing staff noted a decline in the condition of Resident #15's pressure ulcers and failed to consistently assess the wounds, consult with the physician to obtain appropriate treatment orders, and consistently provide pressure ulcer treatments to promote wound healing. The Administrator and Interim Director of Nursing (IDON) were notified of the IJ on 08/03/2024 at 1:30 PM and were provided the IJ template at 1:43 PM. A removal plan was requested. The removal plan was accepted by the State Survey Agency (SSA) on 08/06/2024 at 3:50 PM. The IJ was removed on 08/06/2024 at 6:30 PM after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance remained at the lower scope and severity of isolated harm that was not immediate jeopardy for F686. Findings included: (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A facility policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised 04/2018, specified, Assessment and Recognition 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses. The policy also indicated, Treatment/Management 1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc. [et cetera]), and application of topical agents. The policy indicated, Monitoring 1. During resident visits, the physician will evaluate and document the progress of wound healing - especially for those with complicated, extensive, or poorly-healing wounds. 2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. 1. An Admission Record indicated the facility admitted Resident #15 on 07/28/2022. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus, obesity, and bilateral above the knee amputations. The Admission Record revealed diagnoses of Stage III pressure ulcers to the left and right buttocks were added to the resident's list of diagnoses on 07/19/2024. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/08/2024, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had two Stage III pressure ulcers, one of which was present upon admission. The MDS also revealed Resident #15 had moisture-associated skin damage. Per the MDS, the resident had treatments for pressure ulcers that included a pressure reducing device for the bed, a nutrition or hydration intervention to manage skin problems, and pressure ulcer/injury care. Resident #15's care plan included a focus area revised 08/16/2023 that indicated the resident had a recurring Stage III pressure ulcer to the left buttock due to being bedfast, incontinent of bowel, obesity, edema, and a history of a previous ulcer. Interventions directed staff to provide nutritional and hydration support (initiated 02/01/2023); provide a pressure reduction/relieving mattress (initiated 02/01/2023); provide treatment as ordered (revised 05/01/2024); and turn and reposition the resident per schedule (revised 05/01/2024); however, the care plan revealed the resident was noncompliant with repositioning. Resident #15's care plan revealed no focus area for the Stage III pressure ulcer to the right buttock was added to the care plan until 08/03/2024 (during the survey). Interventions initiated 08/03/2024 directed staff to evaluate the need for a pain reliever prior to cleansing or dressing changes, provide treatment as ordered, and perform weekly wound assessments. Resident #15's care plan included a focus area, initiated 08/05/2022 and revised 07/31/2024, that indicated the resident was at risk for altered nutritional status and dehydration related to pressure injuries (ulcers). The care plan indicated on 08/05/2022, the dietitian documented a wound was present and nutritional estimates of protein, calories, and hydration had been made. An intervention initiated by the dietitian on 12/08/2022 directed staff to provide Prostat (protein supplement) daily. (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #15's Progress Notes, dated 04/17/2024, revealed a Weight and Skin Review was documented by the RD. The notes revealed the RD reviewed Weekly Skin Reviews, dated 04/11/2024, that revealed the resident had a Stage III pressure ulcer to the left buttock that measured 6.3 centimeters (cm) in length by (x) 0.6 cm in width x 0.1 cm in depth and a Stage III pressure ulcer to the right buttock that measured 1.7 cm in length x 0.5 cm in width x 0.1 cm in depth. The notes revealed the resident was receiving ProMod (protein supplement) once per day and ascorbic acid (vitamin C supplement). Per the notes, the RD recommended adding zinc sulfate (zinc supplement) for 14 days to promote wound healing. The notes revealed the goal was for skin improvement by the next review. There was no documented evidence the RD assessed Resident #15's nutritional status again until 07/31/2024, after the survey was initiated. Resident #15's Order Recap Report, printed 08/02/2024, revealed physician orders were initiated on 03/28/2024 to clean the recurrent Stage III pressure ulcer to the left superior buttock and the recurring Stage III pressure ulcer to the right buttock with normal saline, pat the area dry, apply Calmoseptine (a moisture barrier/skin protectant) and Vaseline/A&D Ointment (treats and prevents skin irritation) to the wound bed, and cover the area with a non-adherent dressing every shift for 21 days. The report revealed that order's end date was 04/04/2024, after which the physician ordered the same treatment again, beginning on 04/04/2024 and ending on 04/11/2024. The same order was repeated beginning 04/11/2024 and ending 04/18/2024. The same treatment order was repeated beginning on 04/18/2024 and ending 04/25/2024. The same treatment order was repeated beginning 04/25/2024 and ending 05/16/2024. The Order Recap Report contained no evidence the resident had a physician's order to treat a pressure ulcer to the left inferior buttock. Weekly Wound Reviews completed in April 2024 for Resident #15's left buttock pressure ulcer revealed the following: - The Weekly Wound Review, dated 04/04/2024, indicated Resident #15's left buttock pressure ulcer was a Stage III wound measuring 6.3 cm in length x 0.6 cm in width x 0.1 cm in depth. The review indicated the wound base was comprised of 90% epithelial tissue and 10% red granulation tissue. - The Weekly Wound Review, dated 04/18/2024, indicated Resident #15's left buttock pressure ulcer was a Stage III wound. The length had decreased to 3.2 cm; however, the width had increased to 1.7 cm. The depth remained 0.1 cm. The review indicated the wound base was comprised of 50% pink epithelial tissue (decreased from 90%) and 50% red granulation tissue (increased from 10%). - The Weekly Wound Review dated 04/25/2024 indicated Resident #15's left buttock pressure ulcer was a Stage III wound that measured 3.0 cm in length. The width of the wound had increased to 2.4 cm. The depth remained 0.1 cm. The review revealed the wound base was comprised of 75% pink epithelial tissue and 25% red granulation tissue. The review indicated Calmoseptine cream was unavailable for three weeks and the pressure ulcer declined in that time. The section of the Weekly Wound Review form designated for information regarding physician notification was not completed to indicate the physician was informed of the Calmoseptine being unavailable or of a decline in the resident's wound. The review was signed as completed by Licensed Vocational Nurse (LVN) #17. The surveyor attempted to contact LVN #17 for a telephone interview on 08/03/2024 at 11:18 AM and 08/05/2024 at 3:21 PM and left two voice mail messages requesting a return call. LVN #17 did not return the surveyor's call as of the survey exit date (08/07/2024). (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #15's April 2024 Treatment Administration Record (TAR) revealed no documented evidence the pressure ulcer treatment for the left buttock pressure ulcer was provided as scheduled on eight occasions during the month, on 04/03/2024 night (PM) shift, 04/04/2024 day (AM) shift, 04/05/2024 AM shift, 04/11/2024 AM shift, 04/18/2024 AM shift, 04/25/2024 AM shift, 04/29/2024 AM shift and 04/30/2024 PM shift. According to the TAR, staff documented the pressure ulcer treatment, which included Calmoseptine, was provided all other days as scheduled, and there was no indication the Calmoseptine was not available. Weekly Wound Reviews completed in April 2024 for Resident #15's right buttock pressure ulcer revealed the following: - The Weekly Wound Review dated 04/04/2024 indicated the right buttock pressure ulcer was a Stage III wound that measured 1.7 cm in length x 0.5 cm in width x 0.1 cm in depth. The review indicated the wound bed was comprised of 100% granulation tissue. - The Weekly Wound Review dated 04/25/2024 indicated the right buttock pressure ulcer was a Stage III wound that measured 6.1 cm in length x 2.5 cm in width x 0.2 cm in depth. The review revealed the wound base was comprised of 75% epithelial tissue and 25% granulation tissue. The review also indicated the Calmoseptine cream was unavailable for three weeks and that the pressure ulcer had declined in that time. The section of the review form designated for information regarding physician notification was not completed to indicate the physician was informed of the Calmoseptine being unavailable or of a decline in the resident's wound. The review was signed as completed by LVN #17. The surveyor attempted to contact LVN #17 for a telephone interview on 08/03/2024 at 11:18 AM and 08/05/2024 at 3:21 PM and left two voice mail messages requesting a return call. LVN #17 did not return the surveyor's call as of the survey exit date (08/07/2024). Resident #15's April 2024 TAR revealed no documented evidence the right buttock pressure ulcer treatment was provided as scheduled on eight occasions during the month, on 04/03/2024 night (PM) shift, 04/04/2024 day (AM) shift, 04/05/2024 AM shift, 04/11/2024 AM shift, 04/18/2024 AM shift, 04/25/2024 AM shift, 04/29/2024 AM shift and 04/30/2024 PM shift. According to the TAR, staff documented the treatment, which included Calmoseptine, was provided all other days and there was no indication Calmoseptine was not available. After the Weekly Wound Reviews dated 04/25/2024 for the left superior buttock and right buttock pressure ulcers, there was no further documentation of assessments of Resident #15's pressure ulcers until 05/23/2024, approximately one month without a documented assessment. Weekly Pressure Injury/Ulcer Progress Reports for May 2024 indicated the following regarding a newly identified Stage III pressure ulcer to Resident #15's left inferior buttock area: (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The Weekly Pressure Injury/Ulcer Progress Report, dated 05/23/2024, indicated Resident #15 had developed a new a Stage III pressure ulcer to the left inferior buttock that measured 1 cm in length x 1 cm in width. The depth measurement was left blank. The report revealed the wound had 100% epithelialization. The report indicated the treatment being provided was the same as the other pressure ulcers, which included cleaning the wound with normal saline, patting the area dry, applying Calmoseptine and Vaseline/A&D Ointment, and covering the area with a non-adherent dressing. The report revealed the physician notification portion of the form was not completed and there was no documented evidence the facility notified the physician of a new pressure ulcer to the left inferior buttock. - According to a Weekly Pressure Injury/Ulcer Progress Report dated 05/30/2024, the Stage III pressure ulcer to the left inferior buttock measured 1.1 cm length by 1 cm width, with no depth documented. The report indicated the wound was red but provided no other information about the appearance of the wound. The report indicated the treatment with Calmoseptine /Vaseline continued. Weekly Pressure Injury/Ulcer Progress Reports for May 2024 revealed the following regarding the Stage III pressure ulcer to Resident #15's left superior buttock: - The Weekly Pressure Injury/Ulcer Progress Report, dated 05/23/2024, indicated the Stage III pressure ulcer to the left superior buttock measured 5.5 cm in length x 2.9 cm in width, with no depth measurement provided. The wound had increased in length and width since the most recent documented assessment on 04/25/2024, yet the report indicated the wound had 100% epithelialization. The treatment was to clean the wound with normal saline, pat dry, apply Calmoseptine/Vaseline, and cover with a non-adherent dressing. The report revealed the physician notification portion of the form was not completed and there was no documented evidence the resident's physician was notified of the increase in size of the pressure ulcer to the left superior buttock. - The Weekly Pressure Injury/Ulcer Progress Report, dated 05/30/2024, indicated the pressure ulcer to Resident #15's left superior buttock measured 5.5 cm in length x 2.7 cm in width, with no depth measurement recorded. The report indicated the wound was red and had no undermining/tunneling; however, there was no other documentation regarding the appearance or stage of the wound. Weekly Pressure Injury/Ulcer Progress Reports for May 2024 revealed the following regarding the pressure ulcer to Resident #15's right buttock: - The Weekly Pressure Injury/Ulcer Progress Report, dated 05/23/2024, indicated Resident #15 had a Stage III pressure ulcer to the right buttock that measured 3 cm in length x 0.5 cm in width, with no depth measurement provided. The report revealed the wound was pink and had 100% epithelialization with no drainage/odor or pain. The treatment was to clean the wound with normal saline, pat dry, apply Calmoseptine/Vaseline, and cover with a non-adherent dressing. - The Weekly Pressure Injury/Ulcer Progress Report, dated 05/30/2024, indicated Resident #15 had a Stage III pressure ulcer to the right buttock that measured 3.1 cm in length x 0.8 cm in width, with no depth measurement provided. The report indicated the wound was red but provided no other information about the appearance or stage of the wound. (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #15's Order Recap Report revealed treatment orders to the left superior buttock and right buttock Stage III pressure ulcers with Calmoseptine and Vaseline/A&D ointment ended on 05/16/2024, and there were no further orders to treat the left superior and right buttock pressure ulcers until 05/20/2024 when an order was written to clean the pressure ulcers with warm water, dry the area, apply Calmoseptine and Vaseline ointment, and cover the area with a non-adherent dressing every (day and night shift). Resident #15's May 2024 TAR revealed no documented evidence treatment was provided to the pressure ulcer to the left inferior buttock in May 2024. The TAR revealed no documented evidence treatment was provided to the left superior or right buttock pressure ulcers on 05/04/2024 during the PM/night shift. Further review of the TAR revealed no treatment orders for the pressure ulcers to the right, left inferior, or left superior buttocks from the evening/night shift on 05/16/2024 until the evening/night shift on 05/20/2024. Consequently, there was no documented evidence a treatment was provided to the pressure ulcers on those dates. Weekly Pressure Injury/Ulcer Progress Reports for June 2024 revealed the following regarding a newly identified pressure ulcer to Resident #15's left sub-inferior buttock: - A Weekly Pressure Injury/Ulcer Progress Report, dated 06/06/2024, indicated Resident #15 had developed a new pressure ulcer to the left sub-inferior buttock that measured 0.4 cm in length x 0.5 cm in width, with no depth measurement provided. The report indicated the wound was red, had no drainage/odor, no pain, and no tunneling/undermining. No further information was documented regarding the type of tissue present in the wound bed, the appearance, or the stage of the wound. The report revealed the treatment being provided was to clean the wound with normal saline, pat the area dry, apply Medi-honey (an agent used for healing and removal of dead tissue), and cover the area with a non-adherent dressing. The physician notification portion of the form was not completed, and Resident #15's health record revealed no documented evidence the resident's physician was notified the resident had developed a new pressure ulcer to the left sub-inferior buttock. - A Weekly Pressure Injury/Ulcer Progress Report, dated 06/13/2024, indicated the pressure ulcer to Resident #15's left sub-inferior buttock had increased in size to 1.1 cm in length x 0.5 cm in width, with no depth measurement provided. The treatment information on the report did not reference the prior instructions to apply Medi-Honey to the wound; instead, the report indicated the wound was being treated by cleaning with normal saline, patting the area dry, applying Calmoseptine, and covering with a non-adherent dressing. Weekly Pressure Injury/Ulcer Progress Reports for June 2024 revealed the following regarding the pressure ulcer to Resident #15's left superior buttock area: - The Weekly Pressure Injury/Ulcer Progress Report, dated 06/06/2024 revealed the left superior buttock pressure ulcer measured 4 cm in length x 2.4 cm in width, with no depth measurement provided. The report indicated the wound tissue was red and necrotic, with no drainage/odor, pain, or undermining. The report did not indicate the stage or any other description of the wound. The report indicated the treatment was to clean with normal saline, pat dry, apply Medi-Honey, and cover with a non-adherent dressing. (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The Weekly Pressure Injury/Ulcer Progress Report, dated 06/13/2024 for the pressure ulcer to the left superior buttock, revealed the wound measured 3.5 cm in length x 2 cm in width, with no depth measurement provided. The report indicated the pressure ulcer tissue was red and necrotic, and the wound had no drainage/odor, no pain, and no tunneling/undermining. There was no other documentation regarding the appearance or stage of the wound. The report did not reference the previous instructions to apply Medi-Honey to the wound; instead, the report indicated the treatment consisted of cleaning with normal saline, patting the area dry, applying Calmoseptine, and covering the pressure ulcer with a non-adherent dressing. Weekly Pressure Injury/Ulcer Progress Reports for June 2024 revealed the following regarding the pressure ulcer to Resident #15's left inferior buttock: - The Weekly Pressure Injury/Ulcer Progress Report, dated 06/06/2024, revealed the pressure ulcer to the left inferior buttock measured 1.3 cm in length x 1 cm in width, with no depth measurement provided. The report indicated the wound tissue was red and necrotic, and the wound had no drainage/odor, pain, or tunneling/undermining. The report indicated the wound treatment consisted of cleaning with normal saline, patting dry, applying Medi-Honey, and covering with a non-adherent dressing. - The Weekly Pressure Injury/Ulcer Progress Report, dated 06/13/2024, revealed the pressure ulcer to Resident #15's left inferior buttock measured 2 cm in length x 1 cm in width, with no depth measurement provided. The report indicated the wound tissue was red and necrotic, and the wound had no drainage/odor, pain, or tunneling/undermining. The report did not reference the previous instructions to apply Medi-Honey to the wound; instead, the report indicated the treatment consisted of cleaning with normal saline, patting the area dry, applying Calmoseptine, and covering the pressure ulcer with a non-adherent dressing. Weekly Pressure Injury/Ulcer Progress Reports for June 2024 revealed the following regarding the pressure ulcer to Resident #15's right buttock: - The Weekly Pressure Injury/Ulcer Progress Report, dated 06/06/2024, revealed the pressure ulcer to the right buttock measured 1.9 cm in length x 0.6 cm in width, with no depth measurement provided. The report indicated the wound tissue was red and necrotic, and the wound had no drainage/odor, pain, or tunneling/undermining. The report indicated the wound treatment consisted of cleaning with normal saline, applying Medi-Honey, and covering with a non-adherent dressing. - The Weekly Pressure Injury/Ulcer Progress Report, dated 06/13/2024, revealed the pressure ulcer to the right buttock measured 1.3 cm in length x 0.4 cm in width, with no depth measurement provided. The report indicated the pressure ulcer tissue was red and necrotic, and the wound had no drainage/odor, no pain, and no tunneling/undermining. There was no further documentation regarding the appearance or stage of the wound. The report did not reference the previous instructions to apply Medi-Honey to the wound; instead, the report indicated the treatment consisted of cleaning with normal saline, patting the area dry, applying Calmoseptine, and covering the pressure ulcer with a non-adherent dressing. Resident #15's Weekly Pressure Injury/Ulcer Progress Report, dated 06/13/2024, indicated the pressure ulcer to the left inferior buttock measured 2 cm in length x 1 cm in width, with no depth measurement given. (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Weekly Pressure Injury/Ulcer Progress Report, dated 06/20/2024, indicated Resident #15 had multiple wounds to the left buttock with a total measurement of 9.3 cm in length x 2.2 cm in width, with no depth measurement provided. The report indicated the wound tissue was red and necrotic, and the wounds had no drainage/odor, no pain, and no tunneling/undermining. No other information was provided regarding the appearance or stage of the wound. The report revealed the pressure ulcers continued to be treated by cleaning with normal saline, patting the area dry, applying Calmoseptine, and covering with a non-adherent dressing. The physician notification portion of the report was not completed, and there was no documented evidence the physician was notified that the left buttock now had multiple wounds with an overall increase in size. Weekly Pressure Injury/Ulcer Progress Reports, dated 06/20/2024, indicated Resident #15 had a pressure ulcer to the right outer buttock that measured 0.6 cm in length by 0.5 cm in width (no depth measurement provided) and a pressure ulcer to the right inner buttock that measured 1 cm in length x 0.4 cm in width (no depth measurement provided). The reports indicated both pressure ulcers were red and necrotic with no drainage/odor or tunnelling/undermining. The reports contained no other description of the appearance or stage of the wounds. The reports revealed both pressure ulcers were being treated by cleaning with normal saline, patting dry, applying Calmoseptine, and covering with a non-adherent dressing. The physician notification sections of the reports were not completed, and there was no documented evidence the physician was notified of the development of an additional pressure ulcer to the right buttock. Resident #15's Order Recap Report revealed an order started on 06/20/2024 to treat the recurring Stage III pressure injury to the right buttock. The order did not specify whether the treatment order was for the right inner or outer buttock. A Weekly Pressure Injury/Ulcer Progress Report, dated 06/27/2024, indicated Resident #15 the multiple open areas to site on the left buttock. The report did not include individual measurements for each wound or open area and indicated an overall measurement of 10 cm length by 7 cm width, with no depth measurement provided. This indicated an increase in the length and width of the pressure ulcers. The report indicated the wound was red and necrotic, had no drainage/odor, no pain, and no tunneling/undermining, but provided no other information about the appearance or stage of the wounds. The report revealed the treatment to the pressure ulcer continued to be cleaning the area with normal saline, patting the area dry, and applying Calmoseptine. The report indicated the treatment now included applying a non-adherent foam dressing. A Weekly Pressure Injury/Ulcer Progress Report, dated 06/27/2024, indicated Resident #15 now had multiple wounds to the right buttock; however, the report did not include individual measurements for each wound. The report indicated a measurement of 2.5 cm length by 1.9 cm width, with no depth measurement provided. The report indicated the wound was red and necrotic, with no drainage or odor, no pain, and no tunneling, but no other information about the appearance of the wound, including the stage. The report revealed the treatment to the pressure ulcer to the right buttocks continued to be cleaning the area with normal saline, patting the area dry, and applying Calmoseptine. The report indicated the treatment now included applying a non-adherent foam dressing. Resident #15's June 2024 TAR revealed the following: (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Treatment instructions for the left buttock healing STG [stage] 3 pressure ulcer to the left buttock (specific location on buttock not documented) indicated the wound was to be cleaned with warm water and dried, then Calmoseptine and Vaseline ointment were to be applied and the wound was to be covered with a non-adherent dressing every shift. The TAR indicated this treatment started on 06/01/2024 and continued through the day shift on 06/06/2024. No treatment was documented as having been provided on the night shift on 06/06/2024, and the next treatment protocol was not initiated for the left buttock until the night shift on 06/07/2024. - Treatment instructions for the left buttock pressure ulcer (specific location on buttock not documented) indicated the wound was to be cleaned with normal saline and patted dry, the Medi-Honey and a non-adherent dressing were to be applied every day and night shift for 21 days. The TAR indicated this treatment was initiated on the night shift on 06/07/2024 and continued through the night shift on 06/12/2024. The treatment scheduled on the day shift on 06/13/2024 was not initialed by a nurse as having been provided. - Treatment instructions for the left buttock pressure ulcer (specific location on buttock not documented) indicated the wound was to be cleaned with normal saline and patted dry, then Calmoseptine and a non-adherent dressing were to be applied one time daily for 21 days. The TAR indicated this treatment started on 06/13/2024 and continued through 06/26/2024. There was no documentation any treatment was provided to the left buttock pressure ulcer on 06/27/2024, and the next treatment protocol was not initiated until 06/28/2024. - Treatment instructions for the left buttock pressure ulcer (specific location on buttock not documented) indicated the wound was to be cleaned with normal saline and patted dry, then Calmoseptine and a non-adhesive foam dressing were to be applied one time daily for 21 days. The TAR indicated this treatment started on 06/28/2024 and continued through the end of the month. - Treatment instructions for the right buttock healing STG [stage] 3 pressure ulcer (specific location on buttock not documented) indicated the wound was to be cleaned with warm water and dried, then Calmoseptine and Vaseline ointment were to be applied, and the wound was to be covered with a non-adherent dressing every day and night shift. The TAR indicated this treatment was provided twice daily beginning 06/01/2024 and continuing through the day shift on 06/06/2024. - Treatment instructions for the right buttock pressure ulcer (specific location on buttock not documented) indicated the wound was to be cleaned with normal saline and patted dry, then Medi-Honey and a non-adherent dressing were to be applied every day and night shift for 21 days. The TAR indicated this treatment was provided twice daily beginning with the night shift on 06/07/2024 and continuing through the evening shift on 06/12/2024. The scheduled treatment for the day shift on 06/13/2024 was not initialed by a nurse as having been provided, and a new treatment protocol was initiated for wound treatments once daily on 06/13/2024. - Treatment instructions for the right buttock pressure ulcer (specific location on buttock not documented) indicated the wound was to be cleaned with normal saline and patted dry, then Calmoseptine and a non-adherent dressing were to be applied once daily. The TAR indicated this treatment was provided daily from 06/13/2024 through 06/26/2024. No treatment was initialed as provided on 06/27/2024, and the next treatment protocol was not initialed as having been initiated until 06/28/2024. (continued on next page)

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	08/07/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Treatment instructions for the right buttock pressure ulcer (specific location on buttock not documented) indicated the wound was to be cleaned with normal saline and patted dry, then Calmoseptine and a non-adherent foam dressing were to be applied once daily for 21 days. The TAR indicated this treatment was provided daily beginning on 06/28/2024 and continued through the end of the month. The Order Recap Record revealed orders to treat the pressure ulcers daily with Calmoseptine were discontinued on 06/27/2024, and another order for treatment was dated as ordered 06/27/2024; however, the Order Recap Record indicated the new treatment was not started until 06/28/2024. After the Weekly Pressure Injury/Ulcer Progress Report, dated 06/27/2024, Resident #15's health record contained no documented evidence the facility assessed the resident's pressure ulcers again until 07/11/2024, which was a period of 14 days with no assessment documented. Weekly Pressure Injury/Ulcer Progress Reports for July 2024 revealed the following regarding the pressure ulcer to Resident #15's left buttock: - A Weekly Pressure Injury/Ulcer Progress Report, dated 07/11/2024, indicated the site of the pressure ulcer was L [left] buttock. No [TRUNCATED]

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	08/07/2024

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. 45555 Based on interview, record review and facility policy review, the facility failed to ensure an environment free of accidents and hazards for 1 (Resident #39) of 4 residents reviewed for accidents. Specifically, the facility failed to prevent repeat falls for Resident #39. Findings included: A facility policy titled, Falls and Fall Risk, Managing, revised 03/2018, specified, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy revealed the section titled Resident-Centered Approaches to Managing Falls and Fall Risk included 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls and 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The policy revealed the section titled Monitoring Subsequent Falls and Fall Risk included 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling and 4. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. An Admission Record indicated the facility admitted Resident #39 on 04/17/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Parkinson's disease, rheumatoid arthritis, muscle weakness, and a history of falling. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2024, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had one fall without injury and one fall with major injury since the previous assessment. Resident #39's care plan included a focus area initiated 04/21/2024 and revised 07/19/2024, that indicated the resident was at risk for falls related to generalized weakness, gait/balance problems, being unaware of safety needs, severe cognitive impairment, confusion, history of falling, history of non-compliance with using the call light or asking for help to get in and out of bed without assistance, a history of dangling their feet off the bed, and indicated that the resident strived for independence. Interventions directed staff to anticipate and meet the resident's needs (initiated 04/21/2021), keep the call light within reach at all times (initiated 04/21/2024), follow the facility fall protocol (initiated 04/21/2024), and provide therapy intervention as needed (initiated 07/19/2024). (continued on next page)

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	08/07/2024

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	Resident #39's care plan included a focus area initiated 04/23/2024, that indicated the resident was at risk for injuries due to a recent fall incident related to balance problems and poor safety awareness. Interventions directed staff to have a certified nursing aide (CNA) complete visual checks of the resident every 15 minutes (initiated 04/23/2024 and revised 05/01/2024); when the resident becomes restless, assist to wheelchair and encourage to go out to the lobby area to watch television (initiated 04/23/2024 and revised 05/01/2024); invite to daily in house activities of preference and encourage participation (initiated 04/23/2024); and monitor for side effects from medications, labs, and appetite as cause for falls (initiated 04/23/2024). Resident #39's Progress Notes revealed an Event Initial Note, dated 05/12/2024 at 4:00 PM, that indicated Resident #39 had a witnessed fall. The note indicated the resident was found lying on the floor in their room and the roommate stated the resident attempted to get out of bed by themself and fell . The note indicated the resident sustained a 1.5 centimeter (cm) long by 1.5 cm wide skin tear to the right wrist. Resident #39's Progress Notes revealed an Event follow up note, dated 05/13/2024 at 3:22 AM, that indicated Resident #39 had no delayed injuries from the fall. The note indicated interventions to reduce risk of reoccurrence included to remind the resident to call for help and wait for assistance, keep a call light in reach, and keep the resident's bed in the lower position. Resident #39's Progress Notes revealed an Event follow up note, dated 05/13/2024 at 2:32 PM, that indicated the resident was unable to remember to call for assistance. Resident #39's Progress Notes revealed an IDT [Interdisciplinary Team] Event Review note, dated 05/13/2024 at 4:11 PM, that indicated Resident #39 had a witnessed fall on 05/12/2024 at 4:00 PM. The review indicated the resident's roommate called for assistance because the resident was on the floor next to the bed. The note indicated that per interview with the roommate, Resident #39 was trying to get up multiple times without assistance and was trying to self-transfer to a wheelchair without assistance and fell . The review indicated the Root Cause Analysis for event revealed the resident had impulsive behavior and non-compliance with asking for help and had a history of falls and restlessness. The review indicated the IDT recommended to check the resident every two hours, place the resident in the wheelchair in the morning after breakfast and place in front of the nursing station, continue the bed in the lowest position when in bed, and re-educate the resident on the importance of asking for assistance. Resident #39's Progress Notes revealed an Event follow up note, dated 05/14/2024 at 5:04 PM, indicated the resident was cognitively impaired and unable to remember to ask for assistance. Resident #39's Progress Notes revealed an Event Initial Note, dated 06/29/2024 at 9:00 PM, completed by Licensed Vocational Nurse (LVN) #2, that indicated Resident #39 had a witnessed fall on 06/29/2024 at 7:15 AM. Per the note, the resident had a fall out of bed on their head that was witnessed by a CNA, who was assisting another resident. The note indicated the CNA emphasized that the resident's head had a hard impact with the ground. Per the note, the resident was complaining of a pain level of 10 out of 10 (on a scale of 0 to 10 with 10 being the worst pain), sustained a 2 cm long by 2 cm wide raised area to the left front side of the forehead and a 10.5 cm long by 0.5 cm wide abrasion/bruising to the mid to lower back. The note indicated interventions to prevent the event from happening again were to complete frequent rounding, encourage the resident to use their call light and keep the bed in the lowest position. (continued on next page)

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	08/07/2024

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	Resident #39's Progress Notes revealed a Progress Note, dated 06/30/2024 at 7:15 AM, that indicated a physician was notified of Resident #39's fall on 06/29/2024. The note indicated that the physician gave orders to send the resident out to the hospital for further evaluation. The note indicated that the resident was sent to the hospital on 06/29/2024 at 7:45 PM via ambulance. The note indicated the resident returned from the hospital with no new orders and no abnormal findings. Resident #39's Progress Notes revealed an IDT progress note, dated 07/01/2024 at 10:40 AM, that indicated the IDT met to discuss Resident #39's witnessed fall on 06/29/2024. The note indicated that a CNA found the resident when completing rounds trying to get out of bed, and the resident fell on the floor. The note indicated the resident sustained a skin tear and skin discoloration and was sent out to the hospital for further evaluation. The note indicated the resident was sent back to the facility with no new orders. The note indicated the resident was a high risk for falls due to a history of falls, impulsive behavior, and forgetfulness. The note indicated the IDT recommended staff to make sure that the resident's bed was in the lowest position when the resident was in bed. During a phone interview on 08/02/2024 at 6:46 AM, CNA #16 stated she was walking another resident past Resident #39's room when she saw Resident #39 fall headfirst out of the bed that was in a high position. She stated whoever the resident's CNA was left the bed in a high position. She stated she told the nurse who was sitting at the desk, and she went in with another person. CNA #16 stated she thought the resident was sent out. She stated she was not questioned about the fall or what she saw and did not write a witness statement. During an interview on 08/05/2024 at 9:42 AM, LVN #2 stated that when she went into Resident #39's room after the fall on 06/29/2024, the bed was in a position that if the resident were to swing their legs over the side, their feet would touch the floor. She stated she interviewed the CNA that reported it to her but not the CNA assigned to the resident. She stated she did her normal paperwork about the fall, but she sent the resident out to the emergency room , so she did not put in any new interventions. She stated the management team should have done that when the resident returned. She stated no one from the management team asked her about the fall or any details of it. During an interview on 08/04/2024 at 10:52 AM, the Interim Director of Nursing (IDON) stated that an investigation for a fall would include interviews with the resident, staff, and roommate if applicable. She stated they would meet as a team, determine the root cause, and implement new interventions. During an interview on 08/06/2024 at 10:16 AM, the IDON stated she was not able to find any interviews or further investigation for Resident #39's falls in May 2024 or June 2024. She stated the IDT was responsible for implementing new interventions. She stated they met in the morning and reviewed the falls from the previous day or evening. She stated therapy staff, social services staff, the Activities Director, and the whole team discussed the fall and the root cause and determined what was the best interventions to prevent injury or another fall that was specific to the resident. She stated if the interventions were related to CNA care, then the interventions would be put on the task section in the CNA charting to alert the CNAs and it would also be put on the care plan. (continued on next page)

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	08/07/2024

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	During an interview on 08/06/2024 at 11:37 AM, the Administrator stated a fall investigation should be initiated by the nurse on the floor and they should get statements from the CNA or other staff to get a picture of the situation and notify the physician, the on-call supervisor, and the responsible party. He stated the nurse should assess the resident and complete change of condition documentation. He stated the root cause analysis was completed with the IDON in collaboration with the Administrator. He stated interventions were put in by the IDT. The Administrator stated there should have been a more thorough investigation into Resident #39's falls.

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	08/07/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46194 Based on interview, record review, and facility policy review, the facility failed to ensure pharmacy recommendations were implemented for 3 (Residents #29, #42, and #50) of 5 sampled residents reviewed for unnecessary medications. Findings included: An undated facility policy titled, Consultant Pharmacist Services Provider Requirements, indicated, 1) Reviewing the medication regimen (medication regimen review) of each resident at least monthly, or more frequently under certain conditions, incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review (see IIIA1: MEDICATION REGIMEN REVIEW(MONTHLY REPORT)), and documenting the review and findings in the resident's medication record. The policy revealed 10. A written or electronic report of findings and recommendations resulting from the activities as described above is given to the administrator and/or director of nursing (at least monthly). 11. Resident-specific recommendations are documented in the resident's (active record). 1. An Admission Record revealed the facility admitted Resident #29 on 04/29/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of essential primary hypertension. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/15/2024, revealed a Staff Assessment for Mental Status (SAMS) determined Resident #29 had short- and long-term memory problems and had severely impaired cognitive skills for daily decision making. Resident #29's care plan included a focus area initiated 04/16/2023 that indicated the resident had the potential for altered tissue perfusion related to hypertension. Interventions directed staff to give metoprolol as ordered by the physician. Resident #29's Consultant Pharmacist's Medication Regimen Review, dated 05/30/2024, revealed a pharmacy recommendation for hold parameters for systolic blood pressure (SBP) and heart rate (HR) to be added to the resident's metoprolol physician order. Resident #29's Orders Summary Report, with active orders as of 08/04/2024, contained an order dated 06/07/2021, for metoprolol tartrate tablet 50 milligrams (mg) with instructions to give one tablet by mouth two times a day for hypertension. Further review revealed there were no hold parameters included in the order. On 08/04/2024 at 2:16 PM, the Interim Director of Nursing (IDON) stated she would send any note to the physician by fax (facsimile) and follow his response. She stated the physician needs to be notified of all medication regimen reviews. She stated if there was a change to the order the Director of Nursing (DON) was responsible for following up and overseeing the medication regimen reviews were being completed. She stated Resident #26's metoprolol orders should have hold parameters and did not. (continued on next page)

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	08/07/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An Admission Record revealed the facility admitted Resident #42 on 08/25/2022. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus and hypokalemia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/01/2024, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Resident #42's care plan included a focus area initiated 08/07/2022, that indicated the resident had the potential for alteration in blood glucose. Interventions directed staff to administer medications as ordered, such as metformin. The care plan included a focus area initiated 08/27/2022 that indicated the resident had the potential for complications related to hypokalemia. Interventions directed staff to give potassium gluconate per physician orders. Resident #42's Consultant Pharmacist's Medication Regimen Review, dated 05/30/2024, revealed a pharmacy recommendation for potassium supplements to be given with food and a full glass of fluid and do not crush or chew. Further review revealed a pharmacy recommendation for metformin to be given with meals. Resident #42's Consultant Pharmacist's Medication Regimen Review, dated 06/27/2024, revealed a pharmacy recommendation for potassium supplements to be given with food and a full glass of fluid and do not crush or chew. Further review revealed a recommendation for metformin to be given with meals. Resident #42's Orders Summary Report, with active orders as of 08/04/2024, contained an order dated 08/25/2022 for metformin hydrochloride (HCL) tablet 500 milligrams (mg), with instructions to give one tablet by mouth two times a day for diabetes mellitus. Further review revealed there were no special instructions for the medication to be given with meals included in the order. Further review revealed the Orders Summary Report contained an order dated 11/25/2023, for potassium chloride extended release (ER) tablet 10 milliequivalent (meq), with instructions to give one tablet by mouth two times a day for supplement. Further review revealed there were no special instructions included in the order to be given with food and a full glass of fluid and not to crush or chew. On 08/04/2024 at 2:16 PM, the Interim Director of Nursing (IDON) stated she would send any note to the physician by fax (facsimile) and follow his response. She stated the physician needs to be notified of all medication regimen reviews. She stated if there was a change to the order the Director of Nursing (DON) was responsible for following up and overseeing the medication regimen reviews were being completed. She stated Resident #42's potassium supplement and metformin should have had special instructions per the Consultant Pharmacist recommendations, and there were no special instructions. 3. An Admission Record revealed the facility admitted Resident #50 on 04/30/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of cerebral infarction. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/05/2024, revealed Resident #50 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. (continued on next page)

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	08/07/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #50's Consultant Pharmacist's Medication Regimen Review, dated 05/30/2024, revealed a pharmacy recommendation for the resident's spironolactone and carvedilol orders to include hold parameters for systolic blood pressure (SBP) and heart rate (HR), and the resident's Colace order to include a hold for loose stools. Further review revealed a pharmacy recommendation for the resident's Flomax order to include that the capsules should be swallowed whole; do no crush, chew, or open, and to give 30 minutes after mealtime. Resident #50's Medication Administration Record [MAR], for the timeframe from 08/01/2024 through 08/04/2024, revealed a transcription of an order dated 05/13/2024 for Colace 100 milligrams (mg) with instructions to give two capsules by mouth in the morning for constipation. The transcription of the Colace order did not include instructions to hold for loose stools. The MAR revealed a transcription of an order dated 05/15/2024 for Flomax 0.4 mg with instructions to give one capsule by mouth at bedtime for difficulty voiding. The transcription of the Flomax order did not include instructions to swallowed whole; do no crush, chew, or open, and to give 30 minutes after mealtime. The MAR revealed a transcription of an order dated 05/03/2024 for spironolactone 25 mg with instructions to give one tablet by mouth one time a day for hypertension. The transcription of the spironolactone order did not include hold parameters for SBP and HR. The MAR revealed a transcription of an order dated 06/04/2024 for carvedilol 3.125 mg with instructions to give one tablet by mouth two times a day for hypertension. The transcription of the carvedilol order did not include hold parameters for SBP and heart rate HR. On 08/04/2024 at 2:16 PM, the Interim Director of Nursing (IDON) stated she would send any note to the physician by fax (facsimile) and follow his response. She stated if there was a change to the order the Director of Nursing (DON) was responsible for following up and overseeing the medication regimen reviews were being completed. She stated Resident #50's spironolactone, carvedilol, Flomax, and Colace should have had special instructions per the Consultant Pharmacist recommendations, and there were no special instructions. On 08/04/2024 at 2:50 PM, the Administrator stated the staff should follow up on pharmacy recommendations when they were sent. He stated it was the responsibility of the DON with the support of the interdisciplinary team (IDT) team. On 08/05/2024 at 4:52 PM, the Consultant Pharmacist stated medication regimen reviews should be followed up within 72 hours, but it should be done by at least the time they reviewed it again. She stated the recommendations should be updated in the order. She stated the medication regimen reviews were completed on medications monthly. The Consultant Pharmacist stated the facility was trying to be consistent with all blood pressure medications and ensure they had hold parameters. On 08/06/2024 at 11:03 AM, the Physician stated he was notified during rounds or by fax of the medication regimen reviews. He stated that after the facility received the signed agreed upon recommendation, the change should be made the same day or the next day. He stated if there was a new order given it should be addressed within 24 hours.

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	08/07/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to have a medication error rate less than 5 percent (%). The facility had 4 errors out of 28 total opportunities, resulting in a medication error rate of 14.28%, affecting 2 (Resident #61 and Resident #43) of 5 residents observed during medication administration. Findings included: A facility policy titled, Administering Medications, revised in 04/2019, specified, 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, no staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication; b. preventing potential medication or food interactions; and c. honoring resident choices and preferences, consistent with his or her care plan. The policy further specified, 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications: and b. Vital signs, if necessary. An Admission Record indicated the facility admitted Resident #61 on 07/06/2024. According to the Admission Record, the resident had a medical history that included diagnoses of congestive heart failure, hypertensive heart disease, and unspecified atrial fibrillation. Resident #61's Order Summary Report, listing active orders as of 08/05/2024, contained the following orders: -an order, dated 07/06/2024, for amlodipine 2.5 milligrams (mg) one time a day for hypertension. The order included instructions to Hold if SBP [systolic blood pressure] less than 100 or HR [heart rate] below 60; -an order, dated 07/06/2024, for metoprolol tartrate 12.5 mg two times a day for atrial fibrillation. The order included instructions to Hold if SBP less than 100 or HR less than 60; -an order, dated 07/06/2024, for Valsartan 80 mg one time a day for hypertension. The order did not include any specific instructions or hold parameters; and -an order, dated 07/06/2024, for ascorbic acid (vitamin C) 250 mg one time a day. On 07/31/2024 at 8:34 AM, Licensed Vocational Nurse (LVN) #6 entered Resident #61's room and obtained the resident's blood pressure, which measured 90/63 millimeters of mercury (mmHg), and HR, which measured 100 beats per minute (bpm). LVN #6 was observed to prepare and administer ascorbic acid 500 mg, instead of 250 mg as ordered by the physician. LVN #6 held all of Resident #61's blood pressure medications due to the resident's SBP, including their Valsartan 80 mg, despite the Valsartan order not specifying any hold parameters. (continued on next page)

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	08/07/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Admission Record indicated the facility admitted Resident #43 on 03/23/2024. Resident #43's Order Summary Report, listing active orders as of 08/05/2024, contained orders, dated 03/23/2024 for ferrous sulfate (iron supplement) 325 mg two times a day for supplement and calcium carbonate 600 mg with vitamin D 200 units and minerals one time a day for supplement. The calcium carbonate with vitamin D and minerals order specified not to give the medication within one to two hours of the ferrous sulfate. Resident #43's 07/2024 Medication Administration Record (MAR) revealed the ferrous sulfate was scheduled to be given at 8:00 AM each day, and the calcium carbonate with vitamin D and minerals was scheduled to be given at 9:00 AM each day. On 07/31/2024 at 9:09 AM, LVN #2 prepared and administered medications to Resident #43. LVN #2 administered calcium carbonate 600 mg with vitamin D 800 units, instead of calcium carbonate 600 mg with vitamin D 200 units, as ordered by the physician. LVN #2 also administered the resident's ferrous sulfate 325 mg at the same time. During an interview on 07/31/2024 at 11:26 AM, LVN #2 confirmed she gave Resident #43's ferrous sulfate and calcium carbonate with vitamin D at the same time. LVN #2 also confirmed she gave calcium with 800 units of vitamin D, instead of 200 units. During an interview on 08/05/2024 at 4:52 PM, the Consultant Pharmacist stated calcium and iron should be given at different times because if given at the same time, the calcium inhibited the absorption of the iron, and it would not be effective. She stated the iron should be given with food or a snack and should be separated from the calcium by at least two hours for the maximum efficiency. During an interview on 08/06/2024 at 10:16 AM, the Interim Director of Nursing (IDON) stated that when nurses were administering medications, they should open their computer, look at each physician order that was due, take the medication pack and validate the card with the order on the computer, and validate the label with the physician order. She stated they should be following any special instructions included with the orders. She stated the nurses should do a triple check to ensure they have the right resident, right medication, right dose, right route, and right time. During an interview on 08/06/2024 at 11:37 AM, the Administrator stated nurses should follow the orders, and they should contact the physician to clarify orders when needed.

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46194 Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to maintain an infection prevention and control program to prevent the transmission of Coronavirus Disease 2019 (COVID-19) to staff and residents. Specifically, the facility failed to: 1. Ensure timely COVID-19 testing of symptomatic staff and residents and the implementation of COVID-19 testing during an outbreak, 2. Ensure staff were wearing proper Personal Protective Equipment (PPE), 3. Ensure signage was posted of proper PPE for rooms with positive COVID-19 residents, and 4. Ensure staff were fit tested for N-95 respirator masks. The failed practices had the potential to affect all residents that resided in the facility. It was determined the facility's noncompliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.80 Infection Control at a scope and severity of L. The IJ began on [DATE] when the Maintenance Director worked in the facility with symptoms of COVID-19. The Maintenance Director was not immediately tested for COVID-19, but the next day, on [DATE], tested positive for COVID-19. At that time, COVID-19 outbreak testing was not initiated for facility residents and staff. On [DATE], while symptomatic, Nursing Assistant (NA) #1 was asked to continue working while waiting for additional staff. During this time, NA #1 cared for Resident #51. On [DATE] NA #1 tested herself at home for COVID-19, and the result was positive. On [DATE], Resident #51 was sent to the hospital due to COVID-19. As of [DATE], 32 residents and 12 staff members had tested positive for COVID-19. On [DATE] at 5:51 PM, the Administrator and Interim Director of Nursing (IDON) were notified of the IJ and provided the IJ template at that time. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on [DATE] at 5:05 PM. The IJ was removed on [DATE] at 1:10 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance for F880 remained at the lower scope and severity of widespread, with actual harm that was not immediate jeopardy for F880. In addition, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for 3 (Resident #5, #9, and #60) of 3 residents reviewed for EBP. Findings included: (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. An undated facility policy titled, COVID-19, revealed the section titled 2. Monitoring Signs and Symptoms, indicated, b. These symptoms may appear ,d+[DATE] days after exposure (based on incubation period of SARS-CoV-2 [severe acute respiratory syndrome coronavirus 2] virus): i. Fever ii. Cough iii. Shortness of breath or difficulty breathing iv. Myalgia v. Chills or repeated shaking with chills vi. Headache vii. Sore throat viii. Runny nose ix. Loss of taste or smell x. Nausea/vomiting xi. Diarrhea c. Emergency warning signs include: i. Trouble breathing ii. Persistent pain or pressure in the chest iii. New confusion or inability to arouse iv. Bluish lips or face. The policy revealed the section titled 3. Resident Assessment, indicated, a. Criteria to Guide Evaluation of Persons Under Investigation (PUI) for COVID-19. The policy revealed the section titled Clinical Criteria, indicated, At least one of the following symptoms: - cough - shortness of breath - difficulty breathing. The policy revealed the section titled 4. Staff and Visitor Screening if Community Wide COVID-19 Illness, indicated, b. If a staff member develops signs & [and] symptoms of a respiratory infection during work, the staff member needs to: i. immediately stop work & put on a facemask ii. Inform the Infection Preventionist of any individuals, equipment or locations the person came in contact 1. Contact & follow local health department recommendations for next steps (e.g. [exempli gratia; for example], testing, locations for treatment). An email from the Department of Public Health, dated [DATE], sent to the facility in response to the facility's report of COIVD-19 positive staff members revealed the following instructions, A single new case of SARS-CoV-2 infection in any HCP [health care provider] or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using broad-based approach regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. A LTC [Long Term Care] Respiratory Surveillance Line List, dated [DATE], revealed the Maintenance Director had symptoms starting on [DATE] including fever, myalgia, sore throat, upset stomach, and cramping. The list revealed the Maintenance Director tested positive for COVID-19 on [DATE]. On [DATE] at 1:07 PM, the Infection Preventionist (IP) stated the Maintenance Director became symptomatic during a shift, tested positive for COVID-19, and went home. The IP stated the Maintenance Director was at the facility for a few hours and due to him not feeling well he wore a mask while he was at the facility. The IP stated the Maintenance Director asked to be tested sometime into his shift, and he tested positive for COVID-19. The IP stated staff should stay home if they are not feeling well. The IP stated the Maintenance Director was at the facility before she came in to work, and the Maintenance Director should have requested a test earlier if he was not feeling well. On [DATE] at 2:52 PM, the IP stated the Maintenance Director had worked and fixed a window on [DATE]. (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 3:57 PM, the Maintenance Director stated he worked at the facility every day. The Maintenance Director stated on [DATE] he had a sore throat, headache, low energy, and fever and sweats at night. The Maintenance Director stated on [DATE] he had started the day and did not feel well, and that morning he had done some general things inside and outside the building. The Maintenance Director stated he told his boss he was not feeling well, and the Infection Preventionist (IP) tested him. The Maintenance Director stated he tested positive, and he went home. A LTC [Long Term Care] Respiratory Surveillance Line List, dated [DATE], revealed Nursing Assistant (NA) #1 had symptoms starting on [DATE] including cough, myalgia, chills, and headache. The list revealed NA #1 tested positive for COVID-19 on [DATE]. On [DATE] at 8:30 AM, the Infection Preventionist (IP) stated NA #1 tested positive for COVID-19 at home. On [DATE] at 1:07 PM, the IP stated NA #1 became symptomatic early in the morning, worked four hours, and was sent home. The IP stated NA #1 tested at home and sent a picture of the test from home. The IP stated she did not test NA #1 because NA #1 just said she was not feeling well. The IP stated it seemed like an isolated case, there were no other cases, and no one else had symptoms. On [DATE] at 9:17 AM, NA #1 stated she picked up a shift to work on [DATE]. NA #1 stated she started feeling weak with chills around 7:30 AM, and she told the scheduler. NA #1 stated the scheduler asked her to stay until 10:00 AM when other staff would be there. NA #1 stated she still felt bad on Saturday ([DATE]), so she tested herself and was positive. On [DATE] at 9:06 AM, NA #1 stated she had helped with Resident #51 on [DATE]. NA #1 stated Resident #51 was constantly trying to go out the doors, and the alarms would go off. NA #1 stated Resident #51 usually had one-to-one supervision. NA #1 stated no one was assigned to do one-to-one supervision with the resident that morning, so she was helping to keep Resident #51 from exiting. An Admission Record revealed the facility admitted Resident #51 on [DATE]. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease and Alzheimer's disease. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #51 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a staff assessment of mental status (SAMS). A LTC [Long Term Care] Respiratory Surveillance Line List, dated [DATE], revealed Resident #51 had symptoms on [DATE] including cough, myalgia, fatigue, and mucous. The list revealed Resident #51 tested positive for COVID-19 on [DATE]. A late entry nursing progress note, dated [DATE] at 10:00 AM, revealed Resident #51 had altered level of consciousness, weakness, cough, and behavioral symptoms. The note revealed Resident #51 was wandering throughout the building sneezing and coughing. The note revealed hospice recommended sending Resident #51 out for further evaluation. (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A nursing progress note, dated [DATE] at 11:38 AM, revealed Resident #51 tested positive for COVID-19 and was experiencing cough, congestion, blowing mucus in their hands, and spitting on the floor. The note revealed an ambulance was called to transport Resident #51 to a medical center. On [DATE] at 4:22 PM, the Infection Preventionist (IP) stated Resident #51 was not tested for COVID-19 on [DATE] because she thought it was just a cold. The IP stated Resident #51 was tested on [DATE]. On [DATE] at 1:43 PM, Licensed Vocational Nurse (LVN) #2 stated Resident #51 wandered the halls. LVN #2 stated the morning Resident #51 was sent to the hospital the resident was coughing and sneezing phlegm. On [DATE] at 1:53 PM, LVN #3 stated on [DATE] Resident #51 slept most of the day. LVN #3 stated Resident #51 had days where the resident slept most of the day. LVN #3 stated the morning Resident #51 was sent out to the hospital the resident had nasal secretions, throat clearing, and was not their normal self. Registered Nurse (RN) #12, a hospice nurse, was interviewed on [DATE] at 8:36 AM about her visit with Resident #51 on [DATE]. RN #12 stated Resident #51 was lying down, seemed lethargic, and a family member was concerned Resident #51was not waking up. RN #12 stated Resident #51's roommate stated Resident #51 had been lying down since yesterday. RN #12 stated Resident #51 was coughing, but the cough was not a concerning cough for her. RN #12 stated Resident #51's lungs had rales (abnormal lung sounds). RN #12 stated she spoke to the nurse on the floor who stated Resident #51's usual behavior was sleep for long periods. RN #12 stated she told the floor nurse about the cough and rales for monitoring. RN #12 stated she was not aware Resident #51 was exposed to COVID-19 when a staff member tested positive, and that would have changed her decision to treat the resident. RN #12 stated she would have done a COVID-19 test and maybe even have started Resident #51 on an antibiotic, if the resident had tested COVID-19 positive. A handwritten COVID-19 testing log, dated [DATE], revealed staff and resident testing for COVID-19 began after Resident #51 tested positive for COVID-19. A handwritten COVID-19 testing log, dated [DATE], revealed 103 staff and residents were tested for COVID-19. A handwritten testing log, dated [DATE], revealed 92 staff and residents were tested for COVID-19. A handwritten testing log, dated [DATE], revealed four staff and residents were tested for COVID-19. On [DATE] at 8:30 AM, the IP stated COVID-19 started with the Maintenance Director being symptomatic on [DATE]. The IP stated that since there was only one staff member who tested positive, it was an isolated case, and she did not implement testing. The IP stated, on [DATE], another staff member tested positive, and she did not test any other staff or residents. The IP stated she did not start testing all staff and residents until Resident #51 tested positive on [DATE]. The IP stated two other residents tested positive on [DATE], and all staff and residents were tested . The IP stated all staff and residents were tested again on [DATE]. The IP stated on [DATE] she tested symptomatic staff and residents. On [DATE] at 11:51 AM, during a follow up interview, the IP stated she tested symptomatic residents and staff only on [DATE] due to testing supplies being expired. The IP stated she did not want to use outdated testing supplies. (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 1:07 PM, the IP stated there were not many stores locally from which to get testing supplies. The IP stated with the amount they needed there was nowhere to get the supplies, and they would have emptied out the drug stores as there was only one big pharmacy in the area. The IP stated she started outbreak testing for COVID-19 if there were three or more cases as that was considered an outbreak. On [DATE] at 1:55 PM, the Interim Director of Nursing (IDON) stated outbreak investigation and testing would start with three or more staff or residents positive for COVID-19. The IDON stated if the facility was in outbreak, every resident and staff should be tested on day one, day three, and day five. The IDON stated the facility was currently in outbreak as there was one COVID-19 positive resident on each hall for a total of three residents. The IDON stated if staff were not feeling well prior to work they would stay outside and test prior to working. The IDON stated she was not aware there were no testing supplies for the fifth day of testing. The IDON stated she would have expected the IP nurse to contact her for guidance upon finding outdated testing supplies. The IDON stated she would have expected the IP to look up the information on the company website that supplied the equipment to find the true expiration date, and it had been her understanding that testing supplies could be used beyond the expiration date. On [DATE] at 2:21 PM, the Administrator stated testing should be done per CDPH's (California Department of Public Health) guidance. The Administrator stated an outbreak was considered three or more positives, and the testing schedule would be day one, day three, and day five during the outbreak. The Administrator stated all the residents and staff would be tested . The Administrator stated he was unaware there were no testing supplies available for the fifth day of testing, [DATE]. The Administrator stated there was a sister facility with which they could share supplies, and he was asked to bring testing supplies on [DATE]. On [DATE] at 5:16 PM, the IP stated she tested staff and residents if they showed enough symptoms of COVID-19 like a sore throat, fever, no taste, and diarrhea, for those symptoms that would signal COVID-19, or if someone told her they needed to be tested . The IP stated she would test if there were different signs than just a cold. On [DATE] at 11:40 AM, the IDON stated if someone had new signs or symptoms testing would be initiated immediately. 2. An undated facility policy titled, COVID-19, indicated, 7. PPE [personal protective equipment] a. Gloves i. Perform hand hygiene, then put on clean, non-sterile gloves upon entry into the patient room or care area. The policy revealed, b. Gowns i. Put on a clean isolation gown upon entry into the patient room or area. The policy revealed, c. Respiratory Protection i. Use respiratory protection (i.e. a respirator) that is at least as protective as a fit-tested NIOSH [National Institute for Occupational Safety and Health]-certified disposable N95 filtering facepiece respirator before entry into the patient room or care area. The policy revealed, d. Eye Protection i. put on eye protection (e.g., goggles, a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. An Admission Record revealed the facility admitted Resident #21 on [DATE]. According to the Admission Record, the resident had a medical history that included diagnosis of mild persistent asthma with acute exacerbation. (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. A late entry nursing Progress Note, dated [DATE], indicated Resident #21 had a change of condition and tested positive for COVID-19 with signs and symptoms of being tired, weak, increased confusion, and drowsy. An Admission Record revealed the facility admitted Resident #22 on [DATE]. According to the Admission Record, the resident had a medical history that included diagnoses of encephalopathy and muscle weakness. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. A nursing progress note, dated [DATE] at 5:52 PM, revealed Resident #22 tested positive for COVID-19 with signs and symptoms of feeling weak and a of temperature of 101.1 F (degrees Fahrenheit). An observation of Resident #21's and Resident #22's room, on [DATE] at 10:08 AM, revealed signage on the wall by the entry that indicated staff should wash their hands and make sure their eyes and nose were covered prior to entry. The observation revealed enhanced barrier precaution (EBP) signage on the door of the room requiring staff to wash their hands and wear gown and gloves. The observation revealed Housekeeper (HK) #4 inside the room replacing trash can liners, cleaning the bathroom, and mopping the floors. The observation revealed HK #4 had an N-95 mask and gloves on. During the observation HK #4 exited Resident #21's and Resident #22's room, without removing her gloves in the room, to get cleaning supplies from the housekeeping cart. The observation revealed HK #4 taking her gloves off and placing them in the trash can on her cleaning cart. At the time of the observation, HK #4 stated staff were required to wear a mask and gloves inside the room where Resident #21 and Resident #22 resided. HK #4 stated staff were only required to wear a gown if they were providing care to the resident. HK #4 stated PPE should be taken off once staff exited the room at the door and placed in a bag and taken to the storage room. During an observation and interview on [DATE] at 10:19 AM, HK #5 was observed to go into Resident #21's and Resident #22's room donning an N-95 mask. At the time of the observation, HK #5 stated the signage on the wall meant that staff were supposed to wear more PPE when inside the room. HK #5 stated, since the residents had COVID-19, staff should wear additional PPE including a facemask, gloves, and a gown when entering the room. HK #5 stated he should have had additional PPE on when entering the room. An observation and interview on [DATE] at 8:12 AM, revealed Licensed Vocational Nurse (LVN) #6 donning an N-95 mask and gloves in Resident #21's room while taking the resident's blood pressure reading. LVN #6 stated he should wear the mask and the gloves while in Resident #21's room, but he was not required to wear a face shield or a gown. After observing the signage at the door, LVN #6 stated he missed seeing the sign that said to cover the eyes, nose, and mouth. On [DATE] at 8:30 AM, the Infection Preventionist (IP) stated PPE required to enter an isolation room was a gown, gloves, goggles, and an N-95 mask. (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 1:55 PM, the Interim Director of Nursing (IDON) stated staff going into COVID-19 positive rooms should don PPE prior to entering the room including a gown, gloves, an N-95 mask, and a face shield. On [DATE] at 2:21 PM, the Administrator stated staff should use the proper PPE including a gown, face shield, gloves, and a mask, and the N-95 mask was preferred. The Administrator stated staff should put PPE on at the entry of the room and should take the PPE off inside the room. 3. A LTC [Long Term Care] Respiratory Surveillance Line List, dated [DATE], revealed Resident #21 tested positive for COVID-19 on [DATE], Resident #22 tested positive for COVID-19 on [DATE], Resident #24 tested positive for COVID-19 on [DATE], Resident #29 tested positive for COVID-19 on [DATE], Resident #47 tested positive for COVID-19 on [DATE], Resident #37 tested positive for COVID-19 on [DATE], and Resident #56 tested positive for COVID-19 on [DATE]. An observation on [DATE] at 9:12 AM of Resident #47's room revealed the room had no signage or personal protective equipment (PPE) bins outside the room. Resident #47's room should have had signage to ensure staff wore proper PPE inside the room of a resident with COVID-19. An observation on [DATE] at 10:08 AM of Resident #21's and Resident #22's room revealed signage on the door that indicated droplet precautions and to fully cover the eyes, nose, and mouth before room entry. The observation revealed enhanced barrier precaution (EBP) signage on the door that indicated staff must clean their hands and gown and glove only during certain care. An observation on [DATE] at 10:18 AM of Resident #37's and Resident #56's room revealed the room had signage indicating droplet precautions, but there was no signage to ensure staff wore a gown and gloves. An observation on [DATE] at 11:18 AM of Resident 24's room revealed the room had droplet precaution signage on the wall in the hallway by the door that indicated everyone must fully cover their eyes, nose, and mouth before room entry and to remove face protection before room exit. There was no signage observed to indicate staff should be in full PPE including a gown, gloves, an N-95 mask, and a face shield to enter the Resident #37's room. An observation on [DATE] at 11:25 AM of Resident #29's room revealed the door open and signage on the door requiring eyes and nose to be covered. There was no signage observed to indicate staff should be in full PPE including a gown, gloves, an N-95 mask, and a face shield prior to entering the room. On [DATE] at 8:30 AM, the Infection Preventionist (IP) stated COVID-19 positive residents were in isolation with signage outside their doors indicating proper PPE. The IP stated staff were required to wear proper PPE to enter an isolation room which was a gown, gloves, goggles, and an N-95 mask. On [DATE] at 11:02 AM, the Director of Staff Development (DSD) stated the proper signage for COVID-19 isolation rooms was droplet and contact precaution signs. (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	4. A facility policy titled, Personal Protective Equipment - Contingency and Crisis Use of N-95 Respirators (COVID-19 Outbreak), revised ,d+[DATE], revealed the section titled Objective indicated To prevent transmission of infectious agents through the inhalation of airborne particles or droplet nuclei. The policy revealed, 1. When N95 filtering facepiece respirators (FFR) are available and there is not an anticipated shortage, the facility operates under conventional capacity measures, including: The policy revealed, f. adopting just in time fit testing if feasible. On [DATE] at 8:12 AM, Licensed Vocational Nurse (LVN) #6 was observed donning an N-95 mask and gloves while taking a blood pressure reading for Resident #21 who was COVID-19 positive. LVN #6 stated he had not been fit tested for the N-95 mask. On [DATE] at 8:30 AM, the Infection Preventionist (IP) stated staff were required to wear a gown, gloves, goggles, and an N-95 mask inside rooms with positive COVID-19 residents. The IP stated not all staff had been fit tested for the N-95 masks. On [DATE] at 2:21 PM, the Administrator stated staff should use the proper PPE including gown, face shield, gloves, and a mask. The Administrator stated using an N-95 mask was preferable. The Administrator stated not all staff were fit tested for N-95 masks. On [DATE] at 5:06 PM, a Removal Plan was submitted by the facility and the accepted by the state survey agency. It read as follows: Magestic Mountain Care Center 1. How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken; 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; 4. How the facility plans to monitor its performance to make sure that solutions are sustained; Version 7, F880 01.1 Failed to Provide Testing Residents who were found to be COVID-19 Positive had their physician notified, obtained appropriate orders to treat their symptoms, and were placed on alert monitoring. On [DATE] the Infection Preventionist (IP) and designee initiated COVID-19 testing for all 53 Resident in house and staff members. 01.2 All Residents had the potential to be affected by the deficient finding. (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	All Residents and staff will be tested on the first day, third day, and fifth day. If there are new cases, the testing will continue every three to seven days until there are no new cases for fourteen days. On [DATE], 3 new COVID-positive Residents were identified and placed on close monitoring by following COVID 19 protocol and monitoring for any change of condition pertaining to COVID 19. Resident identifier #215 Resident identifier #33 Resident identifier #53 On [DATE] one additional employee tested positive for COVID-19 and was removed from the schedule. 01.3 On [DATE] the Interim Director of Nursing (DON) reeducated the IP and staff with an in-service on the following: - COVID-19 testing guidelines and the importance of compliance with testing and ensuring adequate supplies of testing kits to prevent the spread of COVID 19. -Donning and doffing with proper personal protective equipment (PPE) - N-95 fit-testing protocols. Any staff not on duty at the time of the in-service will be educated by the IP or Designee prior to the start of their next shift. The IP/Designee will post a schedule of staff required to COVID 19 test at least one day prior to the testing date. The staff posting will be next to the time clock. This will also be followed up with a group text message. Any staff reporting back on duty will need to be tested for COVID-19 prior to the beginning of their next shift. On [DATE] the DON and designee educated the staff with an in-service about the signs and symptoms of COVID-19. If staff identifies any symptoms from residents or themselves, they must report it to the IP or designee as soon as possible. Any reported symptoms from residents or staff must result in the immediate administration of a COVID test. 01.4. The IP/Designee will report the COVID-19 testing results at the next daily stand-up meeting. They will then follow-up the announcement with the appropriate corrective action. (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The DON will audit the IP/Designee testing process on day one, day three, and day five to ensure that the residents and staff were tested for COVID-19. Any deficiencies will be corrected immediately, and the Administrator will be notified. The Administrator will review the plan of correction and submit all findings of non-compliance to the Quality Assessment and Assurance (QAA) committee. The QAA Committee shall review and monitor the effectiveness of this Plan of Correction monthly through [DATE]. The identified deficient practice was the IP's failure to adhere to the protocol of testing residents and staff on day one, day three, and day five. The deficient practice has been corrected subsequent to the findings. 2.1 Proper PPE On [DATE] an IP from one of our sister facilities provided an in-service training to 40 out of 84 active staff on the following: - The guidelines for COVID-19 testing and the importance of compliance, including ensuring the adequacy of testing kit supplies to prevent the spread of COVID-19. -Donning and doffing with proper PPEs -[DATE] the IP from sister facilities initiated the skills competency validation for staff, ensuring the proper donning and doffing of PPE. -N-95 fit testing protocols. Any staff out on leave of absence (LOA) will be educated by the IP or designee prior to the start of their next shift. The IP or designee will provide an in-service to the remaining staff that were not in-serviced on [DATE]. The Administrator/DON will verify that the remainder of the staff are educated with an in-service training. 2.2 All Residents had the potential to be affected by the found deficiencies. All Residents and staff will be tested on the first day, third day, and fifth day. If there are new cases, the testing will continue every three to seven days until there are no new cases for 14 days. (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The DON/Designee shall conduct random observations of at least three staff members each week to validate proper donning and doffing of appropriate PPE for four weeks or until substantial compliance is achieved. Annual competency-tests for doffing and donning are to be completed by all staff. On [DATE], three additional residents tested positive for COVID-19 and were placed on close monitoring for any change of condition. Resident identifier #215 Resident identifier #33 Resident identifier #53 On [DATE] one additional employee tested positive for COVID-19 and was removed from the schedule. On [DATE], the IP from our sister facility initiated the skills competency validation for all active staff, ensuring the proper donning and doffing of PPE. On [DATE], the IP from our sister facility will complete the skills competency validation for all active staff, ensuring the proper donning and doffing of PPE. 2.3 On [DATE] the DON in-serviced and reeducated the IP on the following: - COVID-19 testing guidelines, emphasizing the importance of compliance and ensuring adequate supplies of testing kits to prevent the spread of COVID-19. -Donning and doffing with proper PPEs -N-95 fit testing protocols. The IP/Designee will complete a skills competency validation for newly hired staff on the proper donning and doffing of appropriate PPE during orientation. On [DATE], the IP from our sister facility initiated skills competency validation for staff on the proper donning and doffing of PPE. 2.4 The DON/Designee will conduct random observations of at least three staff members per week to validate proper donning and doffing of appropriate PPE for four weeks or until substantial compliance is achieved. (continued on next page)

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	08/07/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Any findings will be corrected immediately, and the administrator will be notified. The administrator will submit all non-compliance findings related to the plan of correction to the Quality Assessment and Assurance (QAA) Committee. The QAA Committee will review and monitor the effectiveness of this plan of correction monthly through [DATE]. 3.1 Proper Signage On [DATE], the IP updated the signage for the five rooms of residents with COVID-19. 3.2 All residents had the potential to be affected by the identified deficiency. On [DATE], three