

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555539	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Coalinga Regional Medical Ctr Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 1191 Phelps Ave. Coalinga, CA 93210	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713</p> <p>Based on interview and record review the facility failed to ensure residents were free from abuse and neglect for one of three sampled residents (Resident 1), when Resident 1 was left outside for approximately one hour without supervision and the temperature was 92 degrees Fahrenheit on 9/29/24.</p> <p>This failure resulted in Resident 1's body temperature to reach 101.1 degrees Fahrenheit (normal body temperature range from 97 degrees to 99 degrees Fahrenheit) and elevated heart rate of 136 beats per minute (normal heart rate for adults is between 60-100 beats per minute) and had the potential for Resident 1 to experience heat exhaustion, dehydration and/or sunburn of the skin.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of abnormalities of gait (walking) and mobility (movement), respiratory failure, conversion disorders with seizures, pain, and muscle weakness</p> <p>During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 9/10/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 0 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 had severe cognitive impairment.</p> <p>During an interview on 10/17/24 at 10:25 a.m. with the director of nursing (DON), the DON stated on 9/29/24, Resident 1 was left outside by the activities assistant (AA). The DON stated the facility staff was alerted by the facility housekeeper that Resident 1 was sitting outside in the heat. The DON stated that the AA was immediately sent home, and Resident 1 was assessed for injuries. The DON stated it was the responsibility of the AA to monitor Resident 1 while he was outside and to have brought him back inside the facility when he was done.</p> <p>During a review of professional reference titled, The Weather Channel, dated 9/29/24, the reference indicated that the outside temperature was recorded at 92 degrees Fahrenheit.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/24 at 10:54 a.m. with the activities director (AD), the AD stated he was notified of the incident involving Resident 1 being left outside by AA. The AD stated the AA should have known that any resident including Resident 1 required consistent monitoring especially when they were outside. The AD stated that when Resident 1 was left outside there was a risk for heat exhaustion, heat stroke and dehydration.</p> <p>During an interview on 10/17/24 at 11:06 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that on 9/29/24 she was alerted by the housekeeping staff that Resident 1 was sitting outside by himself when the weather was hot. LVN 1 stated the certified nursing assistant (CNA) assisted Resident 1 back into the facility. LVN 1 stated Resident 1 was assessed, and he felt hot with an elevated temperature of 101 .1 degrees Fahrenheit and an elevated heart rate of 136. LVN 1 stated they immediately began cooling measures and continuous monitoring. LVN 1 stated a full head to toe skin assessment was completed, and Resident 1 had no visible injuries. LVN 1 stated she spoke with the AA and concluded Resident 1 was left outside for approximately one hour. LVN 1 stated the AA indicated she had taken Resident 1 outside; forgot he was there, and it was not in her job duties to monitor Resident 1 while he was outside. LVN 1 stated the CNA on shift and LVN 1 were not made aware that Resident 1 was taken outside. LVN 1 stated when Resident 1 was left outside there was a risk for dehydration and heat exhaustion.</p> <p>During an interview on 10/17/24 at 11:32 a.m. with activities assistant (AA) 1, the AA 1 stated part of the activities for the facility was for the residents to have the option to go outside. AA 1 stated every resident should have been monitored when they were sitting outside. AA 1 stated while residents were outside in hot wheather, it was the responsibility of the AA assigned to offer cold water or popsicles to keep residents from overheating. AA 1 stated it was the responsibility of the AA on shift to monitor all residents that were in the activities room. AA 1 stated that residents could have requested to go outside but on days when the temperature was above 80 degrees Fahrenheit, they would not do an outside activity to avoid exposing the residents to the heat. AA 1 stated that when Resident 1 was left outside he could have been sun burned or possibly dehydrated.</p> <p>During an interview on 10/17/24 at 11:38 a.m. with CNA 1, CNA 1 stated it was not appropriate for Resident 1 to have been left outside unmonitored. CNA 1 stated when Resident 1 was left outside there was a potential for heat exhaustion or could have caused Resident 1 to lose consciousness from dehydration.</p> <p>During an interview on 10/17/24 at 12:15 p.m. with the DON, the DON stated it was the facility's expectation for all staff including the activities staff, to monitor all residents when they were outside and to not leave them unattended. The DON stated it was the responsibility of the AA to monitor Resident 1 while he was in the activities room and outside. The DON stated it was not appropriate when the CNA left Resident 1 outside and did not remain with resident to monitor. The DON stated there was a potential for heat exhaustion when Resident 1 was left outside.</p> <p>During a telephone interview on 10/17/24 at 12 :24 p.m. with the administrator (ADM), the ADM stated the employee involved was properly trained on neglect and chose not to follow the training. The ADM stated it was not appropriate for the employee to have left Resident 1 outside unmonitored because he should have been monitored. The ADM stated when he spoke with the employee, she was aware Resident 1 was outside but did not monitor. The ADM stated the employee had been terminated from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Activity Assistant Job description, undated, the job description indicated, . To provide routine care and services to clients that supports the medical model of care in the Activities Department . Employees will be required to perform any other job related duties requested by their supervisor . Implements an interactive daily program, including large and small groups, special events, and community outings, provides one to one programming for clients who are unable or unwilling to participate in group programs . Meet the client's mental health and social needs, be aware of developmental tasks and physiological changes associated with the aging process, maintain/ support the client's right to maintain personal choices . Provide supervision and assistance to all residents when participating in indoor or outdoor activities .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, dated 1/2024, the P&P indicated, . Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms . As part of the resident abuse prevention, the administration will, Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual .</p>		