STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555539	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coalinga Regional Medical Ctr Dp/Snf	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on interview and record review the facility failed to ensure accuracy of documentation according to professional standards for three of three sampled residents (Resident 1, Resident 2 and Resident 3), when the assistant director of nurses/minimum data set (ADON/MDS) nurse documented and electronically signed for the social services director (SSD) on 1/3/25 and 1/6/25 in Resident 1, Resident 2 and Resident 3 ' s multidisciplinary care conference (MCC-meeting that could consists of director of nurses, physician, dietary staff, therapy staff, social services, activities, resident and resident representative to discuss resident care) notes. This failure resulted in falsified documentation and could have caused delay in care resulting from the inaccuracy of the documentation for Resident 1, Resident 2, and Resident 3. Findings: During a review of Resident 1's Admission Record (AR- a summary of information regarding a resident which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis for anxiety (constant worry or feeling afraid), dysphagia (difficulty swallowing) and transient ischemic attack (temporary disruption of blood flow in the brain). 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 2/19/25, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 11 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 had moderate cognitive impairment. During a review of Resident 2's AR, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis for muscle wasting, dysphagia (difficulty swallowing), major depressive disorder (persistent feeling of sadness and loss of interest). During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 1's BIMS score was 13 out of 15 which indicated Resident 2 was cognitively intact. (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's AR, the AR indicated, Resident 3 was admitted to the facility on [DATE] with diagnosis for major depressive disorder (persistent feeling of sadness and loss of interest), cerebral infarction (blood flow is blocked I the brain) and schizoaffective disorder (condition with symptoms of hallucinations, sadness). During a review of Resident 3's MDS, dated [DATE], the MDS indicated, Resident 3's BIMS score was 14 out of 15 which indicated Resident 2 was cognitively intact. During an interview on 3/27/25 at 10:31 a.m. with the SSD, the SSD stated there was documentation being falsified in Resident 1 ' s records. The SSD stated there were documents that were signed on behalf of the SSD department, even when the SSD was not physically in the facility. The SSD stated the resident assessments had to be completed thoroughly and accurately because the assessments were regarding residents ' mood and behavior and contributed to the plan of care. The SSD stated the instances were reported to the administration but felt there was retaliation from administrative staff following the report. During an interview on 3/27/25 at 10:45 a.m. with the licensed vocational nurse (LVN) 1, LVN 1 stated there were instances when LVN 1 was signed as an attendant to resident care conferences or resident assessments but was not in attendance. LVN 1 stated she could not recall the dates or time but had noticed multiple instances in which that had occurred. LVN 1 stated the instances were not reported to the administration for fear of retaliation against LVN 1. LVN 1 stated it was important to have complete and accurate documentation to effectively care for the resident. During an interview on 3/27/25 at 10:51 a.m. with the ADON/MDS nurse, the ADON/MDS stated the role of the MDS was to ensure documentation was complete and accurate. The ADON/MDS stated if the assessments were found to be incorrect, she would delete the documented portion completed by the other department members and correct it. The ADON/MDS stated she would not notify the department members when the documentation was changed or deleted. The ADON/MDS stated she oversaw documenting during the MCC meetings for residents in the facility. The ADON/MDS stated, the only person she would add as physically attending the care conference meetings was the DON, even when the DON was not physically in the facility. The ADON/MDS stated she had not falsified documentation for any resident. During an interview on 3/27/25 at 11:24 a.m. with the director of clinical operations (DCO), the DCO stated there was a complaint made by a former employee regarding instances of false documentation, but it was determined the ADON/MDS was completing the documentation to assist the members of the IDT. The DCO stated documentation should have been complete and accurate according to the residents ' assessments and IDT documentation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/27/25 at 11:57 a.m. with the SSD and DON present, Resident 1 ' s, Multidisciplinary Care Conference (MCC), dated 1/6/25, Resident 2 ' s, MCC, dated 1/3/25 and Resident 3 ' s, MCC, dated 1/3/25, were reviewed. Resident 1 ' s MCC indicated, . Attendance at meeting . social worker . Social work summary, orientation status, Resident alert and oriented x3. Resident able to make needs known to staff . Problems/needs, monthly [medical doctor] visit, monthly with [nurse practioner psychiatrist] . discharge goals, long-term care anticipated . Name [social services director electronic signature] . Resident 2 ' s MCC indicated . Attendance at meeting . social worker . Social work summary, orientation status, Resident is alert and oriented. Able to verbalize needs . Problems/needs, monthly with [medical doctor] . discharge goals, long-term care anticipated . Name [social services director electronic signature]. Resident 3 ' s MCC indicated, . Attendance at meeting . social worker . Social work summary, orientation status, Resident alert and oriented. Able to verbalize needs . Problems/needs, monthly with [medical doctor], monthly discharge goals, long-term care anticipated . Name [social services director electronic signature] . The SSD stated she was not present during the MCC meetings for Resident 1, Resident 2 and Resident 3 but documentation showed the SSD was present during the meeting. The SSD stated the MCC was electronically signed and completed when SSD was not present during the conference. The SSD stated each department in the facility oversaw their portion of the MCC and the SSD portion should not have been completed by any other facility department. During a concurrent interview and record review on 3/27/25 at 12:10 p.m. with the DON and SSD present, Resident 1 ' s, Multidisciplinary Care Conference, dated 1/6/25, Resident 2 ' s, MCC, dated 1/3/25 and Resident 3 ' s, MCC, dated 1/3/25, were reviewed. Resident 1 ' s MCC indicated, . Attendance at meeting . social worker . Social work summary, orientation status, Resident alert and oriented x3. Resident able to make needs known to staff . Problems/needs, monthly [medical doctor] visit, monthly with [nurse practioner psychiatrist] . discharge goals, long-term care anticipated . Name [social services director electronic signature] . Resident 2 ' s MCC indicated . Attendance at meeting . social worker . Social work summary, orientation status, Resident is alert and oriented. Able to verbalize needs . Problems/needs, monthly with [medical doctor] . discharge goals, long-term care anticipated . Name [social services director electronic signature]. Resident 3 ' s MCC indicated, . Attendance at meeting . social worker . Social work summary, orientation status, Resident alert and oriented. Able to verbalize needs . Problems/needs, monthly with [medical doctor], monthly discharge goals, long-term care anticipated . Name [social services director electronic signature] . The DON stated all documentation should have been complete and accurate. The DON stated the purpose of the MCC was to bring all departments together and discuss the needs of the resident and how the residents were progressing. The DON stated it was every departments responsibility to only complete the portion that pertained to their department and to not complete the portion of another department as they would not have the knowledge to accurately reflect the care given. The DON stated when a department was not going to be present for the MCC, it was the expectation that no one would be completing their portion of the conference until they returned to the facility. During a concurrent telephone interview and record review on 4/3/25 at 11:00 a.m. with the DON, the SSD ' s, Daily Time Report, dated 1/1/25-1/31/25, was reviewed. The DON stated the Report indicated, the SSD did not have documented working hours on 1/3/25 and 1/6/25. The DON stated the SSD was not present in the facility on the dates of the completed MCC ' s for Resident 1, Resident 2 and Resident 3. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s job description titled, ADON/MDS Coordinator, undated, the job description indicated, . The Assistant Director of Nursing (ADON) and MDS Nurse is responsible for assisting in the overall nursing management of the [Facility name] and coordinating the completion of accurate and timely MDS assessments for all residents . Monitor and report on the accuracy and completeness of MDS assessments and related documentation. Provide staff training on MDS processes, documentation, and related procedures . During a review of a professional reference from the American Nurses Association titled, Principles for Nursing Documentation, dates 2010, the reference indicated, . Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice . Documentation of nurses ' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing ' s contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care . Entries into organization documents or the health record (including but not limited to provider orders) must be Accurate, valid, and complete, Authenticated; that is, the information is truthful, the author is identified, and nothing has been added or inserted, Dated and time-stamped by the persons who created the entry . During a review of the facility ' s policy and procedure (P&P) titled, Documentation Policy, undated, the P&P indicated, . The purpose of this policy is to establish standardized practices for documenting care, treatment and patient progress in the skilled nursing facility (SNF) setting . this policy applies to all healthcare providers . it is the policy of [facility name] that all healthcare providers document patient care accurately, timely, and legibly in the patient ' s medical record. Documentation must be complete . and reflect a true and accurate account of the patient ' s status, treatments, and outcomes . general requirements . accuracy all entries must be accurate and reflect the patient ' s current condition . signature. All entries must be signed and dated by the healthcare provider responsible for the care. For electronic documentation, this may include an electronic signature . corrections. If errors are made, corrections must be made in a way that maintains the integrity of the original entry .