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	07/17/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were free from abuse for one of four sampled residents (Resident 1), when on 7/13/25 the activity assistant (AA) 2 was physically and verbally aggressive toward Resident 1 during the smoking break.This failure resulted in verbal and physical abuse toward Resident 1 and placed Resident 1 in an unsafe living environment.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 (excessive worry and fear), expressive language disorder (condition that affects a person's ability to use language, both written and spoken), dysphasia (disorder that affects the ability to understand, produce or use language).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 3/3/2025, 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.During an interview on 10/17/25 at 10:05 a.m. with the interim administrator (IADM), the IADM stated she had received a report on 7/15/25 from Resident 3, stating she had witnessed a AA 2 hitting Resident 1 with a clothing protector during the smoke break and yelling at Resident 1 on 7/13/25. The IADM stated the facility initiated an investigation that revealed Resident 2 and Resident 3 were both witnesses to the incident. The IADM stated the allegation was found to be substantiated and AA 2 was suspended pending termination.During a review of Resident 3's admission Record, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnosis for Anxiety (excessive worry and fear).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 3 was cognitively intact.During a concurrent observation and interview on 7/17/25 at 10:39 a.m. with Resident 1 and Resident 3, both residents were observed outside during their smoke break. Resident 3 stated on 7/13/25, Resident 1, Resident 2 and Resident 3 were outside preparing for a smoke break accompanied by AA 2. Resident 3 stated AA 2 approached Resident 1 with the clothes protector used while smoking. Resident 3 stated AA 2 placed Resident 1's clothing protector with enough force to hear a thump from Resident 1's chest. Resident 1 observed moving his head to indicate yes in agreement. Resident 3 stated, Resident 1 reacted by standing up in front of AA 2, then AA 2 was heard raising his voice stating, Hit me so I can put you in jail for hitting a healthcare worker. Resident 3 stated Resident 1 had not reacted even though AA 2 tried to provoke and instigate a fight. Resident 1 observed moving his head to indicate yes in agreement.During a review of Resident 2's admission Record, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis for Anxiety (excessive worry and fear).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's BIMS score was 15 out of 15 which indicated Resident 2 was cognitively intact. During a review of Resident 2's, Nurse's Note, dated 7/15/25, the note indicated, . [Resident 2] reported that on Sunday 7/13/25 [Resident 1] was in a foul mood and was walking outside because that's what he likes to do. Later he went outside to smoke, and [AA 2] was real upset with [Resident 1] because he would not go inside earlier and when it came time to put on the smoking vest [AA 2] approached [Resident 1], who was reportedly sitting down on the bench, and very sharply shoved the vest into [Resident 1] chest, you could hear the thump. [Resident 1] stood up and got into a fighting stance and for the first time ever I heard [Resident 1] speak. [Resident 2] then stated that [AA 2] replied with try to touch me, if you do, you'll go to prison for assaulting a healthcare worker. [Resident 2] reported that she did not know exactly what [Resident 1] had said, because Resident 1 did not speak most of the time and when he does you cannot understand him, but she recalls [AA 2] response. After [AA 2] had made that statement [Resident 1] reportedly turned around, put his cigarette out, which he never does, he always finishes it and went back inside. [Resident 1] did not go back outside the rest of the shift until [AA 2] went home for the night. [Resident 2] reports feeling safe in the facility.During an interview on 7/17/25 at 10:47 a.m. with Resident 2, Resident 2 stated that on 7/13/25, Resident 1, Resident 2 and Resident 3 were outside preparing for a smoke break accompanied by AA 2. Resident 2 stated AA 2 approached Resident 1 with the clothes protector used while smoking

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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. (continued on next page)

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow facility's policies and procedures and meet professional standards of quality for one of three sampled Residents (Resident 1), when staff did not document Resident 1's change of condition (COC) or Situation, Background, Assessment and Recommendation communication form (SBAR- communication tool that provides critical information and ensures that important details are clearly communicated) for a staff to resident allegation of abuse on 7/13/25.This failure had the potential to result in the inaccurate assessment of Resident 1, delay in care and was at risk for further abuse. 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 (excessive worry and fear), expressive language disorder (condition that affects a person's ability to use language, both written and spoken), dysphasia (disorder that affects the ability to understand, produce or use language). 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 3/3/2025, 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.During a review of Resident 2's, Nurse's Note, dated 7/15/25, the note indicated, . [Resident 2] reported that on Sunday 7/13/25 [Resident 1] was in a foul mood and was walking outside because that's what he likes to do. Later he went outside to smoke, and [AA 2] was real upset with [Resident 1] because he would not go inside earlier and when it came time to put on the smoking vest [AA 2] approached [Resident 1], who was reportedly sitting down on the bench, and very sharply shoved the vest into [Resident 1] chest, you could hear the thump. [Resident 1] stood up and got into a fighting stance and for the first time ever I heard [Resident 1] speak. [Resident 2] then stated that [AA 2] replied with try to touch me, if you do, you'll go to prison for assaulting a healthcare worker. [Resident 2] reported that she did not know exactly what [Resident 1] had said, because Resident 1 did not speak most of the time and when he does you cannot understand him, but she recalls [AA 2] response. After [AA 2] had made that statement [Resident 1] reportedly turned around, put his cigarette out, which he never does, he always finishes it and went back inside. [Resident 1] did not go back outside the rest of the shift until [AA 2] went home for the night. [Resident 2] reports feeling safe in the facility.During a review of Resident 2's admission Record, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis for Anxiety (excessive worry and fear).During a review of Resident 1's Minimum Data Set, dated [DATE], the MDS indicated Resident 2's Brief Interview for Mental Status score was 15 out of 15 which indicated Resident 2 was cognitively intact.During an interview on 7/17/25 at 11:28 a.m. with licensed vocational nurse (LVN) 1, LVN 1 stated the facility process was to complete a COC for any change in resident health status. LVN 1 stated there should have been a COC completed for the alleged staff to resident abuse incident. LVN 1 stated the purpose of the COC was to accurately document what had occurred and to communicate it through the electronic medical record (EMR). During a concurrent interview and record review on 7/17/25 at 12:20 p.m. with interim director of nurses (IDON), Resident 1's electronic medical record (EMR) was reviewed. The IDON stated the EMR indicated there was no COC completed for Resident 1's allegation of staff to resident abuse that occurred on 7/13/25. The IDON stated it was important to ensure all documentation was completed for Resident 1's incident of abuse, to monitor Resident 1 for changes in health status and well-being.During a concurrent interview and record review with the interim administrator (IADM), the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2001, was reviewed. The P&P indicated, . A significant change of condition is a major decline or improvement in the resident's status that will not normally solve itself without intervention by staff. required interdisciplinary review and/or revision to the care plan. the nurse will make detailed observation and gather relevant and pertinent information for the provider, including information prompted by the SBAR . The IADM stated there should have been a COC completed for any resident changes in health status and for the staff to resident abuse incident with Resident 1.During a review of a professional reference from the American Nurses Association titled, Principles for Nursing Documentation, dates 2010, the reference indicated, Clear