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	11/12/2025

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. (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 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 observation interview and record review the facility failed to follow its policy and procedure (P&P) titled Charting and Documentation in accordance with professional standards of practice for one of three sampled residents (Resident 1), when the licensed nurses did not change Resident 1's wound dressing every shift as ordered by the physician for two days and documented in the electronic medical record that the wound treatment was completed. This failure had the potential to result in delay in care, wound healing, and cause an infection from bacteria buildup.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 injury at C5 level of cervical spinal cord (damage to the nerves in the neck that control muscles in the upper body), Stage 4 pressure ulcer (Stage 1: The skin is intact but looks red, and may feel warm, firm, or painful. Stage 2: The skin breaks, creating a shallow open sore or a ruptured blister. Stage 3: The sore deepens into a crater that reaches the layer of fat beneath the skin. Stage 4: The damage extends through the skin to the muscle, bone, or joints, open wound with exposed bone). 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 11/11/2025, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact. During an interview on 11/12/25 at 12:01 p.m. with Resident 1 in his room, Resident 1 stated he had a wound to the coccyx (small bone at the bottom of the spine) that required wound dressing change every day. Resident 1 stated there were days when the nurses would not complete his treatment as ordered by the physician. Resident 1 stated the last time the wound dressing was changed was on 11/9/25. Resident 1 stated he had requested the nurse to change his dressing for the past two days but was unsuccessful. Resident 1 stated he felt neglected by the facility nurses when he would request the wound dressing be changed and the nurses did not complete the treatment order. During a concurrent observation and interview on 11/12/25 at 12:12 p.m. with licensed vocational nurse (LVN) 1, Resident 1's wound dressing and wound to the coccyx were observed. The wound dressing was observed initialed and dated 11/9/25. LVN 1 stated that according to the date on the wound dressing, Resident 1's wound dressing was last changed on 11/9/25. During a record review of Resident 1's, Order Summary Report, dated 10/13/25, the order summary indicated, . Coccyx pressure ulcer stage 4- Cleanse with wound cleaner, pat dry, pack loosely with gauze w/ [brand name medication], cover foam dressing. As needed. Coccyx pressure ulcer stage 4- Cleanse with wound Phone cleaner, pat dry, pack loosely with gauze w/ [brand name medication], cover foam dressing. Every shift. The order summary indicated Resident 1 had a physician order for routine wound dressing changes every shift, everyday and as needed in between. During a record review of Resident 1's, Treatment Administration Record (TAR), dated 11/2025, the TAR indicated, . Coccyx pressure ulcer stage 4- Cleanse with wound Phone cleaner, pat dry, pack loosely with gauze w/ [brand name medication], cover foam dressing. Every shift. The TAR indicated, Resident 1's treatment order was signed as completed on 11/9/25, 11/10/25, and 11/11/25. During an interview and record review on 11/12/25 at 12:20 p.m. with LVN 1, Resident 1's, Order Summary Report, dated 10/13/25 and Resident 1's, Treatment Administration Record (TAR), dated 11/2025, were reviewed. The order summary indicated, . Coccyx pressure ulcer stage 4- Cleanse with wound cleaner, pat dry, pack loosely with gauze w/ [brand name medication], cover foam dressing. As needed. Coccyx pressure ulcer stage 4- Cleanse with wound Phone cleaner, pat dry, pack loosely with gauze w/ [brand name medication], cover foam dressing. Every shift. The TAR indicated, . Coccyx pressure ulcer stage 4- Cleanse with wound Phone cleaner, pat dry, pack loosely with gauze w/ [brand name medication], cover foam dressing. Every shift. LVN 1 stated the TAR indicated the wound dressing treatment order was completed on 11/9/25, 11/10/25, and 11/11/25 but based on the concurrent wound dressing observation, the last date on the wound dressing was 11/9/25. LVN 1 stated the facility process was for the nurse to complete the treatment order from the physician and to initial and date the wound dressing to validate the wound dressing was changed. LVN 1 stated it was important to initial and date the wound dressing to ensure the wound dressing was

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 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 follow its policy and procedure (P&P) titled Charting and Documentation in accordance with professional standards of practice for one of three sampled residents (Resident 2), when the certified nursing assistants (CNA) did not document Resident 1's urine output every shift on 10/31/25, 11/1/25, 11/2/25, 11/5/25, 11/9/25, 11/10/25, 11/12/25. This failure had the potential to result in delay in care and cause an infection from not assisting Resident 2 with urine elimination. Findings:During a review of Resident 2'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 2 was admitted to the facility on [DATE] with diagnosis for cerebral infarction (blocked or reduced blood supply to the brain), calculus of kidney (hard piece of material that form in one or both kidneys), muscle weakness, constipation. During a review of Resident 2's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 7/9/2025, the MDS indicated, Resident 2's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 8 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 2 had moderate cognitive impairment. During a review of Resident 2's, Bladder Elimination Record, dated 10/31/25-11/12/25, the bladder elimination record indicated Resident 2 had been assisted with urination on: 10/31/25- 5:04 a.m. Amount four times for the day, 11/1/25- 3:26 a.m. amount three times for the day, 11/2/25 5:05 a.m. amount five times for the day, 11/3/25- 4:56 a.m. four times & 5:41 p.m. four times, 11/4/25- 5:59 a.m. amount six times & 5:04 p.m. amount four times, 11/5/25- 5:59 a.m. amount six times for the day, 11/6/25- 5:53 a.m. amount four times & 2:26 p.m. amount three times, 11/7/25- 5:18 a.m. amount five times & 4:49 p.m. four times, 11/8/25- 5:59 a.m. amount six times for the day, 11/9/25- 5:59 a.m. amount six times for the day, 11/10/25- 5:59 a.m. amount six times & 8:50 a.m. five times, 11/11/25- 5:57 a.m. five times & 5:17 p.m. five times, 11/12/25- 5:59 a.m. two times for the day. During a concurrent interview and record review on 11/12/25 at 10:51 a.m. with Licensed vocational nurse (LVN) 3, Resident 2's, Bladder Elimination record, dated 10/31/25-11/12/25, was reviewed. LVN 3 stated the bladder elimination record was completed by the certified nursing assistants (CNA) who were caring for Resident 2. LVN 3 stated the expectation was for the CNAs to document the number of times Resident 2 was assisted during the working shift with urine elimination. LVN 3 stated the bladder elimination record was incomplete, as some of the CNA entries were not completed for the days of 10/31/25, 11/1/25, 11/2/25, 11/5/25, 11/9/25, 11/10/25, 11/12/25. LVN 3 stated the incomplete documentation on the bladder elimination record indicated the care did not occur because it was not accurately documented. LVN 3 stated it was important that CNAs complete all documentation timely and accurately to ensure Residents are monitored appropriately when voiding. LVN 3 stated the CNA documentation was an important part of all residents' care and services provided. During a concurrent interview and record review on 11/12/25 at 1:07 p.m. with the director of nursing (DON), Resident 2's, Bladder Elimination record, dated 10/31/25-11/12/25, was reviewed. The DON stated the expectation was for the CNAs to complete all documentation for all residents before they leave the facility at the end of the shift. The DON stated CNAs were expected to document after each time a resident was assisted to the bathroom, not just at the end of the shift. The DON stated it was important to have complete and accurate documentation to monitor and treat residents as needed. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017, the P&P indicated, . All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record may be electronic, manual or a combination. The following information is to be documented in the resident medical record. Treatments or services performed. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 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