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	02/11/2026

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 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. Based on interview and record review, the facility failed to maintain complete and accurate documentation and follow its policy and procedures titled Falls - Clinical Protocol and Charting and Documentation for two of six sampled residents (Resident 1 and Resident 2), when the Licensed Vocational Nurse (LVN) 1 did not complete the neuro-check (a focused assessment of the nervous system used to identify acute changes in an individual's functional status) on 11/17/25 and 11/18/25 for Resident 1 after an unwitnessed fall on 11/15/25, and the Director of Nursing (DON) did not complete IDT (Interdisciplinary Team; a group of staff members consisting of physicians, nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff) note for Resident 2 on 12/18/25 after an unwitnessed fall on 12/17/25. These failures had the potential to result in the delayed detection of neurological changes which could lead to irreversible functional impairment for Resident 1 after an unwitnessed fall on 11/15/25 and the potential for the IDT to miss opportunities to discuss, intervene, and care plan for Resident 2 after an unwitnessed fall on 12/17/25.Findings: During a record review of Resident 1's admission Record, dated 2/17/26, the AR indicated Resident 1 had a diagnosis of Type 2 Diabetes Mellitus (a chronic metabolic disorder where the body develops insulin resistance resulting in high blood sugar level), Osteomyelitis of the right ankle and foot (an infection and inflammation of the bone or bone marrow), Chronic Obstructive Pulmonary Disease (a progressive lung condition characterized by chronic respiratory symptoms and persistent irreversible airflow limitation), and Chronic Heart Failure (a long-term, progressive clinical syndrome where the heart muscle is too weak or stiff to pump sufficient blood throughout the body). During a record review of Resident 1's Minimum Data Set (MDS; process for clinical assessment of all residents of long term care nursing facilities), dated 1/23/26, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS; an assessment of a resident's cognitive (mental process) status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 12 out of 15 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment) which indicated Resident 1 had moderate cognitive impairment. During a record review of Resident 1's SBAR ([Situation, Background, Appearance, Review] Communication Form; a communication tool licensed staff use to share pertinent information with the resident's physician and responsible party when there is a change in the resident's condition), dated 11/15/25, the SBAR indicated, .Primary Care Clinician Notified: Yes. Date: 11/15/25. Time: 11:25 a.m. Recommendations of Primary Clinicians: Send to ER (Emergency Room) for scan of head and right shoulder. During a record review of Resident 1's Progress Notes (PN), dated 11/15/25, the PN indicated, Writer was called to the dining room by Certified Nursing Assistant (CNA), resident was sitting on the floor next to wheelchair. Resident stated she stood up to get coffee and slid to the floor landing on bottom then falling sideways hitting her right (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shoulder and head. notified [name of primary care physician] got order to send to ER for evaluation. During a concurrent interview and record review on 2/17/26 at 9:52 a.m. with the DON, Resident 1's Neuro Checklist (NC), dated 11/15/25 was reviewed. The NC indicated, Interval: Every 30 min. X2 (every 30 minutes two times an hour), Every 1 hour X3, Every 2 hours X24 hours, Every 4 hours X5, Every 8 hours (for 24 hours). The NC indicated the initial V/S (Vital Signs-blood pressure, Temperature, Pulse, Respiration), Level of Consciousness, Right Pupil, Left Pupil, Right Hand Grip, Left Hand Grip, and Nurse Initial was not completed for 11/17/25 and 11/18/25. The DON stated LVN 1 was assigned to Resident 1 on 11/17/25 and 11/18/25 and LVN 1 should have completed the NC for 11/17/25 and 11/18/25 to indicate that Resident 1's neurological status was assessed. The DON stated that a delay in recognizing early neurological changes could delay the management of a serious neurological problem which could lead to serious negative outcomes such as permanent impaired cognition (mental process), speech, function and mobility. The DON stated medical records should be complete and accurate to reflect the care provided. During a record review of Resident 2's AR, dated 2/11/26, the AR indicated Resident 2 had a diagnosis of Alzheimer's Disease (a chronic, progressive, and irreversible neurodegenerative brain disorder that slowly destroys memory, thinking skills, and the ability to perform simple daily tasks), and Dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking). During a record review of Resident 2's MDS, dated 12/31/25, the MDS indicated, Resident 2's BIMS score was 2 out of 15 which indicated Resident 2 had severe cognitive impairment. During a record review of Resident 2's SBAR, dated 12/17/25, the SBAR indicated, .Primary Care Clinician Notified: Yes. Date: 12/17/25. Time: 3:00 a.m. Recommendations of Primary Clinicians: Notified MD of unwitnessed fall, implemented neuro checks, monitor for delay injuries, one time order CT (Computed Tomography; a medical imaging procedure that uses X-rays and computer technology to create detailed cross-sectional of the body used to visualize bones, blood vessels, and soft tissues) of the head. During a record review of Resident 2's Progress Notes (PN), dated 12/17/25, the PN indicated, Writer was notified by CNA that resident had unwitnessed fall in the bathroom. Resident walked to the bathroom and lost his balance. Small abrasion noted on left big toe. Order for CT of the head place. During a concurrent interview and record review on 2/11/26 at 11:49 a.m. with the DON, Resident 2's IDT Post Incident Meeting (IDT), dated 12/18/25 was reviewed. The IDT indicated, .A. IDT Meeting. 1. Date & Time: 12/18/25 4:18 p.m. The remainder of the record was not completed. The DON stated the IDT note should have been completed to indicate the IDT met to discuss Resident 2's fall, the cause of the fall, interventions to prevent the fall from recurring, who was notified and acknowledge any new orders. The DON stated she should have completed the IDT note and did not. During an interview on 2/11/26 at 11:49 a.m. with the Medical Record Director (MRD), the MRD stated residents' medical records should be complete and accurate to reflect the care provided. The MRD stated partially completed or incomplete documentation of records indicated the service was not provided. During an interview on 2/18/25 at 10:03 a.m. with the Administrator (ADM), the ADM stated the facility was required to maintain complete and accurate documentation of records to reflect the care provided for the residents. The ADM stated the neuro-check was required to be completed to ensure the resident received the proper level of care. The ADM stated the IDT note was required to be completed after an incident to ensure the resident was aligned with the appropriate care plan and the IDT did not miss anything. The ADM stated the IDT was made up of leadership individuals from different departments (nursing, rehabilitation, social services, etc.) to collaborate and provide holistic care (a comprehensive approach to health that treats the whole person which includes physical, emotional, mental, social, and spiritual rather than just symptoms (continued on next page)

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