

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/04/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents were free from verbal, mental, and physical abuse for five of the ten sampled residents (Resident (Res) 2, Res 3, Res 4, Res 5 and Res 6 when: Certified Nursing Assistant (CNA) 2 and CNA 3 mocked, laughed and engaging in demeaning behavior towards Res 2. CNA 2 and CNA 3 did not change Res 3's soiled briefs and did not provide appropriate perineal care (cleansing of the genital and anal area essential for preventing infections, reducing odors, and maintaining skin integrity), or hygiene, failing to clean Resident 3 prior to changing Res 3's brief. CNA 3 struck Res 4 in the face with a chuck pad while cleaning a bowel movement, constituting physical abuse. CNA 2 and CNA 3 were reported by multiple residents to not provide quality care by delaying or not responding to call lights, indicating a pattern of abusive and neglectful practices. Facility staff were aware that activity staff left residents unmonitored during activities and on 6/8/26 Res 5 hit Res 6 on the left side of the face and left arm during activities in the dining room. These failures resulted in Res 2, Res 3, Res 4 and Res 5 subjected to ongoing verbal, psychological, and physical abuse, and placed all residents in the facility at risk for abuse and neglect by CNA 2 and CNA 3. Findings: During an interview on 6/3/26 at 11:35 a.m. with the Director of Nursing (DON), the DON stated that she was familiar with the incident with Res 2, the DON stated that it was reported to her by a staff member (MN) that he felt uncomfortable how Res 2 was treated by CNAs [CNA 2 and CNA 3]. The DON stated she had asked for [MN's] statement. The DON stated (MN) did not provide names for the CNAs until later in the statement. The DON stated that she had started the investigation on 5/6/26 by notifying the Director of staffing development (DSD) and risk (QRM) for the facility. The DON stated that it was not until the DSD was doing in-services the following week that staff came forward with the reporting and two particular staff CNAs name (CNA 2 and CNA 3) came up. The DON stated during the investigation the facility identified additional residents that were mistreated by these two CNAs. The CNO stated that CNA 2 was suspended on 5/15/26 and CNA 3 was suspended on 5/19/25. The CNO stated no other issues were identified, the DON stated all appropriate notifications were completed and resident's care plan was updated. The DON stated that the investigation concluded that significant abuse and neglect occurred within the identified rotation. The actions of [CNA 3] and [CNA 2] constitute violations of resident rights, dignity, and safety, including verbal abuse, psychological abuse, neglect, and in [CNA 3's] case, physical abuse. During an interview on 6/3/26 at 1:20 p.m. with the DSD, the DSD stated that she had been working at this facility since March 2026. The DSD stated she was on vacation from 5/5/26 to 5/13/26. The DSD stated upon returning on 5/13/26, she checked her email and found out about the incident with Res 2. The DSD stated that she immediately started reaching out to her colleagues and started to follow up. The DSD stated that she immediately started in-services with staff on Resident Rights, dignity and abuse prevention/reporting. The DSD stated that one of the staff members [CNA 5] after the in-service, came to her and stated that she needed to discuss what she observed. The DSD stated that staff member [CNA 5] stated on 5/5/25 that she observed CNA 2 yelling at Res 2's face I am wet. The DSD stated that [CNA 5] stated that she had observed CNA 2 being mean to Res (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2, disrespectful, taunting Res 2, mocking the behaviors of Res 2. The DSD stated that [CNA 5] stated that her rotation was very bad and CNA 2 was bad to other patients. The DSD stated that she immediately notified facility's HR, reported to state [California Department of Public Health (CDPH)] and ombudsman. The DSD stated she was further notified by CNA 4 that he had observed CNA 3 being disrespectful to other residents and one occasion, first week last month [May 2026], observed CNA 3 hitting Res 3 with a chuck pad (highly absorbent, waterproof bed pad used to protect mattresses, furniture, and wheelchairs from bodily fluid) on the face. The DSD stated during interviews with staff and other residents, the facility identified other residents that expressed concerns with care provided by CNA 2 and CNA 3. The DSD was asked if the reporting for Res 3's incident [witnessed by CNA 4 - Res 3 was hit on the face with Chuck pad by CNA 3] that was identified during investigation was completed. The DSD stated she was not aware if the facility reported it. The DSD stated she had also interviewed Res 2 and Res 2 stated that CNA 3 will take her out, mock her and leave her outside for extended period. During a concurrent interview and record review on 6/3/26 at 1:43 p.m. with the DON, the facility document titled HR INVESTIGATION REPORT: Alleged Abuse, Neglect, and Violation of Resident Rights [facility name], undated was reviewed. The HR INVESTIGATION REPORT: Alleged Abuse, Neglect, and Violation of Resident Rights [facility name], indicated . Case Information . Investigator: [DON] & [DSD] . Date of Report: 5/26/26 . Date Investigation Opened: 5/15/26 . Employee involved . [CNA 2] . [CNA 3] . Complainants . Multiple residents . Allegations types . Verbal Abuse, Neglect, Psychological Abuse, Violation of resident rights, Failure to report . Summary of Initial Allegation On 5/6/26 [MN], Maintenance reported that he had observed CNA's [CNA 2] and [CNA 3] laughing and mocking a resident. His concern was escalated to [QRM], Quality/Risk Manager and [DSD] for follow up. On 5/15/26, following an in-service training on de-escalation and resident rights/dignity in response to the previous reported incident, [CNA 5] reported an incident that occurred on 5/5/26 to [DSD] . [CNA 5] stated she observed [CNA 2] mocking a resident by repeating phrases the resident frequently says, including I'm wet. The resident [Res 2] involved is a [AGE] year-old female diagnosed with anoxic brain damage [Serious, life-threatening condition caused by a complete lack of oxygen to the brain] and unspecified dementia [when a patient shows clear signs of memory loss and mental decline, but the specific cause cannot be precisely identified or categorized], with a [Brief Interview for Mental Status (BIMS - standardized assessment used primarily in nursing homes and long-term care settings to evaluate a person's brain function, memory, and orientation, range from 0-15, higher number indicating better functioning)] score of 11, indicating moderate cognitive impairment [noticeable decline where individuals require assistance with complex daily tasks]. [CNA 5] reported no other staff involvement on that specific day but stated, That rotation is horrible, implying ongoing concerns. HR was notified immediately, and [CNA 2] was removed from the schedule pending investigation . Investigation Steps . Interview with initial reporter (CNA 5) . Removal of [CNA 2] from schedule pending investigation on 5/15/26 . Interviews with additional CNAs, LVNs, and RNA . Review of resident statements during care conferences . Abuse screening interviews with residents . In-service training initiated for LVNs on chain of command and mandatory abuse reporting . SOC 341 A [Report of Suspected Dependent Adult/Elder Abuse] acknowledgment forms signed by LVNs . Assignment of [NAME] training module on Recognizing and Managing Abuse and Violence . Removal of [CNA 3] from schedule on 5/20/26 pending investigation . The DON was asked what steps were taken between 5/6/26 to 5/15/26 [Date of investigation open] to ensure residents were safe, free from abuse and neglect from CNA 2 and CNA 3 after the MN reported incident on 5/6/26 and the investigation open date listed was 5/15/26. The DON stated she sent an email with MN's concerns reported to her on 5/6/26 to QRM and DSD, and QRM was supposed to follow up. The DON stated she was not able to comment on what steps were taken during that time [5/6/15 to 5/15/26] by QRM or the facility to ensure resident's safety from CNA 2 and CNA 3. The DON was asked if the potential abuse was reported on 5/6/26 to all authorities as needed after she was made aware of the concerns by MN. The DON stated the facility was investigating and the (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing Services a written report of his/her findings . The DON stated she was not aware of this requirement in the facility policy and social services did not follow up in accordance with facility policy with Res 2, Res 3 and Res 4. During an interview on 6/3/26 at 2:30 p.m. with MN and DON, MN stated that he had been in his role at the facility for two years. MN stated that on 5/5/26 he went to check the scale in physical therapy room and observed CNA 2 talking to Res 2. MN stated Res 2 was making some noises and appeared fussy. MN stated he observed CNA 2 mimicking those noises and it was making Res 2 more irritated. MN stated that CNA 2 was getting close to Res 2's face and laughing, mimicking her noises and it was making Res 2 more irritated. MN stated that Res 2's stuff toy fell on the floor and CNA 3 told Res 2 that you are running over him, following her along and just being disrespectful and rude towards Res 2. MN stated CNA 2 and CNA 3 were being rude, disrespectful and were laughing while mimicking Res 2. MN stated it bothered him, and he could not locate DON or leadership that day therefore next day [5/6/26] he saw DON and reported the incident. MN stated if it was his family member being treated this way, he would be very upset, and it was not okay for Res 2 to be treated this way by staff. During an interview on 6/3/26 at 2:45 p.m. with DON, the DON reviewed her email sent on 5/6/26 at 1:08 p.m. to DSD and QRM. The DON stated that her email on 5/6/26 at 1:08 p.m. to [DSD] and [QRM] indicated . Today It was brought to my attention by another staff member that a few CNAs were mocking a patient in residence presence which was making the resident physically upset. The incident occurred at [site location] and were reported as [CNA 2], [CNA 3] and one other CNA that they couldn't remember the name. The staff member who reported this stated it made him feel very frustrated and upset thinking if it was his family member he would have been very upset . The DON stated she had escalated to DSD and QRM and was waiting for guidance on the next steps. The DON stated QRM was supposed to be lead on this investigation and reporting. The DON stated it was not until DSD came back from vacation that services were started and when another staff member notified DSD about the same incident that SOC was filled out and report of potential abuse for Res 2 was submitted. The DON stated she was made aware of the names of the CNA's on 5/6/26 and they both remained on schedule and worked with residents until 5/15/26 for CNA 2 and 5/19/26 for CNA 3. The DON stated she should have followed up with the concerns reported by MN on 5/6/26 with QRM and started investigation, however, she was waiting on QRM. The DON was requested to speak with QRM. The DON stated QRM was out of office on leave. The DON stated five day report of investigation was not submitted to the CDPH. During a concurrent interview and record review on 6/4/26 at 1:59 p.m. with the Interim Facility Administrator (IADM) the facility document titled HR INVESTIGATION REPORT: Alleged Abuse, Neglect, and Violation of Resident Rights [facility name], undated was reviewed. The IADM stated that she was made aware of the incident on 5/15/26 by DON. The IADM stated that facility immediately suspended the CNA 2 and the second CNA, CNA 3 was suspended on 5/19/26. The IADM stated she was unaware that these allegations were reported on 5/6/26 as outlined in HR INVESTIGATION REPORT: Alleged Abuse, Neglect, and Violation of Resident Rights [facility name]. The IADM stated that she was made aware of the incident on 5/15/26 by DON. The IADM stated that facility has provided all staff training on abuse reporting, and patient rights. The IADM reviewed her folder and stated that she did not realized that the incident was first reported on 5/6/26 as listed on HR INVESTIGATION REPORT. The IADM stated she was not copied in DON's email to QRM and DSD. The IADM stated that investigation should have started right away when the concerns were first reported by MN on the 5/6/26. The IADM stated she expected the facility DON and leadership to ensure that CNA 2, CNA 3 and any other staff witnessed potentially abusing the patient had not remained assigned to patients until those allegations were thoroughly investigated. The IADM stated that CNA 2 and CNA 3 should have been removed from direct patient care pending investigation. The IADM stated it was not acceptable that CNA 2 and CNA 3 remain assigned to patients and had access to patients from 5/6/26 until they were suspended [CNA 2 on 5/15/26 and CNA 3 on 5/19/26]. The IADM was asked to see if the QRM was available and IADM stated QRM was out on leave at this time. The IADM was asked if additional (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents [Res 3 & Res 4] that were identified as potentially being abused and/or neglected by CNA 2 and CNA 3 were reported and SOC 341 was filled out. The IADM stated the facility did not report any additional residents as potentially victim of abuse from staff as they were identified as part of the investigation for same resident, Res 2. During a concurrent interview and record review on 6/4/26 at 2:25 p.m. with the IADM and Social Services Coordinator (SSC), the facility policy and procedure (P&P) titled, Reporting abuse to Facility Management, undated was reviewed. The P&P indicated, . when an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy . A completed copy of documentation forms and written statements from witnesses, if any, must be provided to the Administrator. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the Administrator . Upon receiving information concerning a report of abuse, the Director of Nursing Services will request that a representative of the Social Services Department monitor the resident's reactions to and statements regarding the incident and his/her involvement in the investigation . Unless the resident requests otherwise, the social service representative will give the Administrator and the Director of Nursing Services a written report of his/her findings . Inquiries concerning abuse reporting and investigations should be referred to the Administrator and/or to the Director of Nursing Services. The SSC stated she has not followed up with Res 2, Res 3 or Res 4. The SSC stated that no one had reached out to her and asked her to follow up with either of these residents. The SSC stated she was not aware that she had to follow up and DON did not ask her to investigate as stated in the facility P&P. The SSC stated as far as she was aware no one from social services had followed up with these residents after the incident as outlined in the policy. The IADM stated she was also not made aware right away, and unsure if the Administrator (ADM) that was out country was aware at that time. The IADM stated facility process for abuse investigation and reporting was not followed. During an interview with DSD and Medical Record In charge (MR) on 6/4/26 at 2:40 p.m., the DSD stated she had reviewed the Electronic Medical Record (EMR) for Res 3 & Res 4 with MR and neither of the residents had IDT notes, care plan updates and SOC 341 filled out after the investigation revealed potential violations of resident rights, dignity, safety, including abuse and neglect. The DSD stated that SOC 341 should have been filled out promptly as required for each resident. The DSD stated since the incident as part of her training she had created the binder to include resources for Abuse and reporting. The DSD stated it was important to report to ensure resident safety whether it was abuse or not. The DSD stated that Res 2 incident should have been reported after the concerns shared by MN on 5/6/26 and she was unable to comment on why it was not reported and stated that she was out of office at the time of incident. The DSD stated it was concerning to her and she immediately started training staff as soon she saw the email from DON regarding MN's concerns upon returning to office on 5/13/26. The DSD stated staff witnessed Res 3 being stuck on the face by chuck pad by [CNA 3] and failed to report. The DSD stated it was not acceptable. The DSD also stated that she was unable to find any documentation related to the incident of social services follow up, abuse screen, care plan, IDT notes and assessment of psychosocial wellbeing after the facility staff was aware of the incident by CNA 4. The DSD stated plan of care should have been updated, residents should have been assessed for any injuries and the incident for physical abuse should have been reported regardless of time lapses when it was discovered. During an interview on 6/9/26 at 11:45 a.m. with the SSC, the SSC stated she was made aware by facility staff that on 6/8/26 there was an incident in which Res 5 slapped Res 6 on the left side of the face and left arm. The SSC stated the incident occurred in the dining room during resident activities. The SSC stated there were no physical injuries observed but both Res 5 and Res 6 confirmed the incident had occurred. During a review of Res 5's AR, the AR indicated, Res 5 was admitted to the facility on [DATE] with diagnosis of MDD, Anxiety (feelings of tension, worried thoughts, and physical changes like a racing heart). During a review of Res 5's Minimum Data Set (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 5/7/26, the MDS indicated, Res 5's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 13 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 5 was cognitively intact. During a review of Res 6's AR, the AR indicated, Res 6 was admitted to the facility on [DATE] with diagnosis of Dementia without behavioral disturbance. During a review of Res 6's MDS, dated 5/11/26, the MDS indicated, Res 6's BIMS score was 12 out of 15, which indicated Res 6 had moderate cognitive impairment. During a review of Res 6's Progress Note, dated 6/8/26 at 2:35 p.m., the progress note indicated, . [Res 6] stated that she was in fact hit in face by [Res]. [Res 6 also stated she put her hand up to block [Res 5]. [Res 5] also was asked if she hit [Res 6] and [Res 5] stated yes I did, because [Res 6] hit me back after [Res 5] hit her. All residents remain separated at the moment. [Res 6] is not in any pain, distress noted. During an interview on 6/9/26 at 12:26 p.m. with Res 5, Res 5 stated that she recalled the incident when Res 5 went to the dining room for activities which led to a physical altercation with Res 6. Res 5 stated Res 6 had pointed a finger at her and refused to let Res 5 retrieve supplies from the table where Res 6 was sitting. Res 5 stated she proceeded to hit Res 6 with a closed fist but could not recall the location of the hits. During an interview on 6/9/26 at 12:46 p.m. with Res 6, Res 6 stated she was physically hit by Res 5 in the dining room during activities. Res 6 stated she recalled sitting in the dining room working on a project when Res 5 suddenly forced herself to sit at the table and Res 6 stated she asked Res 5 to leave the table. Res 6 stated that Res 5 refused to leave and proceeded to slap Res 6 on the left side of face and arm. Resident 6 stated that during the altercation there were no staff members present in the dining room. During an interview on 6/9/26 at 1:20 p.m. with the director of staff development (DSD), the DSD stated Res 5 and Res 6 had an altercation in the dining room on 6/8/26 during activities. The DSD stated she was in the facility during the altercation and stated there were no staff members present in the dining room during the altercation. The DSD stated that the activities assistant was assigned to complete other duties. The DSD stated the facility process was for the staff to monitor the residents during activities in the dining room. During an interview on 6/9/26 at 1:36 p.m. with certified nursing assistant (CNA) 6, CNA 6 stated that on 6/8/26 Res 5 and Res 6 had an altercation in the dining room during activities. CNA 6 stated she recalled walking into the dining room after hearing screams coming from the area. CNA 6 stated there were no staff members present in the dining room activities during the altercation. CNA 6 stated the process was for staff to monitor residents when they were in activities to ensure safety. During a telephone interview on 6/10/26 at 2:00 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated that on 6/8/26, there was yelling from the dining room during activities that prompted her to investigate further. LVN 5 stated Res 5 and Res 6 were observed yelling at each other and Res 6 had reported that Res 5 had slapped her on the face and arm. LVN 5 stated that when she entered the dining room, there were no staff present in the room during the altercation. LVN 5 stated the facility process was for an activity assistant to be present during activities to monitor the residents' safety. During an interview on 6/9/26 at 1:50 p.m. with the director of nurses (DON), the DON stated the facility process was for the staff to monitor the residents during activities in the dining room. The DON stated that residents should not have been left alone during the time of Res 5 and Res 6 altercation as there should have been an AA present. The [NAME] stated the lack of activity staff was an ongoing issue as the activity staff were assigned other duties when they should have been assigned to stay in the dining room for activities. During a telephone interview on 6/12/26 at 10:00 a.m. with the activities director (AD), the AD stated the expectation was for the activity assistant to remain in the dining room for activities with the residents. The AD stated that due to other activity assistant duties, the facility required two assistants to ensure one staff member was present during the dining room activities and another would perform other duties but since the facility only had one, there was no monitoring for residents in activities during the time of other duty (continued on next page)		

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No. 0938-0391

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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.			
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completion. During a telephone interview on 6/12/26 at 2:00 p.m. with Activity Assistant (AA), the AA stated that on 6/8/26 she was informed that Res 5 and Res 6 had an altercation in the dining room during activities. The AA stated she was not present in the dining room during the altercation due to completing other AA duties. The AA stated she was the only staff member for activities present in the facility at the time of the incident and therefore the dining room was unmonitored. The AA stated residents should not have been left in the dining room during activities for their safety and the facility would benefit from scheduling to separate AA to ensure the dining room activities were monitored. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, dated 2016, the P&P indicated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. As part of the resident abuse prevention, the administration will, protect our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. implement measures to address factors that may lead to abusive situations, provide staff with opportunities to express challenges related to their job and work environment. identify and assess all possible incidents of abuse. During a review of the facility's policy and procedures (P&P) titled, Abuse Investigation and Reporting, dated 2017, the P&P indicated, . All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported . If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual . The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented . Role of the Investigator . Interview the person(s) reporting the incident . Interview any witnesses to the incident . Interview the resident (as medically appropriate) . Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident . Interview the resident's roommate, family members, and visitors . Interview other residents to whom the accused employee provides care or services . The investigator will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process . If the ombudsman declines the invitation to participate in the investigation, that information will be noted in the investigation record. The ombudsman will be notified of the results of the investigation as well as any corrective measures taken . The investigator will consult daily with the Administrator concerning the progress/findings of the investigation . Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator . Reporting . All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies . The State licensing/certification agency responsible for surveying/licensing the facility . The local/State Ombudsman . The Resident's Representative (Sponsor) of Record . Adult Protective Services (where state law provides jurisdiction in long-term care) . An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than . Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or . Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury . Notices will in		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of six sampled residents (Resident (Res) 1) received necessary care and services in accordance with professional standards of practice when: The facility staff failed to identify, assess, investigate, and document an unwitnessed fall reported by Res 1. Nursing staff did not initiate required post-fall protocols, including timely assessment, neurological checks, ongoing monitoring, and implementation of appropriate fall-related interventions in accordance with facility policy. The facility failed to ensure timely physician assessment, and implementation of physician-ordered interventions following the resident's complaint of pain and subsequent diagnosis of a right knee fracture. Res 1's medical record lacked timely documentation of physician involvement and did not reflect prompt follow-through of recommended interventions, including the use of a knee immobilizer. The facility staff failed to update the resident's comprehensive care plan to reflect the change in condition, increased fall risk, and required interventions following the self-reported fall resulting in confirmed fracture. These failures had the potential to cause delay in diagnosis and treatment, unmanaged severe pain, and caused decline in the resident's mobility and functional status. These failures placed the resident at risk for further injury, complications, and unmet medical needs including interventions such as knee immobilizer and elevation of injury site. Findings: During a review of Res 1's History and Physical (H&P), dated 5/19/26 from Hospital A, the H&P indicated, [AGE] years old female with past medical history of [Major Depressive Disorder (MDD - serious mental health condition characterized by a persistently low or depressed mood and a loss of interest in activities)], hypertension [high blood pressure - condition where the force of blood against your vessels is consistently too high], hyperlipidemia [excess fat in blood], chronic back pain [any back discomfort, stiffness, or aching that lasts for three months or longer], history of hematuria [the presence of blood cells in your urine], hypothyroidism [occurs when the butterfly-shaped gland in neck doesn't produce enough hormones causing the body's metabolism to slow down, leading to symptoms like persistent fatigue, unintentional weight gain, and sensitivity to cold], type 2 diabetes mellitus [a condition where body's cells stop responding well to insulin, a vital hormone that regulates blood sugar (glucose) levels by allowing cells to use it for energy making it hard to turn food into energy] presenting as a direct admit [a hospital admission process where a patient's doctor arranges their hospital stay in advance allowing the patient to bypass the Emergency Department (ED) entirely and go straight to an inpatient bed]for right knee fracture [broken bone]. Patient states she was in a wheelchair in her bathroom and attempted to get up to the sink when she slipped on urine on the bathroom floor resulting in a ground-level fall. She reports subsequent right knee pain and inability to ambulate. During a concurrent interview and record review on 6/3/26 at 9:15 a.m. with the Director of Nursing (DON), the facility's document titled Administrative Investigation- 5 Day Report for the incident date 5/13/26 was reviewed. The document titled Administrative Investigation- 5 Day Report indicated, . [Res 1] began complaining of right knee pain on 05/12/2026 [MD 1] notified, order for x-ray obtained and carried out. Results received and sent to MD for review on 05/13/2026. On 05/14/2026 [MD 1] contacted regarding worsening pain of right knee and reviewing of x-ray [painless imaging test that uses safe bursts of invisible energy to snap a picture of the inside body] results. [MD 1] ordered [oxycodone/acetaminophen (medication to treat moderate to severe pain)] . [one time order] for worsening pain and stated he would speak with surgery in the morning. [Res 1] sent to [Hospital A] for treatment of the fracture on 5/19/2026. Investigation: The right knee fracture of unknown origin was identified on 5/14/26. [Res 1] was observed exhibiting unsafe self-transfer and self-positioning behaviors while repeatedly verbalizing threats to intentionally throw herself on the floor or jump from the bed or chair if she does not receive pain medication. Review of [medication administration record] confirmed resident was administered [oxycodone/acetaminophen] as ordered. At (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately [2:30 p.m.] on 5/12/26 resident reported a new onset of right knee pain. Nurse completed assessment and notified [MD 1]. An order for x-ray was obtained as well as a one-time order for [oxycodone/acetaminophen]. Orders carried out in a timely manner. No witnessed fall event was reported prior to onset of pain nor was a report of an unwitnessed fall noted. On 05/13/2026 x-ray results were obtained and forwarded to [MD1] for review. [MD 1] requested imaging films . for complete evaluation. Facility staff coordinated and retrieved requested films and forwarded them to [MD1]. 5/14/26 physician reviewed imaging films and stated he would consult with surgery regarding the findings. Due to confirmation of fracture and inability to determine mechanism of injury SOC 341[standardized Report of Suspected Dependent Adult/Elder Abuse form used across California] completed. On 5/18/26 [MD 1] discussed surgical recommendations with resident and requested communication with her son as well . On 05/19/26 resident chart documentation, diagnostic information, and transfer packet were completed per [MD 1] request and resident was transferred to [Hospital A] for surgical intervention. Investigation findings do not substantiate staff abuse or neglect. Injury appears consistent with resident's repeated unsafe self-positioning behaviors and impaired safety awareness. The DON stated that she was in charge of this investigation and had completed the investigation report. The DON stated as documented in the investigation report, no indication of fall or abuse was identified or mentioned by anyone during the investigation. During a concurrent observation and interview on 6/3/26 at 10:40 a.m. with the DON in the acute hospital on Swing Bed unit, Res 1 was observed sitting at the edge of bed in a wheelchair. Res 1 she had a knee fracture over at the skilled nursing side. Res 1 stated that my roommate at that time had peed everywhere, and when she went to the bathroom in a wheelchair she attempted to stand up with sink and had slipped in the bathroom on the urine puddle. Res 1 stated she wanted to do it herself and did not ask for help. Res 1 stated the facility staff helped afterward. Res 1 stated two facility staff members and nurse had to assist her back up from the bathroom floor. Res 1 stated she was not sent to the ED afterwards and she was not happy about it. Res1 stated she wanted to go the ED. Res 1 was asked if she recalls the date and time of incident and Res 1 stated facility staff had to pick me up and help me, stated they all knew I had a fall and should have record of date and time. Res 1 stated she was unable to recall the exact date, but it was late night going to early morning. Res 1 stated she felt really sore in her leg after the fall. The DON stated that no one else witnessed Res 1 falling and facility investigation did not reveal that Res 1 had experienced any fall prior to the complaint of knee pain. During a concurrent interview and record review with the DON and MDS Coordinator (MDS) on 6/3/26 at 2:10 p.m. Res 1's Electronic Medical Record (EMR) was reviewed. The DON reviewed Nursing Notes from 4/23/26 to 5/19/26 and stated that only fall listed in Res 1's record was on 4/24/26 at 11:59 p.m. The DON stated physician was notified and Res 1 was assessed. The DON stated the nursing note on 4/23/26 at 11:59 p.m. mentions tenderness on no right foot, no right knee injury documented at that fall or on assessment afterwards. The DON stated the Nursing note on 5/12/26 at 5:21 a.m. indicated . Resident was witnessed attempting to slide off wheelchair to the floor screaming for a pain pill. This writer and x3 staff attempted to stop resident from sliding off the wheelchair and repositioned her back into wheelchair, then to back to bed. Resident continued to scream for pain pill. Resident threatened to jump off bed and wheelchair if not given a pain pill. Resident also stated that she was not helped to bed all night. Residents have history of false accusations. All witnesses have helped resident to bed to restroom and back to bed. Resident asked for pain pill every hour this nightshift, changing her pain from back' knee arm head neck and threatening to jump off bed and wheelchair. This writer administered pain pill [as needed] at due time and implemented therapeutic pain preventive measurements, and calmed resident. DON and MD aware. The DON stated resident had history of pain seeking behavior and false accusation and care plan was already in place for these behaviors. The DON stated this was the only documented note regarding patient behavior after the last documented fall [4/24/26] and on 5/12/26 at 2:30 p.m. [nine hours and nine minutes later] nurses note indicated . Notified [MD 1] regarding [night] nurse (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	witnessing [Res 1] attempting to slide off wheelchair and threatening to throw herself on floor if pain pill was not given. [Res 1] continued to request for pain medication during this shift for right knee pain. Pain medication given [as needed] as scheduled by [MD 1]. Notified [MD1] regarding resident's complain of right knee pain. Per [MD1] received order for x-ray to right knee [related to] pain. The DON stated EMR indicated X-ray results were received on 5/13/26 at 6:50 p.m. and MD 1 was made aware. The DON stated nurses note indicated . Resident [compliant of] pain to right knee with confirmed fracture. Right knee pain level 10/10 [10/10 pain score indicates the worst possible, debilitating pain imaginable]. Right knee is warm and tender to touch. Notified [MD 1] of resident's x-ray results to right knee, MD reviewed results and requested actual x-ray film and order for monitor right knee for worsening. No further orders regarding x-ray results given by [MD 1] at this time. Called radiology to request film and received QR code with resident's imaging results. QR code given to medical records to access files for MD to review . The DON stated nurses note on 5/14/26 at 9:00 p.m. indicated MD 1 reviewed resident's x-ray film/images. [MD 1 was also notified of resident's worsening pain to right knee, pain level 10/10. Per [MD 1], will talk to the surgeon in the morning and new order: [oxycodone/acetaminophen] [one time] order.DON aware. The DON stated Nurses Note on 5/15/26 at 11:41 a.m. also indicate that MD 1 was made aware, and Res 1 was in pain. The DON stated Nurses Note dated 5/18/26 at 4:49 p.m. indicates [MD 1] called and spoke with resident regarding possibility of surgery [related to] knee fracture. resident stated she is okay with surgery . The DON stated nurse's notes indicate on 5/18/26 at 5:19 p.m. MD 1 requested Res 1's record to be sent over to [Hospital A]. The DON stated the Nurses note dated 5/19/26 at 8:36 a.m. indicated . [MD 1] requesting all medical records, X-ray's to be faxed to [Hospital A] so that the orthopedic surgeon [surgeon name] can review for possible surgical intervention. The DON stated Nurses Note dated 5/19/26 at 10:59 a.m. indicated MD 1 called and gave verbal order to hold Clopidogrel Bisulfate [blood thinner- use to prevent clot] Tablet 75 [milligram (MG- unit of measurement) (Clopidogrel Bisulfate) and [apixaban - medication to prevent blood clot] Oral Tablet 5 MG (Apixaban) indefinitely until after surgery. Medications placed on hold. The DON stated the order was received to transfer out Res 1 to [Hospital A] on 5/19/26 at 2:43 p.m. and shortly afterwards. The DON reviewed the EMR and all notes between 5/11/26 to 5/19/26 again and stated she was not able to find any documented progress notes, assessment or updates by MD 1 or any physician between 5/11/26 until Res1 was transferred out on 5/19/26. The DON stated confirmed fracture was identified and MD1 reviewed the results on 5/13/26, however Res 1 was not transferred out until 5/19/26. The DON stated she was unable to comment why the Res 1 was not transferred out sooner to [Hospital A] or another area hospital for assessment and management of Res 1's injuries. The DON stated no new interventions were ordered, besides pain medication order. The DON stated Res 1 remain in moderate to severe pain and she was unable to comment on whether the injuries were appropriately managed without physician documentation. The DON stated nursing staff updated the care plan and resident fracture was assessed every shift.During an interview on 6/3/26 at 2:25 p.m. with the MDS Coordinator, the MDS Coordinator stated she had observed Res 1 not getting out bed after the injury/fracture on the 5/12/26 and stated [Res 1] was no longer getting out of bed, was not even going for smoking and choosing to use briefs, and her status declined. The MDS stated Res 1 prior to this injury was able to transfer herself to the bathroom, was in wheelchair and required minimum assistant. The MDS Coordinator stated that this was a change from Res 1's condition. The MDS Coordinator also stated that she was unsure why Res 1 was not transferred out or physician plan was from 5/12/26 until 5/19/26.During an interview on 6/4/26 at 10:05 a.m. with the Licensed Vocational Nurse (LVN)1, and Director of Staffing Development (DSD), the DSD checked the staffing assignment and stated LVN1 was assigned to Res 1 on 5/15/26, 5/16/26 and 5/17/26. LVN 1 stated that she was familiar with Res 1. LVN 1 stated she had gotten a report of knee pain and was told probably fracture and MD 1 was aware. LVN 1 stated she does not recall exact dates or timeline of events. LVN 1 stated Res 1 was in generalized pain and always requesting pain around the clock pain medications. LVN 1 stated (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she does not recall exact medication orders or what Res 1 was getting. LVN 1 stated she does not recall additional details or whether the resident functional ability declined. During an interview on 6/4/26 at 10:25 a.m. with the Certified Nursing Assistant (CAN 1) and DSD, CNA 1 stated she had been working here at the facility for a year. CNA 1 stated she had worked consistently with Res 1 and was familiar with Res 1. CNA stated she had worked with Res 1 after her knee fracture as well. CNA stated she was unsure when resident got the injury or how she got the injury. CNA stated she was made aware X-ray was completed and resident have a fracture. CNA stated Res 1 was in lot of pain in her knee. CNA 1 stated Res 1 stayed in bed for the most part and did not even go for the smoke after her injury. CNA 1 stated Res 1 would complain of significant pain even while in bed when she was moved from side to side. CNA 1 stated Res 1 stayed bed bound for the most part after the knee X-ray till she was transferred. CNA 1 stated Res 1 appeared to her more stressed, frustrated and was complaining that she could not get up and was hurting. CNA 1 stated Res 1 was asking to use brief and could not get up. CNA 1 stated that it was different for Res 1 and she recalls notifying LVN 1 that Res 1 was in lot of pain and unable to get up. CNA. The DSD reviewed the staffing assignments and stated that CNA 1 was assigned to Res 1 on the shifts of 5/12/26, 5/15/26 and 5/17/26. During a phone interview on 6/4/26 at 10:39 a.m. with DSD, Medical Record In-charge (MR) and Res 1's physician (MD 1), MD 1 stated he was familiar with Res 1. MD 1 stated he was contacted regarding Res 1 pain and initially X-ray was completed. MD 1 stated he spoke with Surgeon at [Hospital A], and he was advised nothing urgently was needed as the Res 1 was wheelchair/ bed bound. MD 1 stated he works at [Hospital A] with the Surgeon and had shown the X-ray results to the surgeon. MD 1 stated Res 1 was always in pain; he attempted to wean opioids and Res 1's body cannot tolerate. MD 1 stated no urgent or emergent interventions were needed per surgeon and in his medical decision-making patient did not require transfer to another facility for immediate interventions. MD 1 stated ortho [medical specialty focused on diagnosing, treating, and preventing conditions of the musculoskeletal system such as bones] consult would have taken a long time, and it was best for Res 1 to be stabilized and transfer when surgeon was ready. MD 1 stated per surgeon Res 1's fracture was very bad. MD 1 was asked if he had documented anything in the Res 1's medical record. MD 1 stated he was not sure and unable to comment at this time. MD 1 stated he did assess the resident, was working on the plan with surgeon and had communicated the plan with recommendation. The DSD and MR both validated that they were unable to find any documentation by MD 1 or any physician regarding the assessment, plan and recommendations for Res 1's Fracture or whether it was ok for Res 1 to stay at the facility, between 5/12/26 when the X-ray order was received and until Res 1 was transferred out to [Hospital A]. MD1 stated he will add his documentation in Res 1's medical record today [6/4/26]. During an interview on 6/4/26 at 10:53 a.m. with the Interim Administrator (IADM), the IADM stated that facility administrator (ADM) was out of country, and she is covering as interim ADM. The IADM stated she was not involved in the investigation for Res 1's injury, however, she was provided with updates of the investigation, and she had signed it off on 5/22/26 as no abuse of neglect. The IADM stated the facility could not determine the cause of the injury leading to fracture of right knee in Res 1. The IADM stated there was no evidence that Res 1 had a fall and people at this age can bang their knee and can cause fracture. The IADM was asked if Res 1 should have been transferred out for an assessment and whether facility process was followed. The IADM stated that she does not have scope to make this decision and trust MD 1 decision making. The IADM stated she was not aware of the plan for ortho consult and it should have been documented by MD 1. The IADM stated it was not ideal for MD 1 not to document his assessment and plan in the medical record for Res 1. The IADM stated she has a close working relationship with MD 1 and trusts him to do the right thing. The IADM was asked if the facility has a policy that outlines expectations for physician documentation timeframe. The IADM stated she was unsure of the timeframe requirement and facility policy and stated she would have to check. During an interview on 6/4/26 at 11:20 a.m. with the Res 1 in the acute hospital on Swing Bed unit, Res 1 stated she had a fall and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that's when her knee started to hurt. Res 1 stated it was not for five or six days they sent her out to the hospital. Res 1 stated she kept asking the staff to send her to ED and the staff stated it was up to her physician. Res 1 stated she did not see any physician at the facility prior to transfer out for surgery. Res 1 stated she was certain she had a fall, and she had notified staff multiple times about the fall. During an interview with LVN 2 on 6/4/26 at 11:25 a.m., LVN 2 stated Res 1 was alert and oriented to time, place, person and situation in her assessment. During an interview on 6/4/26 at 12:50 p.m. with the DSD, the DSD stated that she had reviewed the EMR for Res 1 and she was not able to find any documentation that indicate Res 1 had a fall that potentially resulted in the injury to Right Knee leading to fracture. The DSD stated none of the staff recalls Res 1 requesting to go the ER. The DSD stated Res 1 behaviour potentially could have caused the injury. The DSD stated the Res 1 pain was managed and care plan was updated for fracture. The DSD stated that mandated reporting was completed as required. During a phone interview on 6/5/26 at 12:01 p.m. with the MDS, the MDS stated she was the interim DON up until first week of May 2026. The MDS stated she was familiar with Res 1 and had reviewed her EMR for the right knee fracture incident. The MDS stated that Res 1 did experience a fall. The MDS stated Res 1 was trying to get up to go to the bathroom and fell by the toilet. The MDS stated Res 1 did notify the [LVN 3] and [LVN 3] thought Res 1 was faking it. The MDS stated Res 1 was in a wheelchair prior to the fall and was going out to go smoke, Res 1 was getting out of bed to go to the bathroom, and she was getting out of bed to the wheelchair. The MDS stated after the injury, she became bed bound. The MDS stated Res 1 definitely had a fall, however, in reviewing the EMR, fall was not documented. The MDS stated that she was made aware on 5/12/26 in the afternoon and she had advised the nurse assigned [LVN 4] to get an X-ray. The MDS stated that nurse [LVN 4] interviewed Res 1 and her roommate, and they both stated that Res 1 had a fall. The MDS stated that it was on 5/12/26 when the nurse called the physician to get an X-ray order. The MDS stated she should have documented the fall and [LVN 4] should have assessed the Res 1 after she was made aware of the unwitnessed fall. The MDS stated that she had updated the resident care plan for fracture, however, she did not notify Interdisciplinary team or updated the care plan for unwitnessed fall. The MDS stated no additional fall prevention interventions were in place were not assessed and no new interventions were place. The MDS stated Res 1 was at high risk for fall and already had fall last month [April 2026]. During a phone interview on 6/5/26 at 12:37 p.m. with LVN 4, LVN 4 stated that she had worked at the facility since September 2021 and was familiar with Res 1. LVN 4 stated that when she arrived for her shift [5/12/26], the resident complained of knee pain, and the ordered pain medication was not effective. LVN 4 stated she had called MD 1 and suggested obtaining an X-ray of the knee. LVN 4 stated that MDS coordinator was also in agreement with getting an X-ray for Res 1. LVN 4 stated that she documented resident's prior behavioral issues as reported in report from night nurse and MD 1's order to get X-ray. LVN 4 stated on 5/12/26 after speaking with MD 1, she had interviewed Res 1 and her roommate, and both residents provided detailed descriptive accounts indicating an unwitnessed fall on 5/12/26 prior to start of her shift. LVN 4 stated she documented the interviews and provided to DON. LVN 4 stated she did not document interviews in Res 1's EMR and had another nurse in the room as witness during her interviews with Res 1 and her [Res 1's] roommate. LVN 4 stated Res 1 had a history of false accusation, and the nurse before her shift had also documented Res 1 trying to roll down the wheelchair, therefore she had a witness during the interview of Res 1. LVN 4 stated after assessing Res 1's knee, she placed the bed in the lowest position, applied bilateral floor mats, and reinforced call light use. LVN 4 stated staff had to assist the resident with transfers after the injury due to declining function. LVN 4 stated Res 1's pain worsened, she notified the physician [MD1], who ordered the resident sent out for further evaluation/surgery later [5/19/26]. LVN 4 stated that the resident after the fall required gurney transport for X-ray, whereas previously she self transferred to the restroom. LVN 4 stated she did not start any additional assessment, documentation or interventions as required per facility policy and process for unwitnessed fall. LVN 4 stated she does (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not recall whether she updated fall risk assessment or care plan after she identified unwitnessed fall. LVN 4 stated that MDS coordinator was aware of the unwitnessed fall for Res 1. LVN 4 stated she did not document the fall in the EMR. LVN 4 stated she MD 1 was made aware of worsening pain, and she does not recall any additional interventions ordered by MD 1. During a phone interview on 6/5/26 at 1:28 p.m. with the MDS, the MDS stated that she was not aware of the 5-day investigation report and summary of findings. The MDS stated this incident should have been reported as unwitnessed fall. The MDS coordinator stated unwitnessed fall policy should have been followed, and Res 1 should have been assessed for delayed injuries and potential head injuries. The MDS stated she was unable to find updated fall risk assessment or any documentation that indicates fall prevention interventions that were in place were reevaluated after the unwitnessed fall. During a phone interview on 6/5/26 at 1:52 p.m. with the MDS and MD1, MD 1 stated he does not recall whether he was informed of the fall or not. MD 1 stated fracture of Res 1 was consistent with fall, and it would be very hard to have this type of injury without the fall. MD 1 stated he ordered X-ray and interventions. MD1 was asked about the note he placed on 6/4/26 at 11:26 a.m. [Late Entry] for effective date of 5/13/26 at 11:15 a.m. The MD progress note indicated . Recommended knee immobilizer, ice, elevation, and pain control. Patients have a [history of] drug pain seeking behavior and will be careful with opiates. MD 1 stated he communicated these interventions to nursing staff and expected them to be followed. MD 1 was asked about assessment of Res 1 after unwitnessed fall and MD 1 stated he expected residents to be assessed by nurse post fall as per facility policy. MD 1 stated it was important to assess as residents may not complain right away, and neuro checks were important to identify delayed injuries. The MDS stated that the documentation does not reflect that knee was elevated or knee immobilizer was provided. The MDS also stated that these interventions were not discussed in the inter-disciplinary team after the injury and were not care planned. The MDS stated that she could not comment whether the nursing staff was informed of these recommendations and medical record did not have any documentation that these interventions were discussed or recommended by MD 1. During a phone interview on 6/5/26 at 3:11p.m. with the IADM, IADM stated that as far as she was aware Res 1 fracture to the right knee was from unknown injury and she was not made aware of any unwitnessed fall for Res 1. The IADM stated she was not aware of any statements made by residents about a fall or nurse interviewing resident and resident's roommate. The IADM stated if the resident stated unwitnessed fall to nurses, then she expected her staff to do resident assessment and implement interventions such as neuro checks, reporting etc. as per facility policy for unwitnessed fall. The IADM stated she had reviewed Res 1's medical record and was unable to find any documentation regarding fall. The IADM stated she also could not find any physician documentation regarding right knee fracture, assessment and plan up until physician made a late entry note. During a phone interview on 6/5/26 at 3:29 p.m. with the IADM and the DON, the DON stated that she was not made aware of the fall, and the SOC 341 documentation was left on her desk. The DON stated that she was unaware of any resident interviews regarding this incident and had not seen any statements from Res 1 or Res 1's roommate. The DON stated she had spoken with [LVN 4] and she only mentioned about Res 1's knee pain and getting an X-ray ordered. The DON stated she had spoken with the night nurse [LVN 3] and the night nurse also did not mention any falls and resident complaint of fall on the night of 5/11/26 going in to 5/12/26 day shift. The DON stated she did not interview any other staff, CNA or the resident's roommate. The DON stated she does not recall Res 1 expressing concerns to her or anyone about the fall on 5/12/26 or afterwards. The DON stated she also does not recall any staff stating that residents wanted to go to the ER for knee pain. The DON stated nothing was documented in the EMR regarding a fall and she could not conclude if the injury was related to the fall. The DON stated if the patient was stating to nurses that she had an unwitnessed fall then Res 1 should have been assessed for unwitnessed fall as per facility policy. The DON stated that Res 1 had a history of false accusation and pain medication seeking behavior, physician was aware, and care plan was in place for those behaviors. The DON stated she has been off work since 6/3/26 and have not seen the MD note placed (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/04/2026
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 6/4/26 for 5/13/26 and unable to comment on that. The ADM validated she could not find the MD recommended elevation and knee immobilizer for the effective date of 5/13/26 [late entry, note entered on 6/4/26] in care plan or interventions implemented in nursing documentation. During a review of the facility's policy and procedure (P&P) titled, Care Plans - Comprehensive, dated 2010, the P&P indicated, . An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident . facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain . Each resident's comprehensive care plan is designed to . Incorporate identified problem areas . incorporate risk factors associated with identified problems . Reflect the resident's expressed wishes regarding care and treatment goals . Reflect treatment goals, timetables and objectives in measurable outcomes . Identify the professional services that are responsible for each element of care . Aid in preventing or reducing declines in the resident's functional status and/or functional levels . Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change . The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans . When there has been a significant change in the resident's condition . When the desired outcome is not met . During a review of the facility's policy and procedure (P&P) titled, Goals and Objectives, Care Plans, dated 2009 the P&P indicated, . Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence . Care plan goals and objectives are defined as the desired outcome for a specific resident problem . When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly . Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved . Goals and objectives are reviewed and/or revised . When there has been a significant change in the resident's condition . When the desired outcome has not been achieved .During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status dated 2015 the P&P indicated, . The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been . An accident or incident involving the resident . A discovery of injuries of an unknown source . significant change in the resident's physical/emotional/mental condition . A need to alter the resident's medical treatment significantly . Refusal of treatment or medications (i.e., two (2) or more consecutive times) . A need to transfer the resident to a hospital/treatment center . Significant change of condition is a decline or improvement in the resident's status that . Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self-limiting) Impacts more than one area of the resident's health status . Requires interdisciplinary review and/or revision to the care plan . Ultimately is based on the judgment of the clinical staff . The Nurse Supervisor/Charge Nurse will record in the residen		