

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

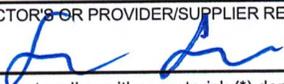
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

E 000	Initial Comments  The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities.  The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities.	E 000	Ceres Post-Acute submits this response and Plan of Correction as a part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceedings.	
K 000	Census: 46 INITIAL COMMENTS  K3 BUILDING: 02 K6 PLAN APPROVAL: 10/01/1977 K7 SURVEY UNDER: 2012 EXISTING  STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V, FULLY SPRINKLERED.  The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a) (b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition.  The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 222 SS=E	Census: 43 Licensed Beds: 46 Egress Doors CFR(s): NFPA 101	K 222		

**RECEIVED**  
By MMonterr at 3:43 pm, May 30, 2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>5/30/25</b>
--	-------------------------------	-----------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 1  Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: <b>CLINICAL NEEDS OR SECURITY THREAT LOCKING</b> Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 <b>SPECIAL NEEDS LOCKING ARRANGEMENTS</b> Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 <b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b> Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222	<b>K222</b> <b>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b> The egress door near Room 1 was immediately repaired to eliminate the need for more than one action to open. A single-action, code-compliant push bar has been installed.  <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</b> All residents have the potential to be affected by this deficient practice.  No residents were found to be affected by this deficient practice.  <b>What measures will be put into place or what systemic changes in the facility will make to ensure that the deficient practice does not recur:</b> All door hardware was checked, and visual checks will be part of the preventive maintenance schedule to inspect egress hardware monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 2 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 <b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b> Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 <b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b> Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain their emergency exit discharge. This was evidenced by an emergency egress door that needed more than one action to unlock. This affected 25 of 46 residents in one of three smoke compartments and could result in delayed egress in the event of an emergency.  NFPA 101, Life Safety Code, 2012 Edition. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied.	K 222	<b>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.</b> The log will be part of the facility QA program, and any deficient practices identified will have a QAPI developed to monitor and/or correct the deficient practice.  <b>Date of Completion of Corrective Action: 05/19/25</b>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 3  Findings:  During a tour of the facility, and interview with the Maintenance Director on 5/19/25, the emergency egress doors were observed.  At 10:47 a.m., the emergency egress door near Room 1 was observed equipped with a door knob that had a turn button lock. When tested, the door knob needed two actions to unlock it. Upon interview, the Maintenance Director stated the door had been that way for some time.	K 222		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101  Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324	<b>K324</b> <b>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b> An immediate inspection of all commercial kitchen equipment was completed by maintenance staff on 5/20/25.  <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</b> All residents have the potential to be affected by this deficient practice.  No residents were found to be affected by this deficient practice.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 324	Continued From page 4  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain their cooking equipment. This was evidenced by the failure to provide kitchen equipment inspection records. This affected 25 of 43 residents in one of three smoke compartments and could result in a fire emergency.  NFPA 101 Life Safety Code 2012 Edition 19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service.  NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition 11.7 Cooking Equipment Maintenance 11.7.1 Inspection and servicing of the cooking equipment shall be made at least annually by properly trained and qualified persons. 11.7.2 Cooking equipment that collects grease below the surface, behind the equipment, or in cooking equipment flue gas exhaust, such as griddles or charbroilers, shall be inspected and, if found with grease accumulation, cleaned by a	K 324	<b>What measures will be put into place or what systemic changes in the facility will make to ensure that the deficient practice does not recur:</b> A log will be created to check the kitchen equipment monthly, thoroughly inspect and clean as needed.  <b>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.</b> The Administrator shall report the outcome of the checks/inspections to the Quality Assurance and Assessment Committee (QA&A) during its' monthly meeting. If determined that the facility has accomplished the objectives in the plan of correction as aforementioned and the results are successful, then the facility shall consider the matter resolved.  The QA&A Committee shall continue to review until such time that the deficiency has been proven to be resolved for 3 consecutive months and/or as advised by the QA&A Committee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 324	Continued From page 5 properly trained, qualified, and certified person acceptable to the authority having jurisdiction.  Findings:  During a tour of the facility, record review and interview with the Maintenance Assistant on 5/19/25, the Kitchen cooking equipment was observed, and records were requested.  At 2:40 p.m., the facility was observed with a six burner gas range with two ovens and one griddle. The facility failed to provide their annual Kitchen equipment inspection records, and no previous records were provided. Upon interview, the Maintenance Assistant stated they do not do that.	K 324	<b>Date of Completion of Corrective Action: 05/20/2025</b>	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353	<b>K353</b> <b>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b> Sprinkler head located on the overhang of the Southwest Emergency Exit by Room 21 was thoroughly cleaned on 5/20/25.  Fire sprinkler vendor was notified and on 6/2/25 the sprinkler head located in closet of administrative DSD office is scheduled to be replaced by vendor.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 353	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the automatic fire sprinkler system. This was evidenced by the failure to maintain sprinkler heads free of foreign material. This affected 18 of 43 residents in one of three smoke compartments and could result in a malfunctioning fire sprinkler system in the event of a fire.</p> <p>NFPA 101, Life Safety Code, 2012 Edition 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.</p> <p>NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. 5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).</p> <p>Findings:  During a tour of the facility and interview with Maintenance Director and Maintenance Assistant on 4/21/25, the facility's automatic fire sprinkler</p>	K 353	<p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</b> All residents have the potential to be affected by this deficient practice.  No residents were found to be affected by this deficient practice.</p> <p><b>What measures will be put into place or what systemic changes in the facility will make to ensure that the deficient practice does not recur:</b> Administrator will audit the reports from the sprinkler system vendor to check for accuracy and completion.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 353	Continued From page 7 system components were observed.  1. At 10:20 a.m., a sprinkler head located on the overhang of the Southwest Emergency Exit by Room 21 was observed. It had spider webs and dirt covering the whole sprinkler head. Upon interview the Maintenance Director stated the sprinkler head was just ignored and may have been that way for a while.  2. At 11:23 a.m., a sprinkler head located in the closet of the Administrator Room was observed with paint covering the sprinkler head. Upon interview, the Maintenance Assistant stated he never paid attention to the closet sprinkler heads and may have been that way for a while.	K 353	<b>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.</b> The Administrator shall report the outcome of the checks/inspections to the Quality Assurance and Assessment Committee (QA&A) during its' monthly meeting. If determined that the facility has accomplished the objectives in the plan of correction as aforementioned and the results are successful, then the facility shall consider the matter resolved.  The QA&A Committee shall continue to review until such time that the deficiency has been proven to be resolved for 3 consecutive months and/or as advised by the QA&A Committee.  <b>Date of Completion of Corrective Action: 06/02/2025</b>		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101  Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 363	<p>Continued From page 8</p> <p>impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by doors that failed to latch. This affected 25 of 46 residents in one of three smoke compartments and could result in the spread of smoke and fire in the event of an emergency.</p> <p>Findings:</p> <p>During a tour of the facility and interview with the Maintenance Director on 5/19/25, the facility's corridor doors were observed, and staff was interviewed.</p> <p>At 10:50 a.m., the corridor door to Room 5 was observed. The door failed to latch when tested. The door was rubbing on the door frame. Upon interview, the Maintenance Director stated the hinges were probably causing the issue and they</p>	K 363	<p><b>K363</b></p> <p><b>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Maintenance staff on the same day after the first failed test addressed the issue with Rm. 5 door not latching by adjusting the hinges and striker plate, retested, and door successfully latched.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</b></p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>No residents were found to be affected by this deficient practice.</p> <p><b>What measures will be put into place or what systemic changes in the facility will make to ensure that the deficient practice does not recur:</b></p> <p>Rounds will be done monthly by maintenance and the proper setting of the doors will be logged and the administrator will review the rounds and develop a log.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 363 K 374 SS=F	Continued From page 9 usually checked on the doors. Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101  Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain their smoke barrier doors. This was evidenced by smoke barrier doors that failed to close and latch when tested. This affected 43 of 43 residents in three of three smoke compartments and could result in the spread of smoke or fire in an emergency.  NFPA 101 Life Safety Code, 2012 Edition 19.2.2.2.7* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of	K 363	<b>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.</b> The Administrator shall report the outcome of the checks/inspections to the Quality Assurance and Assessment Committee (QA&A) during its' monthly meeting. If determined that the facility has accomplished the objectives in the plan of correction as aforementioned and the results are successful, then the facility shall consider the matter resolved.  The QA&A Committee shall continue to review until such time that the deficiency has been proven to be resolved for 3 consecutive months and/or as advised by the QA&A Committee.  <b>Date of Completion of Corrective Action: 05/19/2025</b>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 10 all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8 Self-Closing Devices. 7.2.1.8.1 * A door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2, unless otherwise permitted by 7.2.1.8.3. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met: (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released, and the door leaf becomes self-closing. (5) The release by means of smoke detection of one door leaf in a stair enclosure results in closing all door leaves serving that stair. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and	K 374	<b>K374</b> <b>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b> Fire Alarm System vendor was contacted immediately on 05/19/25. Repair to the automatic door releases were completed. A fire watch was instituted during the repair period. Facility was approved to be taken off from fire watch the following day by Life and Safety.  <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</b> All residents have the potential to be affected by this deficient practice.  No residents were found to be affected by this deficient practice.  <b>What measures will be put into place or what systemic changes in the facility will make to ensure that the deficient practice does not recur:</b> Maintenance will be doing random tests/checks to ensure proper function.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	<p>Continued From page 11 Other Opening Protectives.</p> <p>NFPA 80 Life Safety Code, 2010 Edition 6.1.4.3 Automatic-Closing Doors. Automatic-closing doors shall be permitted to close automatically by means of the installation of a closing device and one of the following: (1) A separate, labeled, fail-safe door holder/release device or a hold-open mechanism that shall be permitted to be an integral part of the basic closing device (2) An integral closing device that allows the door to swing freely and that automatically closes the door during an alarm condition, provided the hold-open mechanisms are released by one or a combination of automatic fire detectors acceptable to the AHJ 6.1.4.3.1 The fire door shall latch upon closure. 6.1.4.4 Power-Operated Fire Doors. Power-operated fire doors shall be equipped with a releasing device that shall automatically disconnect the power operator at the time of fire, allowing a self-closing or automatic device to close and latch the door regardless of power failure or manual operation.</p> <p>Findings:</p> <p>During a tour of the facility and interview with the Maintenance Assistant on 5/19/25, the smoke barrier doors were observed, and staff was interviewed.</p> <p>1. At 12:50 p.m., the cross-corridor smoke barrier doors adjacent to Rooms 15 and 13 were observed. During Fire Alarm Testing, the doors failed to release from the magnetic door holders and close. A smoke detector, pull station and waterflow test were performed. Upon interview,</p>	K 374	<p><b>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.</b></p> <p>The Administrator shall report the outcome of the checks/inspections to the Quality Assurance and Assessment Committee (QA&amp;A) during its' monthly meeting. If determined that the facility has accomplished the objectives in the plan of correction as aforementioned and the results are successful, then the facility shall consider the matter resolved.</p> <p>The QA&amp;A Committee shall continue to review until such time that the deficiency has been proven to be resolved for 3 consecutive months and/or as advised by the QA&amp;A Committee.</p> <p><b>Date of Completion of Corrective Action: 05/20/25</b></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 12 the Maintenance Assistant stated the doors usually close with only the pull station testing. A sprinkler vendor, who was onsite at the time, stated they were sure the smoke barrier doors only close with the sprinkler system testing only. The Maintenance Assistant further stated this never happened before and would call the Fire Alarm System vendor to troubleshoot and would start fire watch.  2. At 12:55 p.m., the cross-corridor smoke barrier door adjacent to Rooms 8 and the Dining Room were observed. During Fire Alarm Testing, the door failed to release from the magnetic door holders and close. A smoke detector, pull station and waterflow test were performed. Upon interview, the Maintenance Assistant stated the doors usually close with only the pull station testing. A sprinkler vendor, who was onsite at the time, stated they were sure the smoke barrier doors only close with the sprinkler system testing only. The Maintenance Assistant further stated this never happened before and would call the Fire Alarm System vendor to troubleshoot and would start fire watch.	K 374		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101  Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident	K 920	<b>K920</b> <b>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b> The four multiplug outlet adapter in Nurse Station 2 was removed on 5/19/25. The two daisy chained power strips and small extension cord in the Telecom Room by Room 21 were removed on 5/19/25.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 13 rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by the use of non-compliant outlet adapters, extension cords, and daisy chained power strips. This affected 18 of 43 residents in one of three smoke compartments and could result in the increased risk of an electrical fire.  NFPA 101, Life Safety Code, 2012 Edition 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.  NFPA 70, National Electrical Code, 2011 Edition 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure	K 920	The brown extension cord was in the Administrative DSD office was removed on 5/19/25.  <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</b> All residents have the potential to be affected by this deficient practice.  No residents were found to be affected by this deficient practice.  <b>What measures will be put into place or what systemic changes in the facility will make to ensure that the deficient practice does not recur:</b> On 5/20/25 Administrator re-educated maintenance staff on NFPA electrical standards. Use of extension cords and outlet adapters is prohibited. Maintenance staff will do visual checks as part of their daily rounds for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CERES POSTACUTE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1711 RICHLAND AVENUE CERES, CA 95307</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 920	Continued From page 14  Findings:  During a tour of the facility and interview with the Maintenance Director and Maintenance Assistant on 5/19/25, the facility's electrical equipment was observed.  1. At 11:20 a.m., a four multiplug outlet adapter was observed in Nurse Station 2. The adapter was plugged into a fixed outlet and had three of four outlets being used. Upon interview, the Maintenance Director stated more plugs are needed as the facility did not have enough.  2. At 11:13 a.m., two daisy chained power strips and small extension cord were observed in the Telecom Room by Room 21. One power strip was powered and connected to another power strip and extension cord. Upon interview, the Maintenance Assistant stated the vendor must have added the surge protector and extension cord.  3. At 11:22 a.m., a brown extension cord was observed in the Administrator Room. The extension cord was observed supplying power to a computer. Upon interview, the Maintenance Assistant stated he did not why it was there.	K 920	<b>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.</b> The Administrator shall report the outcome of the checks/inspections to the Quality Assurance and Assessment Committee (QA&A) during its' monthly meeting. If determined that the facility has accomplished the objectives in the plan of correction as aforementioned and the results are successful, then the facility shall consider the matter resolved.  The QA&A Committee shall continue to review until such time that the deficiency has been proven to be resolved for 3 consecutive months and/or as advised by the QA&A Committee.  <b>Date of Completion of Corrective Action: 05/20/25</b>		