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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055955	A. BUILDING 02 B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA HOME FOR THE AGED	6720 E. KINGS CANYON FRESNO, CA 93727

(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. Census = 103	E 000	California Home for the Aged, Inc. makes its best effort to operate in full compliance with both Federal and State Law. Nothing included in this Plan of Correction is an admission otherwise. California Home for the Aged, Inc. has submitted this Plan of Correction to comply with its regulatory obligation and does not waive any objections to the merits or form of any allegations contained herein. Please note that the California Home for the Aged, Inc. may contest the merits and/or form of any deficiency findings alleged below and may take reasonable efforts or steps to appeal them. This Plan of Corrections does serve as the Facility's written credible allegations of compliance.	
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1969 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, TYPE V, FULLY SPRINKLERED Resident Certified Beds: 120 Resident Census: 103 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	RECEIVED By TNewmann at 3:41 pm, Apr 08, 2025 **K 353: How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** The facility has not identified any residents affected by the deficient practice but recognizes that all residents have the potential to be affected. The facility contracted with MS Fire, a qualified contractor, to inspect each identified area of deficiency, and to determine and obtain the necessary signage for each Inspector Test Valve and all Auxiliary Drain valves. During this inspection the valve located in the medicine room by station 3 was properly identified as an Auxiliary Drain Valve and not an Inspector Test Valve. Signage indicating that this is an Auxiliary Drain valve was placed during the inspection done on 04/02/2025.	04/08/2025
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		04/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/8/2025

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.

4/08/2025: POC accepted per Beverly Ong-Sladek, SSM-1

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K 353	Continued From page 1 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the sprinkler system. This was evidenced by missing signage for inspector test valves, dust on a sprinkler and waterflow testing exceeding 90 seconds. This affected 103 of 103 residents in five of five smoke compartments and could result in a delay of the sprinkler system protection in the event of a fire. NFPA 101, Life Safety Code edition 2012 19.3.5.4 * The sprinkler system required by 19.3.5.1 or 19.3.5.3 shall be installed in accordance with 9.7.1.1(1). 9.7.1.1 * Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1)NFPA 13, Standard for the Installation of Sprinkler Systems	K 353	As this was identified as an Auxiliary Drain valve and not an Inspector Test Valve, MS Fire has corroborated during their inspection that the waterflow expected of this valve was in working order and it is not expected to perform as an Inspector Test Valve, alarming in no more than 90 seconds. This is because Auxiliary Drain valves do not have the restricted head on the discharge pipe to correctly stimulate a fire sprinkler activation as an Inspector Test Valve would, and therefore this is why it took longer than 90 seconds to alarm. During this same inspection the valve located in the courtyard was properly identified as an Auxiliary Drain Valve and not an Inspector Test Valve. Signage indicating that this is an Auxiliary Drain Valve was placed during the inspection done on 04/02/2025. Two other correctly identified Inspector Test Valves were tested during the survey process and performed within regulatory requirements, alarming in less than 90 seconds. The sprinkler located in the storage closet next to Nurses Station 3 was cleaned of dust on 3/26/25 by the Maintenance Lead and reinspected by MS Fire on 04/02/2025. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The facility recognizes that while no residents were identified to have been affected by the deficient practice, all residents have the potential to be affected. The same corrective actions as listed above are the corrective actions taken to eliminate the potential risk to the residents.	04/02/2025 03/26/2025 03/26/2025 04/02/2025 04/02/2025

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K 353	Continued From page 2 NFPA 13, Standard for the Installation of Sprinkler Systems edition 2010 6.7.4.1 All control, drain, and test connection valves shall be provided with permanently marked weatherproof metal or rigid plastic identification signs. Findings: During a tour of the facility and interview with Staff on 3/26/25, the sprinkler components were observed. 1. At 12:20 p.m., the inspector test valve (ITV) located in the medicine room by nurses station 3 was observed missing signage. Upon interview, Staff 1 stated that the facility was unaware why the valve was missing a sign. 2. At 12:35 p.m., the sprinkler located in the storage closet next to nurses station 3 was observed covered in dust. Upon interview, Staff 1 stated that they were unaware of the dust. 3. At 12:50 p.m., the inspector test valve located in the courtyard was observed missing signage. Upon interview, Staff 1 stated that the facility was unaware why the valve was missing a sign. 4. At 1:46 p.m., the waterflow was tested at the ITV located in the medicine room by nurses station 3. When the valve was fully opened, it took 116 seconds for the alarm to initiate. Upon interview, Staff 1 stated that they were unaware why the alarm had a delay.	K 353	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Maintenance Director in-serviced all maintenance personnel on the locations and appropriate signage required for Inspector Test Valves and Auxiliary Drain valves. Also included in this same in-service was the importance of inspecting and cleaning sprinkler heads to keep them free of dust. The facility utilizes TELS Building Management System for all Maintenance related inspections or tasks. A monthly in-house fire sprinkler inspection task was added to the Maintenance TELS system to include checking fire sprinkler heads for dust and Auxiliary Drain Valves and Inspector Test Valves for appropriate signage. Any findings will be immediately corrected and reported by the Maintenance team member completing the task to the Maintenance Lead and/or Director. Housekeeping staff was in-serviced by the Hospitality Director/Environmental Services Director on how to clean fire sprinkler heads to keep them free of dust. **How does the facility plan to monitor its performance to make sure that the corrective actions are implemented and achieved, the solutions are sustained, and that the corrective actions taken are evaluated for effectiveness through integrations into the facility's Quality Assurance system?** The Facility Maintenance Director shall review monthly in-house sprinkler inspection task reports for completion and findings. Compliance and/or findings shall be reported by the Maintenance Director to the Quality Assurance and Performance Improvement Committee monthly for integration and recommendations.	04/04/2025 04/04/2025 04/01/2025 04/17/2025
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101	K 363		

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K 363	Continued From page 3 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 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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 363	**K 363: How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** The mat that prevented the door of room 507 from closing was immediately relocated by the Maintenance Lead to allow the door to fully close. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The facility did not identify any other residents affected by the deficient practice but recognizes any resident in the first bed of the room with a floor mat has the potential to be affected by this same deficient practice. On 3/26/2025 all residents with floor mats were identified and all rooms were inspected to ensure that none of those mats impeded or obstructed the door from closing. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** An in-service by the Director of Staff Development was held for all staff about ensuring that nothing, including floor mats, can prevent the resident room door from closing. The facilities Maintenance Director added a monthly corridor door inspection task to the TELS system, so the maintenance department is instructed to inspect all corridor doors monthly for proper closing and to ensure they are free from obstruction. Any findings shall be corrected immediately. NEXT PAGE INTENTIONALLY BLANK DUE TO FORMATTING.	03/26/2025 03/26/2025 04/03/2025 04/04/2025 04/05/2025 04/06/2025 04/07/2025 04/08/2025 04/04/2025 04/07/2025

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K 363	Continued From page 4 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by an obstructed corridor door. This can increase the passage of smoke through smoke compartments. This affected 23 of 103 residents and one of five smoke compartments. Findings: During a tour of the facility and interview with staff on 3/26/25, the corridor doors were observed. At 1:14 p.m., the door to resident room 507 was observed to be obstructed by a brown floor mat by bed A that stopped the door from closing. Upon interview, Staff 1 stated that the door mat was in the way.	K 363	**How does the facility plan to monitor its performance to make sure that the corrections are implemented and achieved, the solutions are sustained, and that the corrective actions taken are evaluated for effectiveness through integration into the facility's Quality Assurance system?** The Facilities Maintenance Director will review the monthly corridor door inspection reports in TELS and report compliance and any findings to the Quality Assurance Committee monthly for integration and recommendations.	04/17/2025
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the fire drills. This was evidenced by fire drills conducted at repeated times. This affected 103 of 103 residents in five of	K 712	**K 712: How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified to have been affected by the deficient practice. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were identified to have been affected by the deficient practice, but the facility recognizes that all residents have the potential to be affected by the deficient practice. To gain compliance two fire drills were conducted on the am and pm shift at times different than previously completed. A fire drill was conducted on 04/03/2025 at 7:00 am and on 04/04/2025 at 6:30 pm.	04/01/2025 04/01/2025 04/03/2025 04/04/2025

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K 712	Continued From page 5 five smoke compartments and could result in a delayed evacuation in the event of a fire. Findings: During record review and interview with Staff on 3/26/25, the fire drill records were reviewed. At 3:28 p.m., the facility provided fire drills that were conducted at the same time. The AM shift fire drills on 6/28/24, 7/29/24 and 10/29/24 were conducted at 10 a.m. The PM shift drills on 4/30/24 and 8/28/24 were conducted at 3 p.m. Upon interview, Staff 1 stated that they were unaware fire drill times could not repeat.	K 712	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Facilities Maintenance Director in-serviced all Maintenance staff that conduct fire drills of the requirements that such drills are to be held at expected and unexpected times, under varying conditions, at least quarterly on each shift. The Facilities Maintenance Director added a monthly fire drill task to the TELS system so that the Maintenance team can conduct such drills at unexpected and varying times on all shifts quarterly. The Maintenance Director and/or Maintenance Lead will be responsible for ensuring the time of the in-service is appropriate to maintain compliance with the regulation.	04/04/2025
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the utility equipment. This was evidenced by an electrical panel with circuits missing identifiers. This affected the 23 of 103 residents in one of five smoke compartments and could result in delayed access to electrical circuits and possible contribution to a fire. NFPA 101 Life Safety Code 2012 edition 19.5.1.1 Utilities shall comply with the provisions	K 919	**How does the facility plan to monitor its performance to make sure that the corrections are implemented and achieved, that solutions are sustained, and that the corrective actions taken are evaluated for effectiveness through integration into the facility's Quality Assurance system?** The Facilities Maintenance Director will review the monthly fire drill reports to ensure compliance with varying times and shift compliance. Any findings will be corrected within the month by way of a separate drill if required. The Facilities Maintenance Director will report compliance and findings of fire drills to the Quality Assurance Committee monthly for 12 months for integration and recommendations if indicated.	04/17/2025

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K 919	Continued From page 6 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 110.22 Identification of Disconnecting Means. (A) General. Each disconnecting means shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved. 408.4 Field Identification Required. (A) Circuit Directory or Circuit Identification. Every circuit and circuit modification shall be legibly identified as to its clear, evident, and specific purpose or use. The identification shall include sufficient detail to allow each circuit to be distinguished from all others. Spare positions that contain unused overcurrent devices or switches shall be described accordingly. The identification shall be included in a circuit directory that is located on the face or inside of the panel door in the case of a panelboard, and located at each switch or circuit breaker in a switchboard. No circuit shall be described in a manner that depends on transient conditions of occupancy. Findings: During a tour of the facility and interview with Staff on 3/26/25, the electrical circuits were observed. 1. At 1:03 p.m., the electrical panel labeled Panel A located in the mechanical room was observed	K 919	**K 919: How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be affected by the deficient practice in regard to the unlabeled circuits. The Maintenance Lead inspected and identified that circuits 13 and 27 in Panel A and confirmed them to be "spares". They were correctly labeled as "SPARE" on 03/27/2025. The maintenance lead inspected and identified that circuits 26, 28, and 30 on Panel F and confirmed them to be "spares". They were correctly labeled as "SPARE" on 03/27/2025. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to have been affected by the deficient practice and the corrective action taken above ensures that no residents will be affected.	03/27/2025 03/27/2025

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K 919	Continued From page 7 with an unlabeled circuits. The panel had two of 42 circuits missing identifiers (circuits 13 and 27) . Upon interview, Staff 1 stated that the unlabeled circuits were spares. 2. At 1:25 p.m., the electrical panel labeled Panel F located in the mechanical room by resident room 501 was observed with an unlabeled circuits. The panel had three of 42 circuits missing identifiers (circuits 26, 28 and 30) . Upon interview, Staff 1 stated that they were unaware what the circuits serve.	K 919	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Facilities Maintenance Director in-serviced all Maintenance Personnel in regard to the requirements of K919, specifically ensuring all circuit breakers are labeled. The Facility Maintenance Lead will inspect the electrical panels for proper circuit labeling monthly for three months. After this, the Facilities Maintenance Director added an annual "Inspect and Document the Main and Feeder Circuit Breakers" task to the TELS system to ensure the Maintenance Department is inspecting all electrical breaker panels annually for appropriate and proper labeling. **How does the facility plan to monitor its performance to make sure that the corrections are implemented and achieved, that solutions are sustained, and that the corrective actions taken are evaluated for effectiveness through integration into the facility's Quality Assurance system?** The Facilities Maintenance Director will review the monthly inspections by the Facilities Maintenance lead and report findings and compliance to the Quality Assurance committee monthly for three months for integration and recommendations, and then annually thereafter.	04/04/2025 04/07/2025 04/07/2025 04/17/2025
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 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	K 920		

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K 920	Continued From page 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 extension cords. This could result in a fire and affected 23 of 103 residents and one of five smoke compartments. Findings: During a tour of the facility and interview with Staff on 3/26/25, the electrical equipment was observed. 1. At 1:10 p.m., the medical records office was observed with an orange extension cord plugged into a coffee machine. Upon interview, Staff 1 stated that staff was unaware they could not use extension cords. 2. At 1:20 p.m., resident room 503 was observed with a brown extension cord plugged into a phone charger. Upon interview, Staff 1 stated that the resident brought in the extension cord.	K 920	**K 920: How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** The extension cord in room 503 and in the Medical Records office were immediately removed by the Maintenance Lead. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The facility has not identified any other residents affected by the deficient practice. An inspection walk-through of all patient rooms and non-patient rooms was conducted on 03/27/2025 to ensure no other extension cords were in use. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** Maintenance staff were in-serviced by the Facilities Maintenance Director on 4/4/2025 to review K 920 findings and the acceptable and appropriate use of extension cords and/or power strips. An in-service for all staff was conducted by the Director of Staff Development and Maintenance Lead to educate staff that extension cords are not permitted to be used except for temporary purposes and must be removed immediately upon completion of the task for which it was used. Staff were educated to be observant for unauthorized use of extension cords and to remove them immediately, and to report any use of power strips to Maintenance so that Maintenance can ensure the power strip is compliant in its use and design. The Facilities Maintenance Director generated a monthly Room Safety Inspection task within the TELS system so that the Maintenance department can inspect all rooms for use of extension cords and/or power strips monthly. Findings shall be corrected immediately.	03/26/2025 03/27/2025 04/04/2025 04/03/2025 04/04/2025 04/05/2025 04/06/2025 04/07/2025 04/08/2025 04/04/2025

			How does the facility plan to monitor its performance to make sure that the corrections are implemented and achieved, the solutions are sustained, and that the corrective actions taken are evaluated for effectiveness through integration into the facility's Quality Assurance system? The Facilities Maintenance Director will review the monthly Room Safety Inspection task reports from TELS for compliance and findings and shall report compliance and findings monthly for three months to the Quality Assurance Committee monthly for integration and recommendations if indicated.	4/17/25