STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056426	A. BUILDING **02** B. WING _____	**04/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENTIST HEALTH DELANO	**1401 GARCES HWY** **DELANO, CA 93215**

(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 not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 45	E 000		
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive	E 025	Immediate Corrections: The Emergency Management binder and missing documentation were located and returned to the AHDL site. See attached Kern County Emergency Operation Manual, ADHL KCHCC Partner Participation Agreement and the AH Delano Grant Letter. All residents had the potential to be affected by this issue, but no harm was identified for any residents. Sustainment: The Accreditation Manager educated the Facilities Manager on the requirement to maintain the Emergency Operations Manual on site at all times, and to not allow the binder to be removed for any reason, even short term use. Likewise, the Emergency Management Manager was also educated to complete any updates or changes to the manual on site, and not to take it to another location to work on it. Monitoring: The Manager of Facilities will verify the binder is in the unit at least monthly to ensure that the Manual is still on site and has not been removed. This will continue for 6 months to ensure sustainment. Data will be reported out to the SCU Quality Assurance Committee as part of the QAPI program. Person Responsible: Facilities Manager	4/16/25 4/15/25 5/2025 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Isaac Smith
TITLE: Sr. Director, Regulatory & Accreditation
(X6) DATE: 5/7/25

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.

Signed on behalf of Heather Van Housen, Patient Care Executive, Central California Network

5/08/2025: POC accepted per Beverly Ong- Sladek, SSM-1

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E 025	Continued From page 1 patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain an Emergency Operations Plan (EOP). This was evidenced by missing agreements and arrangements with other facilities. This affected the facility and could result in the failure to properly react during an emergency. Findings: During record review and interview with the Safety Director on 4/15/25, the EOP was reviewed. At 4:50 p.m., the facility was unable to provide documentation of arrangements with other	E 025		

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E 025	Continued From page 2 facilities or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. Upon interview, the Safety Director confirmed the finding and stated that they have an agreement with the county but could not provide the documentation.	E 025		
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1974 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 59 Resident Census: 45 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 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire	K 355		

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K 355	Continued From page 3 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by a missed portable fire extinguishers annual inspection. This affected one of two smoke compartments and affected 23 of 45 residents. This could result in the delay to extinguish a fire in the event of an emergency. NFPA 101 Life Safety Code, 2012 Edition 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10 Standard for Portable Fire Extinguishers, 2010 Edition 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Findings: During a tour of the facility and interview with the Maintenance Director on 4/15/25, the portable fire extinguishers were observed. At 1:51 p.m., the exterior portable fire extinguisher located adjacent the generator was	K 355	Immediate Correction: The fire extinguisher was replaced with one that had completed the annual inspection timely. This finding had the potential to affect all residents. No harm was identified. Sustainment: The Facilities Staff was educated by the Facilities Manager on the importance of ensuring all fire extinguishers have their required inspection and maintenance. See attached education signature sheet. Monitoring: The specified fire extinguisher location will be included in ongoing EOC rounds to ensure it doesn't get missed again in the future due to it's remote location. Data will be collected and reported out to the EOC Committee and the SCU Quality Assurance committee as part of the facility QAPI program. Person Responsible: Facilities Manager	4/16/25 4/25/25 4/25/25 and ongoing

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K 355	Continued From page 4 observed with the annual inspection tag dated on 1/18/24. Upon interview, the Maintenance Director confirmed the finding and stated that the inspection was already scheduled.	K 355		
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 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.	K 363	Immediate Correction: The items blocking the doors were removed. All residents have the potential to be impacted by the finding, but no harm was identified and no other doors were found blocked upon inspection. Sustainment: Education was provided to the SCU staff by the Director of Staff Development on the requirement that all fire doors remain clear and able to close properly in order to protect life and property in case of fire. See attached sign in sheets. Monitoring: Rounding will occur three times a week by the Manager of the Special Care Department to verify that no doors are blocked or obstructed in any way. Data will be collected and reported out to the SCU Quality Assurance Committee as part of the facility's QAPI program. Person Responsible: SCU Nurse Manager	4/15/25 5/6/25 5/2025 and ongoing

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K 363	Continued From page 5 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: Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a corridor door being obstructed. This affected one of two smoke compartments and affected 22 of 45 residents. This could result in the spread of fire in the event of an emergency. NFPA 101 Life Safety Code, 2012 Edition 19.3.6.3.1 * Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 13/ 4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes 19.3.6.3.10 * Doors shall not be held open by devices other than those that release when the door is pushed or pulled. Findings: During a tour of the facility and interview with the Maintenance Director on 4/15/25, the corridor doors were observed. 1. At 2:18 p.m., the corridor door of Room 226 was observed being obstructed by a trash can. This resulted in the door being unable to close.	K 363		

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K 363	Continued From page 6 Upon interview, the Maintenance Director confirmed the finding and stated that staff placed it there. 2. At 2:26 p.m., the corridor door of Room 221 was observed being obstructed by a plastic bag full of clothes. This resulted in the door being unable to close. Upon interview, the Maintenance Director confirmed the finding and stated that staff had put it there to move later.	K 363		