

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

PRINTED: 05/02/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555766</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/16/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>SIERRA VIEW MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>465 W PUTNAM AVE PORTERVILLE, CA 93257</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 not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities.  Census = 33	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		4/16/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/02/2025

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.

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E 025	<p>Continued From page 1</p> <p>patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[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.</p> <p>*[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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to maintain an Emergency Operations Plan (EOP). This was evidenced by an expired agreement and arrangement with other facilities. This affected the facility and could result in the failure to properly react during an emergency.</p> <p>Findings:</p> <p>During record review and interview with the Administrator on 4/16/25, the EOP was reviewed.</p> <p>At 2:44 p.m., the facility provided a memorandum of understanding with partner facilities and providers to receive residents in the event of limitations or cessation of operations to maintain</p>	E 025	<p>Sierra View Medical Center Distinct Part Skilled Nursing Unit submits this plan of correction as part of the requirement under the State and Federal regulations. The plan of correction is submitted and shall not be construed as admission to the alleged deficiency cited or any liability. The plan of correction shall constitute as a credible allegation of compliance.</p> <p>Potential Patients affected The organization was unable to find in a retrospective review that any patients had been adversely affected and were not placed in an immediate jeopardy situation.</p>		

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E 025	Continued From page 2 the continuity of services to facility residents that was expired. The contract stated that it will expire in February of 2025. Upon interview, the Administrator confirmed the finding and stated that they were in the process of getting it renewed.	E 025	Immediate Organizational Action During document review it was noted that the Hospitals Memorandum of Understanding (MOU) with its regional partners had expired on February 26, 2025. The MOU is normally updated by the EMS Coordinator-Disaster Services Fresno County MHOAC and sent out for all parties to agree upon. The Environment of Care/Safety & Security Manager from Sierra View notified the coalition of the need for an updated MOU. The EMS Coordinator from Fresno County then submitted an addendum to the coalition for an extension of the MOU until December 31, 2025. All parties agreed and the amendment to the MOU was officially updated. (Please see attachments A & B highlighted areas)  Organizational System Improvements: Persons responsible: Environment of Care/Safety & Security Manager The Environment of Care/ Safety & Security Manager will attend regular meetings with the coalition to ensure the MOU does not lapse.  PI Monitoring: The MOU will be presented no less than annually to the organizations Safety Committee for tracking purposes.		
K 000	INITIAL COMMENTS  K3 BUILDING: 01	K 000			

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K 000	Continued From page 3 K6 PLAN APPROVAL: 2000 K7 SURVEY UNDER: 2012 EXISTING  STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED.  Resident Certified Beds: 35 Resident Census: 33  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 in substantial compliance with 42 CFR §483.90(a)(b)(c)(j) for Long Term Care Facilities.	K 000			
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of	K 923		4/25/25	

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K 923	<p>Continued From page 4</p> <p>noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet</p> <p>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to maintain medical gas cylinders/gas equipment storage. This was evidenced by mixed storage of empty and full oxygen tanks. This affected one of three smoke compartments and affected 11 of 33 residents. This could result in harm during the event of an emergency.</p> <p>Findings:</p> <p>During a tour of the facility and interview with the Administrator on 4/16/25, the oxygen cylinder storage was observed.</p>	K 923	<p>Potential Patients affected</p> <p>The organization was unable to find in a retrospective review that any patients had been adversely affected and were not placed in an immediate jeopardy situation.</p> <p>Immediate Organizational Action</p> <p>During the building tour it was discovered that 3 empty oxygen tanks were being stored in the full section. The facility had Engineering remove the tanks.</p> <p>Organizational System Improvements: Persons responsible:</p>		

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K 923	Continued From page 5 At 10:58 a.m., the storage closet was observed with intermingled storage of oxygen tanks of three empty oxygen tanks being stored in the full section along with four full tanks. Upon interview, the Administrator confirmed the finding and stated they are not sure why the tanks were misplaced.	K 923	Environment of Care/Safety & Security Manager The Environment of Care/ Safety & Security Manager had an additional 6 tank holder ordered so that there is available storage capacity for empty tanks, this will reduce the risk of comingling tanks. (see attachment C)  PI Monitoring: The Facility will utilize its Environment of Care (EOC) rounds to ensure that proper tank storage is being adhered to.	