STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555066	A. BUILDING **02** B. WING _____	**04/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FILLMORE, LLC	**118 B ST** **FILLMORE, CA 93015**

(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 Surveyor: 40649 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. Representing the California Department of Public Health: 40649 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census: 62	E 000		
K 000	INITIAL COMMENTS Surveyor: 40649 K3 BUILDING: 01 K6 PLAN APPROVAL: 5/20/1977 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), 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. Representing the California Department of Public Health:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/21/2022

4/21/22: approved by Cynthia Luc, SSM-I

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K 000	Continued From page 1 40649 The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care Facilities. Census: 62	K 000		
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	K 363		4/29/22

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K 363	Continued From page 2 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: Surveyor: 40649 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a door that failed to self close. This affected 23 of 62 residents and could result in the spread of smoke and fire. Findings: During a tour of the facility and interview with staff on 4/18/22, the corridor doors were observed. At 1:26 p.m., the self closing door to the Station 3 Central Supply Room failed to latch upon three operation attempts. Upon interview, Maintenance Director 1 confirmed the finding.	K 363	Immediate corrective action(s) for those Residents affected by the deficient practice; The Maintenance Supervisor (MS) replaced the latching hardware on Station 3 Central Supply Door on 4/18/22. Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken; The Maintenance Supervisor reviewed the corridor doors 4/18/20-4/19/20 and all doors latched properly. The review of the corridor doors will be documented each month and any door found needing adjustment or replacement of hardware will be addressed immediately to ensure proper closure. Facility measures and systemic changes to assure deficient practice does not recur; The Maintenance Supervisor was inserviced by the Administrator, on 4/21/22, on inspection and documentation	

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K 363	Continued From page 3	K 363	of the corridor doors each month within the TELS system. Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process; The Maintenance Supervisor will provide the QAPI Committee a listing of corridor doors that did not meet the positive latching requirement and the correction of those for the next three months to show how the monthly review of the doors sufficiently meets the standard for all doors to positively latch as required by regulation. The Committee will determine if the current plan achieves compliance or requires revision. Completed by: 4/29/22	