STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055715	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kyakameena Care Center	2131 Carleton Street Berkeley, CA 94704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to complete and update the care plan in a timely manner to reflect residents' care needs for two of two investigated residents when:1. For Resident 48 facility did not update care plan to accurately reflect the resident's required transfer method. This failure resulted in Resident 48 being transferred incorrectly and sustained a left lower leg fracture.2. For Resident 29 facility did not develop comprehensive care plan within 7 days of completion of assessment to address risks of elopement and Interdisciplinary Team did not review Resident 29 episodes of elopement from the facility with appropriate interventions. IDT-Interdisciplinary Team means professional disciplines that work together to provide the greatest benefit to the resident which includes the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically appropriate and person-centered.This failure resulted in Resident 29 to continue to elope from facility and potential risk to result in heat or cold exposure, dehydration or struck by motor vehicle. 1.During a review of Resident 48's admission Record (AR) dated 11/20/25, the AR indicated Resident 48 was admitted to the facility in July 2024 with multiple diagnoses, including diffuse traumatic brain injury (a serious head injury that damages many parts of the brain), seizures (a sudden uncontrollable shaking with rapid and rhythmic body movement), difficulty in walking and lack of coordination. During a review of Resident 48's History and Physical (H&P) dated 7/3/24, the H&P indicated Resident 48 had Myoclonic jerks (very quick, sudden muscle contraction). During a review of Resident 48's Minimum Data Set (MDS, a resident assessment tool to guide resident care) dated 7/31/25, the MDS indicated Resident 48 had a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 13, indicating Resident 48 was cognitively intact. During a review of Resident 48's Documentation Survey Report (ADL float sheet) from 8/1/25 to 8/10/25, the ADL float sheet indicated Resident 48 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity) for transferring from bed to chair or from chair to bed on 12 out of 16 occasions, substantial/maximal (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than the effort.) assistance on 2 out of 16 occasions, partial/moderated (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.) assistance on 1 out of 16 occasions, and set up (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.) assistance on 1 out of 16 occasions. (continued on next page)

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20 /25 9:25 a.m., Resident 48 stated staff had been using a standing lift to transfer her from wheelchair to bed or from bed to wheelchair for a long time due to her sudden trembling and jerking movements. During an interview on 11/20/25 at 9:30 a.m., Resident 48 stated that on 8/11/25 at 10:30 a.m., while two CNAs transferring her from a wheelchair to bed without using a standing lift, her left leg was twisted and fractured. Resident 48 stated she was sent to the hospital on [DATE]. During an interview on 11/20/25 at 9:35 a.m., Resident 48 stated she became nervous during the transfer and began trembling. Resident 48 stated she heard a popping sound during the transfer and felt a burning sensation in her left lower leg afterward. During a review of Resident 48's X-ray report dated 8/11/25, the X-ray report indicated: oblique fracture (the break is slanted) deformities (a body part does not look normal in shape) of the distal tibia (shine bone) and fibula (shin bone) shaft without displacement. Acute distal tibia and fibula fractures of the left lower leg. A record review of Resident 48's after visit (Alta Bates Emergency) summary date 8/11/25, the visit summary indicated a closed fracture of distal end of left tibia, initial encounter. During an interview on 11/20/25 at 9:48 a.m., Certified Nursing Assistance (CAN) 5 stated staff had been using a standing lift to transfer Resident 48 due to her involuntary movements. CNA 5 stated there was no place for CNAs to reference to determine the transfer method or equipment to use for Resident 48. CNA 5 stated that she knew the method because she was Resident 48's regular CNA, but on-call and registry staff did not know. During a phone interview on 11/20/25 at 10:24 a.m., CNA 6 stated she was an on-call CNA. CNA 6 stated on 8/11/25, at 10:30 a.m., Resident 48's assigned CNA was to be giving another resident a shower, and she was asked to assist Resident 48 back to bed. CNA 6 stated she positioned Resident 48's wheelchair on the left side of the bed, facing the head of the bed, and placed her left foot between Resident 48's feet before standing the resident up. During a phone interview on 11/20/25 at 10: 27 a.m., CNA 6 stated during the pivot transfer, Resident 48 began shaking. CNA 6 stated she sat Resident 48 on the edge of the bed but did not hear any popping sound. CNA 6 stated Resident 48 complaining of left ankle pain after being seated. CNA 6 stated at that time, Resident 48's assigned CNA entered the room, and CNA 6 left the resident with the assigned CNA and went out to report the incident to the charge nurse. During a phone interview on 11/20/25 10:30 a.m., CNA 6 stated that she did not know a standing lift was required to transfer Resident 48, and she did not use a gait belt during the transfer. She stated she received an in-service on Safe Patient Transfer on 8/18/25, after the incident. On 11/20/25 at 8:40, with Director of Staff Development (DSD), the facility's policy titled Safe Lifting and Movement of Residents, revision date July 2017 and in-service record titled Safe Patient Transfer dated 8/18/25 were reviewed. DSD stated residents' care plan should include the appropriate transfer method. DSD stated a gait belt should be used while transferring resident if mechanical lift is not used. DSD stated she provided an in-service to CNA 6 after the incident. During an interview on 11/20/25 11:19 a.m., Licensed Vocational Nurse (LVN) 1 stated that CNA 6 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transferred Resident 48 alone without using standing lift, which resulted in Resident 48's left lower leg fracture. LVN 1 stated the care plan should indicate that a standing lift is required for transferring Resident 48. LVN 1 stated the care plan should be updated regularly by the IDT and as needed by nurses. On 11/21/25 at 9:20 a.m., with MDS Coordinator (MDSC), Resident 48's care plan of limited physical mobility dated 7/24/24, revision dated 8/29/24 was reviewed. MDSC stated the care plan should include the transfer method for Resident 48. MDSC stated the care plan should be reviewed and revised quarterly according to the MDS schedule and as needed. On 11/21/25 at 9:23 a.m., with MDSC, during a concurrent interview and record review of Resident 48's care plan created on 8/11/25, the care plan indicated during transfer, Resident 48 hit her left lower leg on the side of the bed frame and heard a popping sound .Resident 48 has a short cast with splint in place. During an interview on 11/21/25 at 9:53 a.m., Director of Nursing (DON) stated the care plan should be updated and that is the responsibility of all departments. When asked how on-call and registry staff were expected to be informed of residents' care needs, the DON stated that they received information through verbal reports during shift changes from nurse to nurse and CNA to CNA. When asked if the method for transferring residents should be included in the care plan and how often the care plan should be updated, DON stated, I don't have the answer. During an interview on 11/21/25 at 11:30 am., Director of Rehab (DR) stated she was aware that staff had been using a lift to transfer Resident 48 due to the resident's severe trembling related to a massive brain injury. DR stated Resident 48 was not on the therapy case load; therefore, the therapy department did not update the care plan. During a review facility's Policy and Procedure (P&P) titled Safe Lifting and Movement of Residents, revision date July 2017 indicated Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. During a review facility's P&P titled Care plans, Comprehensive Person-Centered revision date March 2022, the P&P indicated A comprehensive, person-centered care plan that includes measurable objective and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team reviews and updates the care plan: .d. at least quarterly, in conjunction with the required quarterly MDS assessment. 2.During a review of Resident 29's admission Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 2/4/25, the MDS indicated Resident 29's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 10 and indicated mild cognitive impairment. The MDS indicated Resident 29 was not able to recall the correct year, month, and day of the week. MDS indicated Resident 29 had clear speech, difficulty communicating some words or finish thoughts but able if prompted or given time. MDS indicated Resident 29 had episode of wandering. MDS indicated Resident 29 needed supervision with walking helper provides verbal cues and contact guard assistance. MDS indicated Resident 29 had diagnoses that included unsteadiness on feet, cognitive communication deficit and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aphasia (a brain disorder that affects how you speak and understand language). During a concurrent observation and interview on 11/18/25 at 10:53 a.m. with Resident 29, Resident 29 wandered up and down facility hallway. Resident 29 stated he left the facility because he wanted to see his family. Resident 29 stated he removed the wander guard on his ankle and placed under his pillow before he left. Resident 29 stated that the feeling of wander guard attached to his ankle messed with his head. Resident 29 said he did not like wander guard because wander guard made him felt as if he was in jail. During a review of Resident 29's admission Record (AR), AR indicated Resident 29 was admitted to the facility on [DATE]. During a review of Resident 29's Wandering/Elopement Assessment (EA) dated 3/4/25, indicated, Resident 29 was at risk for elopement. EA indicated Resident 29 eloped from the facility on 3/3/25 at 6:50 a.m. EA indicated Certified Nursing Assistant (CNA) found Resident 29 at the bus station. Resident 29 was brought back to the facility. During a review of Resident 29's Progress Notes (PN) dated 5/28/25, PN indicated Resident 29 eloped at 9:10 p.m. from the facility. Staff notified police. Police found Resident 29 at downtown, informed facility at 10:25 p.m. and returned Resident 29 to the facility. During a review of Resident 29's PN dated 11/5/25, PN indicated Resident 29 eloped from the facility and police department was notified. During a review of Resident 29's EA dated 11/7/25, EA indicated, Resident 29 was found wandering in another town. Resident 29 was evaluated at the emergency department and returned back to the facility via ambulance. During a review of Resident 29's care plan report initiated 11/10/25, indicated Resident 29 leaves facility without notifying staff with intervention that staff will monitor resident's location every shift and engage in activities. During an interview on 11/19/25 at 7:59 a.m. with Administrator (Admin), Admin stated Resident 29 had eloped from the facility on more than one occasion. Admin stated Resident 29 eloped from the facility on 11/5/25 was found in another town by the police and returned to the facility. Admin stated facility had not reported the prior incidents of elopements to the state department. Admin stated facility tried to report the recent elopement of 11/5/25 but find out later that the fax report did not went through. During a concurrent interview and record review on 11/19/25 at 9:31 a.m. with Director of Nursing (DON), Resident 29's admission MDS assessment dated [DATE], EA s and progress notes were reviewed. DON stated Resident 29 had eloped on more than one occasion. DON stated she was not aware that Resident 29's risk for elopement was not addressed with care plan because DON was hired after Resident 29's admission to the facility. DON stated facility intervention included monitoring location and wander guard. DON stated Resident 29 continued to elope because Resident 29 removed his wander guard. DON stated Interdisciplinary team (IDT-an interdisciplinary team is a group of professionals from different fields who collaborate to address complex residents' need) had not met to review Resident 29's repeated episode of elopement. DON could not provide comprehensive care plan that addressed Resident 29's risk for wandering and elopement, repeated incidents of Resident (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	29's elopements with appropriate interventions with each incident of elopement. During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopements, dated 2001, the P&P indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. During a review of facility's policy and procedure (P&P) titled, Care Plan, Comprehensive Person-Center, dated 2001, the P&P indicated, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The IDT in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 29) received adequate supervision to prevent accident hazards when: Resident 29 eloped from the facility and was found by the police in another town. Resident 29's incidents of elopements were not reported to the state department as required by federal or state regulations. Elopement is a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision.This failure caused Resident 29 to continue to elope and had the potential to result in heat or cold exposure, dehydration or struck by motor vehicle. During a review of Resident 29's admission Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 2/4/25, the MDS indicated Resident 29's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 10 and indicated mild cognitive impairment. The MDS indicated Resident 29 was not able to recall the correct year, month, and day of the week. MDS indicated Resident 29 had clear speech, difficulty communicating some words or finish thoughts but able if prompted or given time. MDS indicated Resident 29 had episode of wandering. MDS indicated Resident 29 needed supervision with walking helper provides verbal cues and contact guard assistance. MDS indicated Resident 29 had diagnoses that included unsteadiness on feet, cognitive communication deficit and aphasia (a brain disorder that affects how you speak and understand language). During a concurrent observation and interview on 11/18/25 at 10:53 a.m. with Resident 29, Resident 29 wandered up and down facility hallway. Resident 29 stated he left the facility because he wanted to see his family. Resident 29 stated he removed the wander guard on his ankle and placed under his pillow before he left. Resident 29 stated that the feeling of wander guard attached to his ankle messed with his head. Resident 29 said he did not like wander guard because wander guard made him felt as if he was in jail. During a review of Resident 29's admission Record (AR), AR indicated Resident 29 was admitted to the facility on [DATE]. During a review of Resident 29's Wandering/Elopement Assessment (EA) dated 3/3/25, indicated, Resident 29 eloped from the facility on 3/3/25 at 6:50 a.m. EA indicated Certified Nursing Assistant (CNA) found Resident 29 at the bus station. Resident 29 was brought back to the facility. During a review of Resident 29's Progress Notes (PN) dated 5/28/25, PN indicated Resident 29 eloped at 9:10 p.m. from the facility. Staff notified police. Police found Resident 29 at downtown, informed facility at 10:25 p.m. and returned Resident 29 to the facility. During a review of Resident 29's PN dated 11/5/25, PN indicated Resident 29 eloped from the facility and police department was notified. During a review of Resident 29's EA dated 11/7/25, EA indicated, Resident 29 was found wandering in another town. Resident 29 was evaluated at the emergency department and returned back to the facility via ambulance. During a review of Resident 29's care plan dated 11/10/25, care plan indicated Resident 29 leaves facility without notifying staff. Interventions included that staff would monitor Resident 29's location every shift. During an interview on 11/19/25 at 7:59 a.m. with Administrator (Admin), Admin stated Resident 29 had eloped from the facility on more than one occasion. Admin stated Resident 29 eloped from the facility on 11/5/25 was found in another town by the police and returned to the facility. Admin stated facility had not reported the prior incidents of elopements to the state department. Admin stated facility tried to report the recent elopement of 11/5/25 but find out later that the fax report did not went through. During a concurrent interview and record review on 11/19/25 at 9:31 a.m. with Director of Nursing (DON), Resident 29's admission MDS assessment dated [DATE], EA s and progress notes were reviewed. DON stated Resident 29 had eloped on more than one occasion. DON stated she was not aware that Resident 29's risk for elopement was not addressed with care plan because DON was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hired after Resident 29's admission to the facility. DON stated facility intervention included monitoring location and wander guard. DON stated Resident 29 continued to elope because Resident 29 removed his wander guard. DON stated Interdisciplinary team (IDT-an interdisciplinary team is a group of professionals from different fields who collaborate to address complex residents' need) had not met to review Resident 29's repeated episode of elopement. DON could not provide comprehensive care plan that addressed Resident 29's risk for wandering and elopement, repeated incidents of Resident 29's elopements with appropriate interventions with each incident of elopement.During a review of the facility's policy and procedure (P&P) titled, Unusual Occurrences Reporting, dated 2001, the P&P indicated, As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations.During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopements, dated 2001, the P&P indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.