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	05/20/2026

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, the facility failed to ensure one of three sampled resident's (Resident 1) care plans was revised and updated. The facility also failed to complete post-fall assessment risk and conduct an IDT meeting following each fall. This failure resulted in Resident 1's fall care plan not being updated to include post-fall interventions, which placed Resident 1 at increased risk for accidents and injuries.During a review of Resident 1's admission Record (AR), dated 01/13/26, the AR indicated, Resident 1 had a diagnosis of Adreno myeloneuropathy (condition that makes a person's muscles weak and have walking difficult), muscle weakness, and difficulty in walking.During a review of Resident 1's Annual Minimum Data Set (MDS, an assessment tool used to evaluate a resident's functional capabilities, health needs, and clinical status), dated 4/29/25, the MDS indicated Resident 1 was able to understand others and make self-understood.During a review of Resident 1's admission Brief Interview for Mental Status (BIMS), (BIMS, an assessment for mental status), dated 1/28/26, indicated a score of zero (0) out of 15, which indicated severe cognitive impairment.During a concurrent observation and interview on 5/20/26 at 10:10 a.m. with Resident 1, Resident was observed in bed with the head of the bed elevated at 30 degrees. Call light attached to resident's left quarter rails and bed in low position. No floor mat observed on floor at bedside. Resident's bedside table is on her right with water pitcher. Resident 1 stated, My leg is okay, There's some pain on it. They give me medicine. Resident 1 was unable to recall how her knee was injured or if she fell.During a concurrent observation and interview on 5/20/26 at 10:20 a.m. with Licensed Vocational Nurse (LVN) 1, in Resident 1's room, no floor mat was in place near Resident 1's bed. LVN 1 stated, there was no safety mat near Resident 1's bed. LVN 1 also stated, Resident 1's care plan did not list a floor mat near Resident 1's bed as an intervention.During a review of Resident 1's fall care plan (CP), originally dated 7/24/2024, the CP indicated, Resident 1 is high risk for falls. CP also indicated did not indicate floor mat as part of intervention.During an interview on 5/19/26 2:51p.m., with DON stated there should always be a post IDT meeting for every fall.During a concurrent interview and record review on 5/20/26 at 10:45 a.m. with DON, Resident 1's IDT Post Fall Review (IDT 1) dated 4/16/25 was reviewed. The IDT 1 summary indicated Resident 1 had an unwitnessed fall with bleeding to left eyebrow and was sent to ER. The record indicated that Resident 1 had a prior fall on 9/24/24 with no injury. IDT 1 listed interventions as bed to be in lowest position, and call light to be in reach. IDT Post Fall review (IDT 2) dated 5/21/25 indicated Resident 1 had an unwitnessed fall and was found next to bed in an upright sitting position. The IDT 2 Summary listed intervention to keep bed in lowest position, keeping call light within reach, and resident to ask staff for assistance. No new interventions were added. The DON stated that the facility had no additional IDT documentation for falls on 9/13/24, 6/16/25, 12/31/26.During a concurrent interview and record review on 5/20/26 at 10:45 a.m. with the DON, Resident 1's Morse Fall Scale (MFS) assessments dated 10/30/24, 1/30/25, and 7/24/25 were reviewed. The MFS scores were 75 on 10/30/24, 75 on 1/30/25, and 65 on 7/24/25, indicating Resident 1 remained at high risk for falls during each assessment period. The record did not contain MFS assessment completed after each of Resident 1's subsequent falls. The DON stated that the facility had no additional documentations showing post-fall (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk assessments were conducted. During a review of the facility's policy and procedure titled, Falls and Fall risk, Managing (P&P), dated reviewed March 2018, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 implement and revise individualized fall-prevention interventions for one of three sampled residents (Resident 1), with severe cognitive impairment, impaired mobility, and a documented history of recurrent falls. This failure resulted in Resident 1 sustaining a fall and without additional individualized fall-prevention interventions following recurrent falls, placed Resident 1 at continued risk for additional falls, accidents and injuries.During a review of Resident 1's admission Record (AR), dated 01/13/26 with original admission date on 7/23/2024, the AR indicated, Resident 1 had a diagnosis of Adreno myeloneuropathy (condition that makes a person's muscles weak and have walking difficult), muscle weakness, and difficulty in walking.During a review of Resident 1's Annual Minimum Data Set (MDS, an assessment tool used to evaluate a resident's functional capabilities, health needs, and clinical status), dated 4/29/25, the MDS indicated Resident 1 was able to understand others and make self-understood.During a review of Resident 1's admission Brief Interview for Mental Status (BIMS), (BIMS, an assessment for mental status), dated 1/28/26, indicated a score of zero (0) out of 15, which indicated severe cognitive impairment.During a concurrent observation and interview on 5/20/26 at 10:10 a.m. with Resident 1, Resident 1 was observed in bed with the head of the bed elevated to 30 degrees. Call light attached to resident's left quarter rails and bed in low position. No floor mat observed on floor at bedside. Resident 1 stated, My leg is okay, There's some pain on it. They give me medicine. Resident 1 was unable to recall how her knee was injured or if she fell.During a concurrent observation and interview on 5/20/26 at 10:20 a.m. with Licensed Vocational Nurse (LVN) 1, in Resident 1's room, no floor mat was in place near Resident 1's bed. LVN 1 stated, there was no safety mat near Resident 1's bed. LVN 1 also stated, Resident 1's care plan did not list a floor mat near Resident 1's bed as an intervention.During an interview on 5/20/26 at 1:30 p.m., LVN 2 stated, that staff ensure beds are kept in the lowest position and that floor mats are ordered for residents who have had multiple falls. LVN 2 stated, that if a fall cannot be prevented, the mat provides a cushion for the fall instead of the resident landing directly on the floor. LVN 2 stated, there is no reason for Resident 1 not to have a floor mat. LVN 2 stated, Resident 1 used to have a floor mat there.During an interview on 5/20/26 at 11:56 a.m., Certified Nurse Assistant 1 stated, there were no additional interventions put in place besides keeping the bed in low position to prevent additional falls. CNA stated, Resident 1 did not have any side rails.During an interview on 5/20/26 at 10:22 a.m. with Resident 1's roommate, Resident 2, Resident 2, stated Resident 1 is unable to walk and frequently attempts to get out of bed without assistance. Resident 2 stated, Resident 1 forgets she cannot walk and attempts to get out of bed, which has resulted in falls and injury. Resident 2 stated, she attempts to redirect Resident back to bed, however, Resident 1 does not listen. Resident 2 stated, not many staff speak Resident 1's language. Resident 2 stated, Resident 1 did not have a television or telephone, and that they had been roommates for one year.During a review of Resident 2's Quarterly Brief Interview for Mental Status (BIMS), (BIMS, an assessment for mental status), dated 2/21/26, indicated a score of 15 out of 15, which indicated no cognitive impairment.During a concurrent interview and record review on 5/20/26 at 2:25 p.m., with the [[NAME] delte the] Director of Nursing (DON), Resident 1's fall care plan dated 7/24/2024 was reviewed. The care plan indicated that Resident 1 had falls on 9/13/24, 4/15/25, 5/19/25, 6/16/25, and 12/31/25. DON agreed, Resident 1 is a high fall risk and acknowledged no additional interventions were implemented following the documented falls. DON stated, there should always be interventions after a fallDuring a record review of the facility's Policy and Procedure (P&P) titled, Falls and Fall risk, Managing revised on March 2018, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	falling and to try to minimize complications from falling The policy further indicates under resident centered approaches to managing falls and fall risk that, If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.