

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Kyakameena Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>46194</p> <p>Based on interview, record review, document review, and facility policy review, the facility failed to act upon the Consultant Pharmacist's recommendation for 2 (Resident #2 and Resident #32) of 5 sampled residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>A facility policy titled, Consultant Pharmacist Reports, effective date 06/2021, revealed, The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy.</p> <p>1. An Admission Record revealed the facility admitted Resident #2 on 11/15/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of heart failure.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/23/2024, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.</p> <p>Resident #2's Order Summary Report with active orders as of 06/19/2024, revealed an order dated 11/30/2023 for mometasone furoate inhalation aerosol 200 micrograms per actuation 2 puffs inhale orally twice daily for asthma.</p> <p>The Consultant Pharmacist's Medication Regimen Review, for recommendations created between 05/01/2024 and 05/05/2024, revealed please add to Resident #2 order for mometasone rinse mouth with water after use, do not swallow the water.</p> <p>2. An Admission Record revealed the facility admitted Resident #32 on 01/17/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of hypertension.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/24/2024, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment.</p> <p>(continued on next page)</p>

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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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #32's Order Summary Report with active orders as of 06/20/2024, revealed an order dated 03/05/2024 for Eliquis oral tablet 2.5 milligrams (mg) (apixaban) give one tablet by mouth two times a day for deep vein thrombosis prophylaxis.</p> <p>The Consultant Pharmacist's Medication Regimen Review, for recommendations created between 05/01/2024 and 05/05/2024, revealed Resident #32 had an order for apixaban and the Consultant Pharmacist recommended the facility add shift monitoring to detect any bleeding.</p> <p>Resident #32's Medication Administration Record for 06/2024, revealed evidence to indicate staff monitored Resident #32 for bleeding prior to 06/20/2024.</p> <p>In an interview on 06/20/2024 at 8:29 AM, the Director of Nursing (DON) stated he started the position of DON on 05/01/2024. The DON stated he had not gotten the Consultant Pharmacist's MRR for May 2024. According to the DON, the Consultant Pharmacist recommendations for Resident #2 and Resident #32 had not been acted upon.</p> <p>In an interview on 06/20/2024 at 10:06 AM, the Consultant Pharmacist stated the recommendation should have been addressed by now.</p> <p>In an interview on 06/20/2024 at 10:46 AM, the Administrator stated staff should update a resident's physician order with recommendations from the Consultant Pharmacist.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>18639</p> <p>Based on observation, record review, interview, document review, and facility policy review, the facility failed to ensure a medication error rate of less than 5%. The facility had 4 medication errors out of 26 opportunities, which yielded a medication error rate of 15.38% for 1 (Resident #40) of 4 residents observed for medication administration.</p> <p>Findings included:</p> <p>A facility policy titled, Medication Administration Oral Inhalations, dated 05/2016, indicated, 14. If another puff of the same or different medication is required, follow the manufacturer's product information for administration instructions including the acceptable wait time between inhalations.</p> <p>The undated Dulera Patient Information, revealed, 10. Wait at least 30 seconds to take your second puff of Dulera.</p> <p>A facility policy titled, Medication Administration General Guidelines, dated 09/2018, indicated, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Per the policy, 1. Medications are administered in accordance with written orders of the prescriber.</p> <p>An Admission Record indicated the facility admitted Resident #40 on 12/13/2022. According to the Admission Record, the resident had medical history that included a diagnosis of amyotrophic lateral sclerosis (ALS).</p> <p>Resident #40's Order Summary Report, with active orders as of 06/19/2024, revealed an order dated 08/09/2023, for Dulera (a medication used to treat asthma) Aerosol 200-5 micrograms per action, inhale two puffs two times daily to decrease inflammation in the lungs. The Order Summary Report revealed an order dated 12/13/2022, for omega-3 fatty acid capsule (a medication used to lower triglyceride levels in adults) 500 milligrams by mouth daily for cholesterol control; Peridex Solution (an antiseptic mouthwash used to treat gingivitis) 0.12%, give 15 milliliters every 12 hours for oral care; and riluzole (a prescription medication used for the treatment of ALS) 50 mg one tablet by mouth every 12 hours related to ALS.</p> <p>During a medication administration observation on 06/18/2024 at 9:07 AM, Licensed Vocational Nurse (LVN) #1 administered one puff of the Dulera to Resident #40 followed by a second puff five seconds later. LVN #1 did not administer omega-3 fatty acid capsule, riluzole, or the Peridex Solution to Resident #40 during the medication administration observation.</p> <p>During an interview on 06/18/2024 at 12:11 PM, LVN #1 stated she did not administer the omega-3 fatty acid, riluzole, or the Peridex Solution to Resident #40. LVN #1 confirmed she did not wait at least 30 seconds to administer the second puff of Dulera to Resident #40.</p> <p>During an interview on 06/18/2024 at 12:45 PM, the Director of Nursing stated he expected staff to administer medications according to the physician's orders and per the manufacturer's instructions.</p> <p>(continued on next page)</p>		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/2024 at 10:18 AM, the Administrator stated she expected staff to administer medications according to the physician's orders and per the manufacturer's instructions.		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>46194</p> <p>Based on interview, record review, and facility policy review, the facility failed to transcribe a physician's order for wound care for 1 (Resident #2) of 14 sampled residents.</p> <p>Findings included:</p> <p>A facility policy titled, Wound Care, revised in 10/2010, revealed, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation 1. Verify that there is a physician's order for this procedure.</p> <p>An Admission Record revealed the facility admitted Resident #2 on 11/15/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of heart failure.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/23/2024, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.</p> <p>Resident #2's care plan, initiated on 11/16/2023, revealed the resident had potential/actual skin impairment to skin integrity related to suspected deep tissue injury.</p> <p>Resident #2's Surgical Consult dated 06/12/2024, revealed the physician was asked to see the resident for their opinion on how to manage the resident's wound located on the left inferior knee. The Surgical Consult revealed the wound dressing used was gentamicin (an antibiotic used to treat skin infections), Bactroban (an antibiotic used to treat skin infections), skin prep, and boarded foam. According to the Surgical Consult, the resident's wound was stable and required continued topical wound dressing as noted above.</p> <p>Resident #2's Order Summary Report, with active orders as of 06/19/2024, revealed no order no order for the provision of wound care to the resident's left inferior knee.</p> <p>In an interview on 06/19/2024 at 3:46 PM, the Wound Physician stated Resident #2 had been on topical antibiotics for weeks. The Wound Physician stated that on 06/12/2024 she ordered gentamicin, Bactroban, skin prep, and boarded foam for the resident. The Wound Physician stated she expected the orders to be transcribed into the resident's medical record by the next day shift unless it was a renewal and it was already covered. The Wound Physician stated she did not know what happened or why there were not any wound care orders for the resident. According to the Wound Physician, the treatment nurse should transcribe the orders after rounds.</p> <p>In an interview on 06/20/2024 at 12:58 PM, the Director of Nursing (DON) stated the Wound Physician directed the residents' wound care and the staff were directed to follow their orders. The DON stated the treatment nurse should receive the order and transcribe the order into the resident's electronic medical record (EMR).</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/20/2024 at 1:13 PM, Licensed Vocational Nurse (LVN) #3 stated she performed wound care for Resident #2 daily. Per LNV #3, the wound treatment she provided was gentamicin and Bactroban ointment and covered the wound with foam dressing. LVN #3 stated she failed to transcribe the physician's order for wound care to the resident's EMR that was given to her by the Wound Physician.</p> <p>In an interview on 06/20/2024 at 1:41 PM, the Administrator stated staff should process and implement treatment orders.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>18639</p> <p>Based on observation, record review, interview, and document review, the facility failed to ensure enhanced barrier precautions were implemented for 1 (Resident #26) of 14 sampled residents.</p> <p>Findings included:</p> <p>The Enhanced Standard Precautions for Skilled Nursing Facilities (SNF), 2019 published by the California Department of Public Health (CDPH), revealed, CDPH recommends the use of Enhanced Standard precautions, primarily the use of gowns and gloves for specific care activities, based on the resident's characteristics that are associated with a high risk of MDRO [multidrug-resistant organism] colonization and transmission: Table 1. Characteristics of Residents at High Risk for MDRO Colonization and Transmission Functional Disability: Totally dependent on others for assistance with activities of daily living Incontinence: Habitual soiling with stool or wetting with urine Presence of indwelling devices: urinary catheter, feeding tube, tracheostomy tube, vascular catheters Ventilator-dependence Wounds or presence of pressure ulcer (unhealed) Implement Enhanced Standard Precautions for high risk residents: * Place the high-risk resident in a single bed room. When a single bed room is not available, cohort the resident with a compatible roommate, such as a resident with the same MDRO or resistance mechanism when known. * Wear gowns and gloves while performing the following tasks associated with the greatest risk for MRDO contamination of HCP [health care personnel] hands, clothes and the environment: * Morning and evening care * Device care, for example, urinary catheter, feeding tube, tracheostomy, vascular catheter * Any care activity where close contact with the residents is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, respiratory care</p> <p>An Admission Record indicated the facility admitted Resident #26 on 09/08/2020. According to the Admission Record, the resident had a medical history that included diagnoses of cutaneous abscess of buttock, cellulitis of buttock, functional quadriplegia, chronic osteomyelitis, and neuromuscular dysfunction of bladder.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 06/08/2024, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) of 13, which indicated the resident had intact cognition. The MDS indicated the resident was dependent upon staff for most activities of daily living, had an indwelling catheter, and one unstageable pressure ulcer.</p> <p>Resident #26's care plan initiated on 06/07/2021, indicated the resident had a reopened stage 4 pressure ulcer on their coccyx related to a history of ulcers and immobility. The resident also had another care plan, initiated on 03/11/2022, that indicated the resident had an indwelling catheter related to a diagnosis of neurogenic bladder.</p> <p>During an observation on 06/18/2024 at 1:42 PM, Certified Nurse Aide (CNA) #1 emptied Resident #26's indwelling catheter bag. CNA #1 wore gloves and did not put on a gown.</p> <p>During an observation on 06/18/2024 at 1:45 PM, CNA #2 provided incontinence care for Resident #26. can #2 wore gloves and a mask, but did not put on a gown.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 06/18/2024 at 1:50 PM, Licensed Vocational Nurse (LVN) #3 performed wound care for Resident #26. LVN #3 wore gloves during the wound care, but did not put on a gown.</p> <p>During an interview on 06/18/2024 at 2:14 PM, CNA #2 stated she was not required to use enhanced barrier precautions when she provided incontinence care for Resident #26.</p> <p>During an interview on 06/18/2024 at 2:16 PM, LVN #3 stated she was not required to use enhanced barrier precautions for the wound treatment. LVN #3 stated she believed enhanced barrier precautions would be required for emptying a catheter bag and for the provision of care for a resident who had a feeding tube.</p> <p>During an interview on 06/18/2024 at 2:18 PM, CNA #1 stated she was not required to use enhanced barrier precautions when she provided incontinence care or emptied a catheter bag unless the resident was in isolation and had signs on their door.</p> <p>During an interview on 06/19/2024 at 8:59 AM, the Infection Preventionist (IP) stated all three of the staff should have worn gloves and a gown for enhanced barrier precautions when they provided care for Resident #26. The IP stated the facility followed the Enhanced Standard Precautions for Skilled Nursing Facilities (SNF), 2019 developed by the California Department of Public Health.</p> <p>During an interview on 06/20/2024 at 10:09 AM, the Administrator stated she knew staff wore personal protective equipment as required and would expect them to wear a gown for enhanced barrier precautions when necessary.</p>		

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<p>F 0911</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31524</p> <p>Based on interview and document review, the facility failed to ensure 6 (Rooms 26, 27, 29, 31, 33, and 35) of 16 resident bedrooms in the facility did not have more than four residents.</p> <p>Findings included:</p> <p>The facility Daily Census, dated 06/17/2024, revealed five residents resided in room [ROOM NUMBER] and room [ROOM NUMBER] and six residents resided in Rooms 27, 29, 31, and 33.</p> <p>During an interview on 06/20/2024 at 10:04 AM, the Director of Nursing stated the facility had a room variance waiver in place for the rooms that had more than four occupied beds.</p> <p>During an interview on 06/20/2024 at 10:30 AM, the Administrator stated she expected staff to treat the residents in the rooms with more than four beds the same as all other residents in terms of quality of care and services.</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31524</p> <p>Based on interview and document review, the facility failed to ensure residents' rooms measured at least 80 square (sq) feet (ft) per resident in 6 (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) of 16 resident rooms in the facility.</p> <p>Findings included:</p> <p>The facility request for renewal of waiver for room size, dated 06/17/2024, revealed the following dimensions:</p> <ul style="list-style-type: none"> - In room [ROOM NUMBER], there was 78.42 sq ft for each resident. - In room [ROOM NUMBER], there was 78.42 sq ft for each resident. - In room [ROOM NUMBER], there was 77.59 sq ft for each resident. - In room [ROOM NUMBER], there was 77.59 sq ft for each resident. - In room [ROOM NUMBER], there was 77.59 sq ft for each resident. - In room [ROOM NUMBER], there was 77.59 sq ft for each resident. <p>During an interview on 06/20/2024 at 10:04 AM, the Director of Nursing stated the facility had a room size variance waiver in place for the rooms that provided less than the required 80 sq ft per resident.</p> <p>During an interview on 06/20/2024 at 10:30 AM, the Administrator stated she expected staff to treat the residents in the room with the room size variance waiver the same as all other residents in terms of quality of care and services.</p>