

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/21/2025
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)		
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. Based on interview and record review, for four (Resident 1,10, 19, and 27) of five sampled residents, the facility failed to ensure quarterly Minimum Data Set assessments (MDS - a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) were completed not less frequently than once every three months according to the regulation. This failure had the potential to result in delayed assessment of residents' needs, goals of care and inability to monitor each residents' progress over time. During a review of resident 1,10, 19, and 27's MDS assessment records the following quarterly MDSs were not completed every three months: Resident 1' MDS assessment indicated the last quarterly MDS assessment was completed on 10/28/25 over 120 days. Resident 10's MDS assessment indicated the last quarterly assessment was completed on 10/3/25 over 120 days. Resident 19's MDS assessment indicated the last quarterly assessment was completed on 10/12/25 over 120 days. Resident 27's MDS assessment indicated the last quarterly assessment was completed on 11/2/25 over 120 days. During an interview on 11/21/25 at 11:07 a.m. with MDS coordinator (MDSC), MDSC stated she was aware of the late completion of residents quarterly MDSs. MDSC stated she was recently hired and had been trying to catch up with the late MDSs. During an interview on 11/21/25 at 11:11a.m. with Administrator (Admin), Admin stated facility was aware of late completion of residents MDSs. Admin stated she newly hired staff to assist with the completion of residents MDSs. During a review of the Long -Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, dated October 2019, indicated the quarterly assessment should be completed not later than 14 days after ARD (Assessment Reference Date). The Quarterly assessment is used to track a resident's status to ensure critical indicators of gradual change in a resident's status are monitored. The quarterly assessment is an OBRA (Omnibus Budget Reconciliation Act) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. {Reference: https://downloads.cms.gov/files}		

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, for four (Resident 1,10,19, and 27) of five sampled residents, the facility failed to electronically transmit accurate and complete Minimum Data Set (MDS -a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), data to the CMS system within 14 days after completion of resident's assessment.Definition: CMS - The Centers for Medicare & Medicaid Services provides health coverage through Medicare and Medicaid-a government national health insurance program that provided health insurance for adults and children with limited income and resources.These failures had the potential to result in the delay of assessment of residents' needs, goals of care and inability to monitor each resident's progress over time. During a review of the MDS 3.0 Final Validation Report (FVR), dated 11/11/25, the FVR indicated Resident 1's quarterly assessment was completed on 10/14/25 and transmitted on 11/11/25.Review of MDS 3.0 FVR indicated Resident 10's quarterly assessments was completed on 9/19/25 and transmitted on 11/16/25.Review of MDS 3.0 FVR indicated Resident 19's quarterly assessment was completed on 10/12/25 and transmitted on 11/18/25.Review of MDS 3.0 FVP indicated Resident 27's quarterly assessment was completed on 10/13/25 and transmitted on 11/18/25.During an interview on 11/21/25 at 11:07 a.m. with MDS coordinator (MDSC), MDSC stated she was aware of the late completion of residents quarterly MDSs. MDSC stated she was recently hired and had been trying to catch up with the late MDSs.During an interview on 11/21/25 at 11:11a.m. with Administrator (Admin), Admin stated facility was aware of late completion of residents MDSs. Admin stated she newly hired staff to assist with the completion of residents MDSs.Review of the Long -Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17., dated October 2019, indicated the Assessment transmission: quarterly assessments must be transmitted electronically withing 14 days of the MDS completion date plus 14 days. {Reference: https://downloads.cms.gov/files}		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately code three out of four sampled resident's (Resident 27, 31 and 49) Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) when:1. For Resident 49 section B was not coded accurately for vision.2. Facility inaccurately coded No to No natural teeth or tooth fragments when Resident 27 has no natural teeth. This failure resulted in inaccurate reflection of Resident 27's oral/dental status and had the potential to affect Resident 27's nutrition, oral care, and dietary needs.3. Resident 31's hospice care item was incorrectly coded on MDS to reflect Resident 31's choice.These failures resulted in an inaccurate reflection of Resident 27 and 49's clinical condition which had the potential to affect their health care outcomes. 1.During a concurrent observation and interview on 11/20/25 at 8:36 a.m. with Resident 49, Resident 49 stated he had problem with seeing and using his computer. Resident 49 stated he was not able to read or use his laptop. Resident 49 said the eye doctor came to see him at the facility last year. Resident 49 stated eye doctor diagnosed that Resident 49 has Cataract and gave a referral to ophthalmology- facility to schedule appointment. Resident 49 stated the referral was presented to the staff. Resident 49 stated he had not seen the ophthalmologist and was frustrated and don't know what to do. During a review of Resident 49's Annual Minimum Data Set (MDS), Resident Assessment and Care Screening tool used to guide care, dated 8/21/25 section B indicated Resident 49 had adequate vision sees fine detail such as regular print in newspapers/books. During a concurrent interview and record review on 11/20/25 at 8:13 a.m. with MDS coordinator (MDSC), Resident 49 MDS section B - Hearing, Speech, and Vision dated 8/21/25 and Eyecare report dated 3/29/24 were reviewed. Eyecare report indicated Resident 49 had cataract. MDS section B indicated Resident 49 had adequate vision. MDSC stated that the MDS assessment section B was not coded accurately. 2.During a review of Resident 27's admission Record (AR) dated 11/20/25, the AR indicated Resident 27 was admitted to the facility in June 2018. During an observation on 11/18/25 at 1:01p.m., Resident 27 was observed lying in bed with no nature teeth and no dentures in place. On 11/20/25 at 1:43 p.m., during a concurrent interview and review of Resident 27's nursing admission screening/history dated 4/30/18, MDS Coordinator (MDSC) stated that the nursing admission screening/history indicated Resident 27 had no nature teeth. On 11/20/25 at 1:54 p.m., during a record review and interview with the MDSC, the annual MDS assessment dated [DATE] was reviewed. MDSC stated the item for no nature teeth to tooth fragments should have been coded as yes. MDSC stated that MDSC should assess the resident and review the nursing assessment prior to completing the MDS to ensure accuracy. 3. During a review of Resident 31's AR dated 11/21/25, the AR indicated Resident 31 was admitted to the facility in April 2025. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 31's Order Summary Report (OSR) dated 11/21/25, the OSR indicated an order for admission to Sutter Hospice on routine care with a terminal diagnosis of end stage renal disease (ESRD) dated 4/29/25. On 11/20/25 at 1:57 p.m., during an interview and review of Resident 31's MDS admission assessment dated [DATE], MDSC stated that the hospice care item was incorrectly coded. MDSC explained that it was a coding error and did not reflect Resident 31's choice.		

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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. 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]. (continued on next page)		

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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 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 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 (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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, (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 30 and 48) were provide toenails care and treatment, in accordance with professional standards of practice, when: 1. For Resident 30, facility did not provide appropriate toenails care and treatment for thick, long, brownish black toenails.2. For Resident 48, facility did not provide toenail fungal treatment and toenail trimming for 15 months.This failure resulted in Resident 30 and 48's overgrowth of toenails and increased risk for injury and infection.1.During a review of Resident 30's admission Minimum Data Set (MDS, a federally mandated resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 4/23/25, the MDS indicated Resident 30'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.) Resident 30's score was 09 meaning impaired cognition. MDS indicated Resident 30 was admitted to the facility on [DATE]. Resident 30 had clear speech, able to make self-understood and understood others. MDS indicated Resident 30's diagnoses included Diabetes Mellitus (DM - a chronic disease where the body doesn't make enough insulin causing high level of sugar in blood). During a concurrent observation and interview on 11/18/25 at 10:06 a.m. Resident 30 laid in bed, awake and verbally responsive. Resident 30 had long, thick brownish black toenails. Resident 30 stated he had requested staff to help with his toenail care and is waiting for their assistance. During a concurrent observation and interview on 11/18/25 at 10:13 a.m. with Assistant Director of Nursing (ADON), Resident 30 toenails was long, thick, brownish black coloration. ADON stated Resident 30 needed referral to podiatry. ADON stated facility process was for Certified Nursing Assistant (CNA) to report overgrown toenails and notified charge nurse who refers to podiatrist. During an interview on 11/18/2025 at 1:17 p.m. with Social Services Director (SSD), SSD stated Resident 30 was not seen by the podiatrist due to Resident 30's insurance. SSD stated the podiatrist only accept Medicare part B. 2.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 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 an observation and interview on 11/20/25 9:25 a.m., Resident 48 was observed lying in bed with long toenails on right 1st, 2nd and 3rd toes, and on the left 1st, 2nd, 3rd and 4th toes. Resident 48's two big toenails were thick, long, discolored yellow and brown and protruding, right 2nd, 3rd, left 2nd, 3rd and 4th toenails were long and curved downward, and left 2nd and 4th toenails were loose. Resident 48 stated she could flip the two loose toenails backward and was afraid they could be accidentally ripped off. Resident 48 stated she has not been seen by a podiatrist since her admission (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Kyakameena Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2131 Carleton Street Berkeley, CA 94704	
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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the facility. During an interview on 11/20/25 at 9:51 a.m., CNA 5 stated that she had reported to nurses and administrator that Resident 48's toenails need to be trimmed. CNA 5 stated it was difficult to assist the resident with putting on socks due to the long and loose toenails. During an interview on 11/20/25 at 8:45 a.m., Social Services Director (SSD) stated due to insurance reasons, Resident 48 has not been seen by the podiatrist. SSD stated she was not sure when Resident 48's toenails were last trimmed by a podiatrist. SSD stated residents should be seen by a podiatrist every 6 months and the team were working to ensure that Resident 48 would be seen by a podiatrist. During a record review of Resident 48's Order Summary Report (OSR) dated 11/20/25, the OSR indicated orders for podiatry care every 61 days as needed for mycotic (fungal-infected) nails, date 7/23/24, and a podiatry referral for fungal nail dated 10/22/25. During a review of the facility's policy and procedure (P&P) titled, Foot Care, dated October 2022, the P&P indicated, Residents with foot disorders or medical conditions associated with foot complications are referred to qualified professionals. Foot disorders that require treatment include corns, neuromas, calluses, hallux valgus, hammertoe, heel spurs, and nail disorder.		

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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.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on observation, interview and record review, the facility failed to complete a performance review for three out of three certified nursing assistants (CNA 2, 3, 4) at least once every 12 months. This failure had the potential for a lack of training for any potential deficiencies identified during the performance review process. During a review of personnel files, indicated CNA 2, 3, 4, hired 3/25, 2/22, 11/24 respectively, had no performance review for year 2025. During a concurrent interview and record review on 11/20/25 at 9:02 a.m. with the Director of Staff Development (DSD), CNA 2, 3, 4's CNA annual skills checklist dated 9/11/25, 10/16/25 and 11/4/25 respectively was reviewed, the DSD stated CNA 2, 3, 4 only had annual skills check list. The DSD stated there was no other form the facility had provided for the performance review. The DSD stated the CNA annual skills checklist was their performance review. During a follow up interview on 11/20/25 at 9:38 a.m. with the DSD, the DSD stated asking the facility Administrator (Admin), previous acting DSD and facility consultant for a copy of the performance review form when she first started as a DSD but was not provided. The DSD stated performance review should be completed from the date of hire and annually thereafter. The DSD stated the performance review would show how the CNA performs patient care. The DSD stated the performance review would help the CNA on what skills to improve on. During a concurrent observation and interview on 11/21/25 at 9:32 a.m. with the DSD, in front of nursing station 1, the DSD showed a form titled Employee Performance Review. The DSD stated the form will be used to complete the performance review. During a review of the facility's policy and procedure titled, Performance Evaluation, dated 6/10, indicated, 1. A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to implement its Legionella Water Management Program policy and procedures when facility did not have a water management program. This failure had the potential risk for Legionnaires' disease, and unsafe water usage. During an interview on 11/21/25 at 8:55 a.m. with Administrator (Admin), Admin stated facility did not have a program for managing water systems to prevent Legionnaires' disease and had not tested water for legionella. During a review of the facility's policy and procedure (P&P) titled, Legionella Water Management Program, revised September 2022, the P&P indicated, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review the facility failed to ensure one (Resident 4) of seven sampled residents' rights was free from misappropriation of property and exploitation when Resident 4's missing pants and tops were not replaced or reimbursed. This failure had the potential to cause Resident 4 emotional distress. During a review of Resident 4's admission Minimum Data Set (MDS- a federally mandated resident assessment and care guide tool), dated 7/13/25, the MDS indicated Resident 4'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.) Resident 4's score was 13 meaning intact cognition. Resident 4 had clear speech, able to make self-understood and understood others. MDS indicated Resident 4's diagnoses included Depression (a serious mood disorder characterized by persistent feelings of sadness or loss of interest which negatively impact daily life).During an interview on 11/20/25 at 11:57 a.m. with Resident 4, Resident 4 stated she reported missing five jeans' pants, three tops and underwear to the staff and Director of Nursing (DON) last month. Resident 4 stated her closet, and laundry were checked by staff and could not find her missing personal possession. Resident 4 stated DON was aware of her missing personal items. Resident 4 said DON asked Resident 4's daughter to replace her missing pants and tops and then facility will reimburse Resident 4's daughter. Resident 4 stated she did not want her daughter to take up the responsible of replacing missing items because Resident 4's daughter struggled financially. During a review of Resident 4's Inventory of Personal Possessions (IPP) dated 7/7/25, the IPP indicated one shirt, pants, socks, brassier and jacket were identified upon admission to the facility and entered into Resident 4's IPP record.During an interview on 11/20/25 at 12:04 p.m. with DON, DON stated she was aware of Resident 4's missing pants and tops. DON stated Resident 4's daughter was asked to replace the missing items and facility will reimburse. DON stated she was not aware Resident 4's daughter struggle financially.During an interview on 11/20/25 at 3:54 p.m. with Administrator (Admin), Admin stated she was aware of Resident 4 missing pants and tops. Admin stated Resident 4's daughter was asked to replace the missing pants and tops and facility will reimburse her.During a review of the facility's policy and procedure (P&P) titled, Investigating Incidents of Theft and/or Misappropriation of Resident Property, revised April 2017, the P&P indicated, Residents are not required or requested to waive facility liability for loss or misappropriation of personal property.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 3 and Resident 4) Preadmission Screening and Resident Review (PASRR) were screened accurately and referred to the appropriate state mental authority for Level II PASRR evaluation and determination when Resident 3 and 4 with diagnosis of schizophrenia, bipolar and major depression were screened and documented as not having serious mental illness.(PASRR is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are appropriately placed in nursing homes for long term care).This failure had the potential to prevent residents from receiving appropriate required mental health services. During a review of Resident 3's Annual Minimum Data Set (MDS-an assessment screening tool used to guide care), dated 8/18/25 the MDS indicated Resident 3 was admitted to the facility on [DATE] with diagnosis that included schizophrenia (a severe mental health condition that causes a breakdown between a person's thoughts and reality) Bipolar disorder (a mental health condition characterized by intense shifts in mood, energy, and activity levels, ranging from manic highs to depressive lows) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).During a concurrent interview and record review on 11/18/25 at 2:34 p.m. with Director of Nursing (DON) and Administrator (Admin) Resident 3's PASRR Level I screening dated 8/21/18 was reviewed. PASRR Level I indicated Resident 3 did not had a diagnosis of serious mental illness. DON stated Resident 3's PASRR Level I was not accurately screened or referred to the appropriate state mental authority for Level II PASRR evaluation and determination.During a review of Resident 4's admission Minimum Data Set (MDS-an assessment screening tool used to guide care), dated 7/13/25, the MDS indicated Resident 4 was admitted to the facility on [DATE] with diagnosis that included Major Depressive Disorder (a mental health condition characterized by persistent feelings of sadness and hopelessness). During a concurrent interview and record review on 11/18/25 at 2:34 p.m. with Director of Nursing (DON) and Administrator (Admin), Resident 4's PASRR Level I screen dated 7/5/25 was reviewed. PASRR Level I indicated Resident 4 did not have a diagnosis of serious mental illness. DON stated Resident 4's Level I PASRR was initiated from hospital before admission to facility. Admin stated facility's process was for the admission coordinator to review residents PASRR upon admission from the hospital and determine if there is required follow up. DON stated Resident 4's PASRR Level I was not accurately screened or referred to the appropriate state mental authority for Level II PASRR evaluation and determination.During a review of the facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review (PASRR), dated August 2025, the P&P indicated, The PASRR Level 1 screening is used to identify if an individual that is being admitted to a nursing facility has or is suspected of having a serious mental illness (SMI) or ID/DD/RC.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on interview, and record review the facility failed to ensure one of three sampled residents (Resident 49) was provided appropriate treatment and services to maintain or improve functional mobility to carry out the activities of daily living, when: For Resident 49 facility did not provide Restorative Nursing Services (RNA) treatment for decline in functional mobility as ordered by the physician. RNA is restorative nursing care consisting of nursing interventions to help promote optimal safety and independence. During a review of Resident 49's Minimum Data Set (MDS- a federally mandated resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 8/21/25, the MDS indicated Resident 49'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). Resident 49's score was 13 meaning intact cognition. Resident 49 had clear speech, able to make self-understood and understood others. MDS indicated Resident 49's diagnoses included anxiety disorder (a group of mental health conditions characterized by persistent and excessive feelings of worry, fear or panic that impair daily life), and Depression (a serious mood disorder characterized by persistent feelings of sadness or loss of interest which negatively impact daily life).During an interview on 11/20/25 at 8:36 a.m. with Resident 49, Resident 49 stated he needed regular exercise to help with his mobility. Resident 49 request regular exercise to walk outside of the facility twice a day as ordered by his physician. Resident 49 stated he was walked sometimes once a day and most days nobody walks him. During a review of Resident 49's physician order dated 9/23/25, the physician order indicated, Resident 49 to receive RNA walk two times a day, three times weekly without a front wheel walker on Tuesday, Thursday, Sunday for 12 weeks.During a concurrent interview and record review on 11/20/25 at 9:02 a.m. with Restorative Nursing Assistant (RNA 1), Resident 49 physician order dated 9/23/25 was reviewed. RNA 1 stated Resident 49 was on RNA program. RNA 1 stated she was not aware of the order to walk Resident 49 twice daily. RNA 1 stated she walked Resident 49 once daily when RNA 1 was on duty. RNA 1 could not provide Resident 49's RNA treatment records from September 2025 to November 2025.During a review of Resident 49's at risk for decline in functional mobility, dated 9/29/25, care plan indicated Resident 49 is at risk for decline in functional mobility. Resident 49's care plan indicated interventions included, RNA two times a day, three times a week. Resident 49 to walk for 30 minutes twice a day outside. Maybe walk inside due to weather with supervision level without front wheel walker FWW).During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Services, dated July 2017, the P&P indicated, Residents will receive restorative nursing care as needed to help promote optimal safety and independence		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 49) was assisted to receive proper vision treatment to maintain vision when Resident 49 was not assisted with referral for cataract surgery as ordered by the doctor. This failure had the potential to cause Resident 49 decline in vision, blindness and emotional distress. During a review of Resident 49's Minimum Data Set (MDS- a federally mandated resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 8/21/25, the MDS indicated Resident 49'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). Resident 49's score was 13 meaning intact cognition. Resident 49 had clear speech, able to make self-understood and understood others. MDS indicated Resident 49's diagnoses included anxiety disorder (a group of mental health conditions characterized by persistent and excessive feelings of worry, fear or panic that impair daily life), and Depression (a serious mood disorder characterized by persistent feelings of sadness or loss of interest which negatively impact daily life). During an interview on 11/20/25 at 8:36 a.m. with Resident 49, Resident 49 stated that he had problem with his vision. Resident 49 stated he was not able to read or use his lap top computer. Resident 49 said eye doctor came to see him at the facility last year. Resident 49 stated the eye doctor diagnosed that Resident 49 had Cataract in the right eye and gave referral for ophthalmology consult and facility to schedule appointment. Resident 49 stated the referral was presented to the staff. Resident 49 stated he had not seen ophthalmologist and was frustrated and don't know what to do. During a review of Resident 49's medical record, titled, Advanced Eyecare dated 3/29/24, the eye care record indicated, Resident 49 was seen by eye doctor and diagnosed with cataract right eye with referral to ophthalmology - facility to schedule appointment. During a review of Resident 49's Order Summary Report (OSR), dated 7/3/24, the OSR indicated physician ordered that facility may refer Resident 49 to ophthalmology for cataract surgery. During an interview on 11/20/25 at 8:13 a.m. with Social Services Director (SSD), SSD stated usually eye doctor visit facility every six months. SSD stated that Resident 49's insurance did not cover vision and was not seen by the eye doctor. During a review of the facility's policy and procedure (P&P) titled, Visually Impaired Resident, Care of, dated 2001, the P&P indicated, It is our responsibility to assist the resident and representatives in locating available resources (e.g., Medicare, Medicaid or local organizations), scheduling appointments and arranging transportation.		

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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 11/21/2025
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)		
F 0698 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for three of three sampled residents (Resident 9, 19, and 55) the facility failed to have a formal written agreement with dialysis provider for residents needing dialysis (a treatment for kidney failure to remove waste products and excess fluids by external filtration of blood), that outline responsibilities for care coordination, communication, and emergency preparedness. This failure had the potential for Residents 9, 19 and 55 to not receive consistent care that meets professional standards. During a review of Resident 19's admission Record (AR) dated 11/21/25, the AR indicated Resident 19 was admitted on [DATE] with principal diagnosis of end stage renal disease (ESRD- is the final stage of kidney failure, where the kidneys are no longer able to function adequately to keep the body healthy). During a review of Resident 19's Order Summary Report (OSR) dated 4/20/23, OSR indicated, physician prescribed Resident 19 to receive hemodialysis every Monday, Wednesday and Friday at a dialysis provider. During a review of Resident 55's admission Record (AR), the AR indicated on 12/13/24 Resident 55 was diagnosed with end stage renal disease (ESRD). During a review of Resident 55's Order Summary Report (OSR) dated 5/13/25, OSR indicated, physician prescribed Resident 55 to receive hemodialysis every Monday, Wednesday and Friday at a dialysis provider. During an interview on 11/20/25 at 10:28 a.m. with Administrator (Admin), Admin stated facility did not have a written agreement between the nursing home and the dialysis provider that details responsibilities for care and communication and emergency. During an interview on 11/21/25 at 8:50 a.m. During an interview with Admin, Admin stated she had tried to reach out to dialysis provider but had not been able to contact the dialysis management. 2. During a review of Resident 9's admission Record, printed on 11/21/25, the admission Record indicated Resident 9 was admitted in the facility on 10/28/25 with a diagnosis of ESRD. During a review of Resident 9's Order Summary Report, dated 10/28/25, the Order Summary Report indicated Resident 9 had an order to receive dialysis every Monday, Wednesday and Friday at a dialysis provider for ESRD. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), the MDS dated [DATE] indicated Resident 9 had dialysis treatments while a resident in the facility. During an interview on 11/21/25 at 8:43 a.m. with the Admin, the Admin stated having difficulty getting contract from administrators of the dialysis center after trying to reach out.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review, the facility had six resident rooms (room [ROOM NUMBER], 27, 29, 31, 33, and 35) that accommodated more than four residents in each room. This failure had the potential to result in inadequate space for the delivery of care to each of the residents in each room, or for storage of the residents' belongings. Findings: Room Number Number of Bedroom [ROOM NUMBER] 5 bedroom [ROOM NUMBER] 6 bedroom [ROOM NUMBER] 6 bedroom [ROOM NUMBER] 6 bedroom [ROOM NUMBER] 6 bedroom [ROOM NUMBER] 5 beds During an interview on 11/20/25 at 11:14 a.m. with Resident 24, Resident 24 stayed in a room that accommodated more than four residents. Resident 24 stated that he had enough space for storage of his belonging and was comfortable had no complaints regarding bed space. During random observation of care and services from 11/18/25 through 11/21/25, there was sufficient space for the provision of care for the residents in all rooms. There was no heavy equipment kept in the rooms that might interfere with residents' care and each resident had adequate personal space and privacy. There were no complaints from residents regarding insufficient space for their belongings. There were no negative outcomes attributed to the decreased space and/ or safety concerns in the six rooms. Recommend granting waiver of number residents per room.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility had six resident rooms (room [ROOM NUMBER], 25, 27, 29, 31 and 33) with multiple beds that provided less than 80 square feet 9sq ft) per resident who occupied these rooms.This failure had the potential to result in inadequate space for the delivery of care to each of the residents in each room or for storage of the residents' belongings. During an observation on 11/20/25 at 11:11 a.m. the following rooms had corresponding square footage (sq. ft.0 per bed were identified: Room Activity Room Size Floor Area23 Rt room [ROOM NUMBER].3 sq. ft 78.42 sq. ft/bed25 Rt room [ROOM NUMBER].3 sq. ft 78.42 sq. ft/bed27 Rt room [ROOM NUMBER].6 sq. ft 77.59 sq. ft/bed29 Rt room [ROOM NUMBER].6 sq. ft 77.59 sq. ft/bed31 Rt room [ROOM NUMBER].6 sq. ft 77.59 sq. ft/bed33 Rt room [ROOM NUMBER].6 sq. ft 77.59 sq. ft/bed During an interview on 11/20/25 at 11:14 a.m. with Resident 24, Resident 24 stayed in a room that accommodated more than four residents. Resident 24 stated that he had enough space for storage of his belonging and was comfortable had no complaints regarding bed space. During an interview on 11/20/25 at 11:49 a.m. with Certified Nursing Assistant (CNA 1), CNA 1 stated it was manageable to care for residents in rooms with more than four residents. CNA 1 stated it was easy to use shower chair and lifts in these rooms with no problem. During random observation of care and services from 11/18/25 through 11/21/25, there was sufficient space for the provision of care for the residents in all rooms. There was no heavy equipment kept in the rooms that might interfere with residents' care and each resident had adequate personal space and privacy. There were no complaints from residents regarding insufficient space for their belongings. There were no negative outcomes attributed to the decreased space and/ or safety concerns in the six rooms. Granting of room waiver recommended.		