

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2025
NAME OF PROVIDER OR SUPPLIER Chaparral House		STREET ADDRESS, CITY, STATE, ZIP CODE 1309 Allston Way Berkeley, CA 94702	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to maintain a safe, comfortable and homelike environment when Resident 1's bedside table had scratched marks on top and had chipped edges. This failure resulted in Resident 1 feeling angry. On 12/26/25 at 10:40 a.m., an unannounced visit was made at the facility to investigate a complaint allegation. During a phone interview on 12/26/25 at 2:03 p.m., Resident 1 stated when she was living at the facility, her bedside table had scratch marks on top and peeled edges. Further stated she felt angry about this. During a review of Resident 1's Facesheet, it indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included depression (a mental health disorder characterized by persistently sad mood or loss of interest in activities, causing significant impairment in daily life) and was discharged from the facility on 9/9/25. Review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 8/11/25 indicated a BIMS (Basic Interview of Mental status) score of 15 (meaning Resident 1 was cognitively intact). During a concurrent observation and interview on 12/26/25 at 2:15 p.m., with the Director of Nursing (DON) in the room where Resident 1 used to reside, the bedside table was observed to have scratch marks on top and had chipped edges. The DON described the bedside table as an old furniture. Also, the wall facing the bathroom was observed to have areas of chipped paint. During a concurrent observation and interview on 12/26/25 at 2:33 p.m., with the Maintenance Assistant (MA) in Resident 1's former room, MA described the wall's paint as chipping and stated that the wall with chipped paint had been in that condition for a few months. MA acknowledged that the condition of the room's wall was not homelike. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, revised February 2021, the P&P indicated, Residents are provided with a safe, clean, comfortable and home like environment .1. Staff provides person-centered care that emphasizes the residents comfort, independence and personal needs and preferences. 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, home like setting. These characteristics include: .c. inviting colors and decor .</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555872
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from significant medication errors when Resident 1 received the medication Percocet instead of Norco (Percocet is the brand name for oxycodone/acetaminophen and Norco is the brand name for hydrocodone/acetaminophen for pain. Both medications are for pain but have different opioid ingredients. Opioids are very powerful type of drugs used for pain relief). This failure exposed Resident 1 to the risk of adverse medication effects and discomfort. During a review of Resident 1's Face Sheet, it indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included right femur fracture (broken bone in right thigh bone). A review of Physician's orders dated 8/5/25, indicated an order of Norco or Hydrocodone-Acetaminophen oral tablet 10-325 milligrams (mg., a form of measurement), give one tablet by mouth every four hours as needed for severe pain. During an interview on 12/26/25 at 12:46 p.m. with the Director of Nursing (DON), DON stated that on 8/6/25, two doses of Percocet 10/ 325 mg. (two doses totaled to two tablets) were taken from the E-kit and were given to Resident 1 for pain instead of the ordered Norco 10/325 mg. DON acknowledged this was a medication error and stated the adverse effects for the resident receiving Percocet could have been respiratory distress due to an allergic reaction (an Emergency Kit or E-kit is a small, pre-stocked supply of medications kept in the facility to quickly treat common, sudden symptoms like pain, nausea, or anxiety). A review of Incident of Emergency Kit Non-Compliance, dated 9/5/25, it indicated: Percocet 10/325 mg. tablets (#2 tabs taken on 8/06/25) - Nurse mistakenly took the wrong medication out of the E-kit. (Incident of Emergency Kit Non-Compliance was a document sent by the pharmacist which referred to the facility's failure to follow the rules for using the emergency medication supplies in the E-kit). During a review of the facility's Post Event Review dated 9/8/25, it read: Nurse mistakenly removed Percocet 10/325 mg. from E-kit instead of intended medication. the nurses acknowledged the error. (a post-event review is a comprehensive analysis meeting conducted by the facility after an event to identify areas for improvement, inform future planning or evaluate its success). During an interview on 12/30/25 at 1:00 p.m. with Pharmacist Consultant (PC), PC stated the nurses made medication errors and should have given the correct medication of Norco 10/325 tablet instead of Percocet 10/325 tablets from the E-kit. Further stated the risks of giving Percocet was the possibility for Resident 1 to experience adverse side effects like sedation, nausea and hallucinations. During a review of the facility's policy and procedure (P&P) titled, Administering Medications revised April 2019, the P&P indicated, . 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method(route) of administration before giving the medication .</p>		