KYAKAMEENA SNF

PAGE 02/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/13/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 055715 B. WING NAME OF PROVIDER OR SUPPLIER 11/07/2013 STREET ADDRESS CITY STATE, ZIP CODE KYAKAMEENA CARE CENTER 2131 CARLETON STREET BERKELEY, CA 94704 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES In PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY** K 000 INITIAL COMMENTS K 000 K 000 This Plan of Correction constitutes my K3 BUILDING: 01 written credible allegation of compliance for the deficiencies noted. K6 PLAN APPROVAL: 1967 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: TWO STORY. CONSTRUCTION TYPE V. (III), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 Edition, Existing codes. Representing the California Department of Public Health: 31070 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. K 018 Census: 55 K 018 NFPA 101 LIFE SAFETY CODE STANDARD How corrective action(s) will be K 018 accomplished for those residents found SS=E Doors protecting corridor openings in other than to have been affected by the deficient required enclosures of vertical openings, exits, or practice? hazardous areas are substantial doors, such as The Hopper room located on the first floor those constructed of 13/4 Inch solid-bonded core will be repaired by maintenance staff to wood, or capable of resisting fire for at least 20 ensure it can close and latch properly. minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is 2. The left side of the self-closing double no impediment to the closing of the doors. Doors doors to the Linen closet between Room 28 are provided with a means suitable for keeping and Room 30 on the first floor will be the door closed. Dutch doors meeting 19.3.6.3.6 repaired by maintenance staff to ensure it are permitted. 19.3.6.3 can close and latch properly.

n an asiensk () denotes a deliciency which the institution may r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

PRINTED: 11/13/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 055715 B. WING 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2131 CARLETON STREET KYAKAMEENA CARE CENTER BERKELEY, CA 94704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OF LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) The gum on the latching mechanism on K 018 Continued From page 1 K 018 the door to the Patio Room located on the first floor will be removed by maintenance Roller latches are prohibited by CMS regulations staff and will repair to ensure it can close in all health care facilities. and latch properly. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice. Maintenance staff will be responsible to This STANDARD is not met as evidenced by: inspect all doors during Daily Maintenance Based on observation, the facility failed to Rounds to ensure that all doors have the maintain their doors as evidenced by self-closing ability to close and latch properly. doors that failed to latch, by doors that failed to latch when pulled closed, and by doors that were obstructed. This deficient practice could result in What measures will be put into place or the spread of smoke and fire in the event of a fire what systemic changes the facility will and affected 2 of 2 smoke compartments. make to ensure that the deficient practice does not recur? Findings: Maintenance staff will inspect during the daily performance of maintenance tasks that During the facility tour with the Administrator and all doors will have the ability to latch when the Maintenance staff on 11/7/13, the doors were closed in order to resist the passage of observed. smoke. 1. At 11:35 a.m., the self-closing door to the Hooper room located on the first floor failed to How the facility plans to monitor its latch. The door dragged on the floor. Two performance to make sure that solutions attempts were made. are sustained? Maintenance staff will present findings to the 2. At 11:36 a.m., the left side of the self-closing QA Committee during its monthly meeting for double doors to the Linen closet between Room appropriate action. 28 and Room 30 on the first floor falled to latch. The doors were held open to the fullest extent and released. Two attempts were made. 3. At 11:45 a.m., the door to the Patio room

	T OF DEFICIENCIES	(XI) PROVIDER/SUPPLIER/CLIA	Ligarouse		OMB N	0.0938-039
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	AKAMEENA CARE CENTER AKAMEENA CARE CENTER STREET-ADDRESS, CITY, STATE, ZIP CODE 2131 CARLETON STREET BERKELEY, CA 94704		1 17	1/07/2013		
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K 018	located on the first pulled closed. The stuck on it. 4. At 11:52 a.m., the	age 2 floor failed to latch when latching mechanism had gum ne door to the Enteral feeding tocated on the first floor was	K018	When will corrective action be completed? Corrective action will be complete 12/07/2013.	d by	12/07/201
K 029 SS=D	5. At 11:56 a.m., the Utility closet near Refloor failed to latch, the fullest extent an were made. NFPA 101 LIFE SAI One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 protothe approved automoption is used, the approved automoption is used, the aother spaces by smiddors. Doors are sefield-applied protect 48 inches from the bearmitted. 19.3.2. This STANDARD is	ising by a utility cart. It is self-closing door to the Dirty foom 33 located on the first. The door was held open to id released. Two attempts FETY CODE STANDARD construction (with ¾ hour an approved automatic fire in accordance with 8.4.1 ects hazardous areas. When reas are separated from the open code resisting partitions and eff-closing and non-rated or the plates that do not exceed the option of the door are in the property of the door are in the property of the door are in the property of the plates that do not exceed the property of the door are in the property of the door are in the property of the plates that do not exceed the property of the door are in the property of the plates that do not exceed the property of the door are in the property of the plates that do not exceed the property of the plates that do not exceed t	K 029	K 029 How corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? The clothing cart that was obstructing door to the Heater room in the Laundocated on the first floor will be removed. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be All residents have the potential to be affected by the same deficient practice. Maintenance staff will inspect during Maintenance Rounds to ensure that	g the dry ved. De taken?	
fa e a c e	ailed to maintain the evidenced by a self-carea that falled to late could result in the sp	on and interview, the facility hir hazardous areas as closing door to a hazardous ch. This deficient practice read of smoke and fire in the affected 1 of 4 smoke		cart will not obstruct the door to the H Room in the Laundry Department. What measures will be put into pla what systemic changes the facility make to ensure that the deficient p does not recur?	ce or	

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	the Maintenance sareas were observed. At 12:20 p.m., the Laundry located or by a clothing cart. NFPA 101 LIFE SAREQUIRED automatic continuously maint condition and are in periodically. 19.7 9.7.5 This STANDARD is Based on docume and interview, the fautomatic sprinkler by 4 of 4 missing quirecords, and by sprimproper orientation deflectors. This default malfunction of the going undetected, asprinkler's spray pair	tour with the Administrator and staff on 11/7/13, the hazardous red. door to the Heater room in the other first floor was obstructed after CODE STANDARD of sprinkler systems are ained in reliable operating respected and tested and tested and tested and tested and tested and tested are system. This was evidenced parterly inspection and testing inklers installed in the result in the automatic sprinkler system automatic sprinkler system and an obstruction to the term in the event of a fire, smoke compartments.	K 062	Heater Room in the Laundry Department Room in the Room in the Laundry Department Room in the Room in	o the ritment. rits solutions discuss tions to hely eeded. I by sfound cient earterly e Utility eplaced.	12/07/2013

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	equipment, system, of protection, or any compliance with the device, equipment, a arrangement, level of shall thereafter be or accordance with appror as directed by the NFPA 25, 1998 Edition 2-2.1.1 Sprinklers of shall be orientation, foreign madamage and shall be orientation (e.g., upright Any sprinkler shall be corroded, damaged, orientation. Exception No. 1: Sprinklers shall be corroded, damaged, orientation. Exception No. 2: Sprinklers shall not require inaccessible for separate inaccessible for separate inaccessible for separate shall be corrected. Sprinklers shall be corrected or sprinklers shall be corrected.	or wherever any device, condition, arrangement, level other feature is required for provisions of this Code, such system, condition, of protection, or other feature ontinuously maintained in plicable NFPA requirements authority having jurisdiction. On hall be inspected from the Sprinklers shall be free of aterials, paint, and physical existalled in the proper ght, pendant, or sidewall), are replaced that is painted, loaded, or in the improper linklers installed in ch as above suspended the inspection. Inklers installed in areas that afety considerations due to hall be inspected during lown. In obstructions to spray exted. All not be altered in any pe of ornamentation, paint, er shipment from the place		5. The pendant sprinkler head outside Administrator's Office will be replaced. 6. The pendant sprinkler head inside the Administrator's office will be replaced. 7. The pendant sprinkler head above the Laundry will be replaced. 8. The pendant sprinkler head above the Elevator will be replaced. 9. The two pendant sprinkler heads in the Kitchen will be replaced. 10. The pendant sprinkler head above the Linen closet in the hallway by the exit do the parking lot will be replaced. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be take All residents have the potential to be affected by the deficient practice. Maintenance staff will be responsible for conducting quarterly testing of the sprinkles system and replacing of any defected fire sprinklers. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practices not recur? Administrator and Maintenance Staff will onduct quarterly review of all sprinkler	ne n	

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	manufacturer's installed in the uprigapproximately 6 of tspokes were bent. near the Medication Roof located on the first floor was in orientation. The peinstalled in the uprigapproximately 6 of tspokes were bent. near the wall.	tion review and the facility tour ator and Maintenance staff on atic sprinkler system testing documents were requested, sprinkler system was the records for the quarterly ion was requested. There show that the quarterly testing been conducted for the First and Quarter 2013, Third the Fourth Quarter 2012. Administrator stated the indone, and that they would be company and have them fax and the Administrator was given the ocuments by close of 3. No documents were	K 062	system inspections to ensure that testing are done as scheduled. Maintenance Staff will conduct vis monthly on all sprinkler heads to sit is in the proper orientation and the deflector's spokes are not bent. How the facility plans to monito performance to make sure that are sustained? Maintenance staff will present and findings of inspections and interveduring monthly QA Committee mereview and appropriate action if new When will corrective action be completed? Corrective action will be completed 12/07/2013.	sual checks ensure that hat the rits solutions discuss ntions dine eting for eded.	12/07/2013

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a il s	was installed in the approximately 6 of spokes were bent. approximately 2 in: 4. At 12:02 p.m., the spokes was installed approximately 6 of bent. The sprinkled inches from the was installed inches from the was installed inches from the was installed approximately 6. At 12:06 p.m., the outside of the Administration floor was installed approximately 6. At 12:07 p.m., the inside the Administration was installed approximately pendant sprinkled pendant sprinkled in the improvemental floor was installed approximately 2. At 12:10 p.m., the above the Laundry long prinkled in the improvemental floor was installed approximately 2 inches were bent. The pendant sprinkled in the improvemental floor was installed in the improvemental flo	the sprinkler deflector's The sprinkler was installed ches from the wall. The pendant sprinkler head in a the first floor was installed in the first floor was installed in the upright position, and the deflector's spokes were was installed approximately 2 li. The pendant sprinkler head in the improper orientation are head was installed in the dapproximately 6 of the were bent. The sprinkler was tely 2 inches from the wall. The pendant sprinkler head ator's office located on the ed in the improper orientation are head was installed in the improper orientation. The sprinkler was tely 2 inches from the wall. The sprinkler was installed in the improper orientation approximately 6 of the were bent. The sprinkler was tely 2 inches from the wall. The pendant sprinkler head ocated on the first floor was per orientation. The pendant installed in the upright mately 6 of the deflector's the sprinkler was installed.	K 06			

TAXABLE S	TOTAL CARROL VINCENSIA CONTRACTOR	E & MEDICAID SERVICES			JWR MC	0.0938-039
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	ME OF PROVIDER OR SUPPLIER AKAMEENA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2131 CARLETON STREET BERKELEY, CA 94704	1 - 11	/07/2013
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K 062	above the Elevator installed in the imp sprinkler head was position, and approspokes were bent, approximately 2 inc. 9. At 12:18 p.m., to the Kitchen located in the improper ories sprinkler heads were position, and approximately 2 inc. 10. At 12:43 p.m., to approximately 2 inc.	located on the first floor was roper orientation. The pendant installed in the upright eximately 6 of the deflector's. The sprinkler was installed thes from the wall. We pendant sprinkler heads in on the first floor were installed entation. The two pendant re installed in the upright eximately 6 of the deflector's. The sprinklers were installed thes from the wall. The pendant sprinkler head set in the hallway by the exit lot located on the first floor improper orientation. The ead was installed in the diapproximately 6 of the vere bent. The sprinkler was tely 2 inches from the wall. FETY CODE STANDARD	K 062	K 064 How corrective action(s) will be accomplished for those residents for to have been affected by the deficient		
	Based on observati maintain their portat evidenced by one Al	not met as evidenced by: on, the facility failed to ble fire extinguishers as BC portable fire extinguisher, trable fire extinguisher, that		practice? 1. The pull pin will be locked on the ABrortable fire extinguisher located on the Patio in the designated smoking area. 2. The pull pin will be lock on the K-Clarportable fire extinguisher located in the Kitchen.	ss	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/13/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A BUILDING 01 - MAIN BUILDING 01 COMPLETED 055715 B WING 11/07/2013 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2131 CARLETON STREET KYAKAMEENA CARE CENTER BERKELEY, CA 94704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) How the facility will identify other K 064 | Continued From page 8 K 064 residents having the potential to be had a missing safety seal on the fire affected by the same deficient practice extinguisher's pull pin. This deficient practice and what corrective action will be taken? could result in the pull pin being removed, and the All residents have the potential to be locking mechanism being discharged. This affected by the same deficient practice. affected 1 of 4 smoke compartments, and the designated smoking area. Maintenance staff will be responsible to check the pull pin on all fire extinguishers NFPA 101, 2000 Edition are lock properly during its monthly 9.7.4 Manual Extinguishing Equipment. inspections. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire What measures will be put into place or extinguishers shall be installed, inspected, and what systemic changes the facility will maintained in accordance with NFPA 10, make to ensure that the deficient practice Standard for Portable Fire Extinguishers. does not recur? NFPA 10, 1998 Edition Maintenance staff will inspect all fire 4-3 Inspection. extinguishers to ensure that the pull pin is 4-3.1* Frequency, Fire extinguishers shall be locked properly during monthly visual inspected when checks. initially placed in service and thereafter at approximately 30-How the facility plans to monitor its day intervals. Fire extinguishers shall be performance to make sure that solutions inspected at more frequent are sustained? intervals when circumstances require. 4-3.2* Procedures. Periodic inspection of fire Maintenance staff will present and discuss extinguishers shall include a check of a least the findings of inspections and interventions dine following items: during monthly QA Committee meeting for (a) Location in designated Place review and appropriate action if needed. (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible When will corrective action be and facing outward completed? (d) *Safety seals and tamper indicators not 12/07/2013 Corrective action will be completed by broken or missing 12/07/2013. (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the

operable range or position

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K 069 SS=F	nozzle checked (f. (i) HMIS label in p 4-3.4.2 At least m was performed and the initials of inspection shall be recorded. 4-3.4.3 Records attached to the fire checklist maintain system (e.g., bar opermanent record Findings: During the facility: Maintenance staff extinguishers were 1. At 11:31 a.m., the extinguisher located designated smoking not locked. The popin safety seal count ABC portable fire extinguisher had b 2. At 12:12 p.m., the extinguisher located floor had a pull pin portable fire extinguisher had b NFPA 101 LIFE SA	res, wheels, carriage, hose, and or wheeled units) lace onthly, the date the inspection the person performing the half be kept on a tag or label a extinguisher, on an inspection ed on file, or in an electronic coding) that provides a tour with the Administrator and on 11/7/13, the portable fire	K 069	K 069 How corrective action(s) will be accomplished for those residents to have been affected by the defic practice? The gas valve will be connected to the ANSUL System by the fire protection vendor. How the facility will identify other residents having the potential to be affected by the same deficient prayand what corrective action will be All residents have the potential to be by the same deficient prayand what corrective action service with the complete the installation of the gas on the ANSUL System. What measures will be put into play what systemic changes the facility make to ensure that the deficient process of the mean time, the kitchen current Portable Wet Chemical Kitchen Fire Extinguisher for Class A and Class K for use in case of fire to ensure effect suppression of fire, Kitchen staff is away to use deep fat fryer to cook.	he service be ctice taken? affect nistrator endor s valve ce or will bractice y has a Fires live		

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K 069	Based on observation failed to maintain the videnced by the fill inoperable. This did the lack of extinguit. This affected 4 of 4 Findings: During the facility to Maintenance staff of system was observed. At 12:14 p.m., the ared tagged as non-dated 7/29/13. The gas valve was not did upon interview, the	is not met as evidenced by: ation and interview, the facility he kitchen ansul system as ire suppression system being eficient practice could result in ishment in the event of a fire. If smoke compartments. Our with the Administrator and on 11/7/13, the kitchen ansul wed. ansul system pull device was compliant. The red tag was a red tag note stated that the	K 069	How the facility plans to monito performance to make sure that are sustained? Administrator will report any finding OA Committee during its monthly review and intervention as needed. When will corrective action be completed? Corrective action will be completed 12/07/2013.	gs to the meeting for	12/07/2013
K 147 SS=D	gas valve installation work order. The Administration regarding the requesting to know install the gas valve vendor had been parting for the vendo NFPA 101 LIFE SAME Electrical wiring and	In was included on the original iministrator provided respondences with the e gas valve completion, and when the technician would . The Administrator stated the aid for the entire job, and was or to complete the project. FETY CODE STANDARD equipment is in accordance onal Electrical Code. 9.1.2	K 147	K 147 How corrective action(s) will be accomplished for those residents to have been affected by the defic practice? 1. A cover will be placed on a light fithe Staff Lounge.	cient	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	PROVIDER OF SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 2131 CARLETON STREET BERKELEY, CA 94704		1/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	COMPLETION DATE
	This STANDARD Based on observation maintain their electrosed by the fuse of a multi-outlifixed wiring, and becover. This deficite electrical shock or 4 smoke comparts NFPA 101, 2000 E 9.1.2 Electric. Electrical Code, unwhich shall be perservice, subject to having jurisdiction. NFPA 70, 1999 edit 400-8 Unless spectrosed for the following: (1) As a substitute structure (2) Where run throceilings, suspended floors (3) Where run throsimilar openings	is not met as evidenced by: ation, the facility failed to strical wiring and equipment as facility's failure to prohibit the et adapter as a substitute for y two light fixtures that had no ent practice could result in an electrical fire, and affected 2 of ments. Idition ctrical wiring and equipment ance with NFPA 70, National aless existing installations, mitted to be continued in approval by the authority	K 143	2. The Belkin six plug multi-outlet ac Room 34 Bed B will be removed. 3. A cover will be placed on the light in the Utility closet near the Laundry. How the facility will identify other residents having the potential to be affected by the same deficient pra and what corrective action will be All residents have the potential to be affected by the same deficient practic Maintenance staff will be responsible ensure that all light fixtures have a coto remove any multi-outlet adapters. What measures will be put into pla what systemic changes the facility make to ensure that the deficient p does not recur? Maintenance staff will conduct weekly rounds to ensure compliance. How the facility plans to monitor its performance to make sure that solutare sustained? Maintenance staff will present and discindings of inspections and intervention during monthly QA Committee meeting during monthly QA Committee meeting	dapter in It fixture De ctice taken? De to Over and Ce or will ractice Itions De ctice Itions	
	structural ceilings, s ceilings, or floors	ed behind building walls, suspended ceilings, dropped in raceways, except as in this Code		when will corrective action be completed? Corrective action will be completed by 12/07/2013		12/07/2013
	and the sales and the sales are	1				,

Findings:

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 055715	100000	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	co	TE SURVEY MPLETED	
NAME OF PROVIDER OR SUPPLIER KYAKAMEENA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2131 CARLETON STREET BERKELEY, CA 94704			11/07/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE	
K 147	During the facility Maintenance staff equipment and with 1. At 11:24 a.m., Lounge located of 2. At 11:41 a.m., multi-outlet adapte outlet in Room 34 floor. 3. At 12:09 p.m.,	tour with the Administrator and f on 11/7/13, the electrical iring were observed. The light fixture in the Staff in the second floor had no cover. There was a Belkin six pluger plugged into the electrical in Bed B, located on the first the light fixture in the Utility undry located on the first floor.	K 14				