DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055715	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KYAKAMEENA CARE CENTER	2131 CARLETON STREET BERKELEY, CA 94704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS K3 BUILDING: 01 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. Census: 55	K 000	**K 000** This Plan of Correction constitutes my written credible allegation of compliance for the deficiencies noted.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3	K 018	**K 018** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. The Hopper room located on the first floor will be repaired by maintenance staff to ensure it can close and latch properly. 2. The left side of the self-closing double doors to the Linen closet between Room 28 and Room 30 on the first floor will be repaired by maintenance staff to ensure it can close and latch properly.	

[redacted]

[redacted]

...statement ending with an asterisk (*) denotes a deficiency which the institution may ...
...r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...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 ...ram participation.

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K 018	Continued From page 1 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their doors as evidenced by self-closing 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 the spread of smoke and fire in the event of a fire and affected 2 of 2 smoke compartments. Findings: During the facility tour with the Administrator and the Maintenance staff on 11/7/13, the doors were observed. 1. At 11:35 a.m., the self-closing door to the Hooper room located on the first floor failed to latch. The door dragged on the floor. Two attempts were made. 2. At 11:36 a.m., the left side of the self-closing double doors to the Linen closet between Room 28 and Room 30 on the first floor failed 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	K 018	3. The gum on the latching mechanism on the door to the Patio Room located on the first floor will be removed by maintenance staff and will repair to ensure it can close 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 inspect all doors during Daily Maintenance Rounds to ensure that all doors have the ability to close and latch properly. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Maintenance staff will inspect during the daily performance of maintenance tasks that all doors will have the ability to latch when closed in order to resist the passage of smoke. **How the facility plans to monitor its performance to make sure that solutions are sustained?** Maintenance staff will present findings to the QA Committee during its monthly meeting for appropriate action.	

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K 018	Continued From page 2 located on the first floor failed to latch when pulled closed. The latching mechanism had gum stuck on it. 4. At 11:52 a.m., the door to the Enteral feeding and supplies closet located on the first floor was obstructed from closing by a utility cart. 5. At 11:56 a.m., the self-closing door to the Dirty Utility closet near Room 33 located on the first floor failed to latch. The door was held open to the fullest extent and released. Two attempts were made.	K 018	**When will corrective action be completed?** Corrective action will be completed by 12/07/2013.	12/07/2013
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their hazardous areas as evidenced by a self-closing door to a hazardous area that failed to latch. This deficient practice could result in the spread of smoke and fire in the event of a fire. This affected 1 of 4 smoke compartments.	K 029	**K 029** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The clothing cart that was obstructing the door to the Heater room in the Laundry located 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 taken?** All residents have the potential to be affected by the same deficient practice. Maintenance staff will inspect during Daily Maintenance Rounds to ensure that clothing cart will not obstruct the door to the Heater Room in the Laundry Department. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**	

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K 029	Continued From page 3 Findings: During the facility tour with the Administrator and the Maintenance staff on 11/7/13, the hazardous areas were observed. At 12:20 p.m., the door to the Heater room in the Laundry located on the first floor was obstructed by a clothing cart.	K 029	Laundry and Maintenance Staff will be in-serviced not to obstruct the door to the Heater Room in the Laundry Department. **How the facility plans to monitor its performance to make sure that solutions are sustained?** Maintenance staff will present and discuss findings of inspection and interventions to the QA Committee during its monthly meeting for appropriate action if needed. **When will corrective action be completed?** Corrective action will be completed by 12/07/2013.	12/07/2013
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review, observation and interview, the facility failed to maintain their automatic sprinkler system. This was evidenced by 4 of 4 missing quarterly inspection and testing records, and by sprinklers installed in the improper orientation with bent sprinkler deflectors. This deficient practice could result in a malfunction of the automatic sprinkler system going undetected, and an obstruction to the sprinkler's spray pattern in the event of a fire. This affected 4 of 4 smoke compartments. NFPA 101, 2000 Edition 19.7.6 Maintenance and Testing. NFPA 101, 2000 Edition 4.6.12 Maintenance and Testing	K 062	**K 062** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. Maintenance staff will conduct quarterly testing of the sprinkler system. 2. The pendant sprinkler head in the Utility room across from Room 26 will be replaced. 3. The pendant sprinkler head in the Medication Room at the Nurse's Station will be replaced. 4. The pendant sprinkler head in Room 22 will be replaced.	

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K 062	Continued From page 4 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 25, 1998 Edition 2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.1.2 Unacceptable obstructions to spray patterns shall be corrected. 2-4.1.8 Sprinklers shall not be altered in any respect or have any type of ornamentation, paint, or coatings applied after shipment from the place of manufacture. 9-2.7 Waterflow Alarm. All waterflow alarms shall be tested quarterly in accordance with the	K 062	5. The pendant sprinkler head outside the 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 door to 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 taken?** All residents have the potential to be affected by the deficient practice. Maintenance staff will be responsible for conducting quarterly testing of the sprinkler 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 practice does not recur?** Administrator and Maintenance Staff will conduct quarterly review of all sprinkler	

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K 062	Continued From page 5 manufacturer's instructions. Findings: During documentation review and the facility tour with the Administrator and Maintenance staff on 11/7/13, the automatic sprinkler system testing and maintenance documents were requested, and the automatic sprinkler system was observed. 1. At 10:30 a.m., the records for the quarterly testing and inspection was requested. There were no records to show that the quarterly testing and inspection had been conducted for the First Quarter 2013, Second Quarter 2013, Third Quarter 2013, and the Fourth Quarter 2012. Upon interview the Administrator stated the inspection had been done, and that they would contact the sprinkler company and have them fax the paperwork. The Administrator was given the opportunity to fax documents by close of business on 11/7/13. No documents were received. 2. At 11:49 a.m., the pendant sprinkler head in the Utility room across from Room 26 located on the first floor was installed in the improper orientation. The pendant sprinkler head was installed in the upright position, and approximately 6 of the sprinkler deflector's spokes were bent. The sprinkler was installed near the wall. 3. At 12:01 p.m., the pendant sprinkler head in the Medication Room at the Nurse's Station located on the first floor was installed in the improper orientation. The pendant sprinkler head	K 062	system inspections to ensure that require testing are done as scheduled. Maintenance Staff will conduct visual checks monthly on all sprinkler heads to ensure that it is in the proper orientation and that the deflector's spokes are not bent. **How the facility plans to monitor its performance to make sure that solutions are sustained?** Maintenance staff will present and discuss findings of inspections and interventions dine during monthly QA Committee meeting for review and appropriate action if needed. **When will corrective action be completed?** Corrective action will be completed by 12/07/2013.	12/07/2013

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K 062	Continued From page 6 was installed in the upright position, and approximately 6 of the sprinkler deflector's spokes were bent. The sprinkler was installed approximately 2 inches from the wall. 4. At 12:02 p.m., the pendant sprinkler head in Room 22 located on the first floor was installed in the improper orientation. The pendant sprinkler head was installed in the upright position, and approximately 6 of the deflector's spokes were bent. The sprinkler was installed approximately 2 inches from the wall. 5. At 12:06 p.m., the pendant sprinkler head outside of the Administrator's office located on the first floor was installed in the improper orientation. The pendant sprinkler head was installed in the upright position, and approximately 6 of the deflector's spokes were bent. The sprinkler was installed approximately 2 inches from the wall. 6. At 12:07 p.m., the pendant sprinkler head inside the Administrator's office located on the first floor was installed in the improper orientation. The pendant sprinkler head was installed in the upright position, and approximately 6 of the deflector's spokes were bent. The sprinkler was installed approximately 2 inches from the wall. 7. At 12:10 p.m., the pendant sprinkler head above the Laundry located on the first floor was installed in the improper orientation. The pendant sprinkler head was installed in the upright position, and approximately 6 of the deflector's spokes were bent. The sprinkler was installed approximately 2 inches from the wall. 8. At 12:11 p.m., the pendant sprinkler head	K 062		

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K 062	Continued From page 7 above the Elevator located on the first floor was installed in the improper orientation. The pendant sprinkler head was installed in the upright position, and approximately 6 of the deflector's spokes were bent. The sprinkler was installed approximately 2 inches from the wall. 9. At 12:18 p.m., two pendant sprinkler heads in the Kitchen located on the first floor were installed in the improper orientation. The two pendant sprinkler heads were installed in the upright position, and approximately 6 of the deflector's spokes were bent. The sprinklers were installed approximately 2 inches from the wall. 10. At 12:43 p.m., the pendant sprinkler head above the Linen closet in the hallway by the exit door to the parking lot located on the first floor was installed in the improper orientation. The pendant sprinkler head was installed in the upright position, and approximately 6 of the deflector's spokes were bent. The sprinkler was installed approximately 2 inches from the wall.	K 062		
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their portable fire extinguishers as evidenced by one ABC portable fire extinguisher, and one K-Class portable fire extinguisher, that	K 064	**K 064** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. The pull pin will be locked on the ABC portable fire extinguisher located on the Patio in the designated smoking area. 2. The pull pin will be lock on the K-Class portable fire extinguisher located in the Kitchen.	

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K 064	Continued From page 8 had a missing safety seal on the fire extinguisher's pull pin. This deficient practice could result in the pull pin being removed, and the locking mechanism being discharged. This affected 1 of 4 smoke compartments, and the designated smoking area. NFPA 101, 2000 Edition 9.7.4 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, 1998 Edition 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30- day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of a least the following items: (a) Location in designated Place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) *Safety seals and tamper indicators not broken or missing (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	K 064	**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 check the pull pin on all fire extinguishers are lock properly during its monthly inspections. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Maintenance staff will inspect all fire extinguishers to ensure that the pull pin is locked properly during monthly visual checks. **How the facility plans to monitor its performance to make sure that solutions are sustained?** Maintenance staff will present and discuss findings of inspections and interventions dine during monthly QA Committee meeting for review and appropriate action if needed. **When will corrective action be completed?** Corrective action will be completed by 12/07/2013.	12/07/2013

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K 064	Continued From page 9 (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-3.4.2 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. 4-3.4.3 Records shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or in an electronic system (e.g., bar coding) that provides a permanent record. Findings: During the facility tour with the Administrator and Maintenance staff on 11/7/13, the portable fire extinguishers were observed. 1. At 11:31 a.m., the ABC portable fire extinguisher located on the first floor Patio in the designated smoking area had a pull pin that was not locked. The portable fire extinguisher's pull pin safety seal could be removed. The tag on the ABC portable fire extinguishers showed the fire extinguisher had been inspected on 11/1/13. 2. At 12:12 p.m., the K-Class portable fire extinguisher located in the Kitchen on the first floor had a pull pin that was not locked. The portable fire extinguisher's pull pin safety seal could easily be removed. The tag on the K-Class portable fire extinguisher showed the fire extinguisher had been inspected on 11/1/13.	K 064	**K 069** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The gas valve will be connected to the ANSUL System by the fire protection service vendor. **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 affect by the same deficient practice. Administrator will notify the fire protection service vendor to complete the installation of the gas valve on the ANSUL System. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** In the mean time, the kitchen currently has a Portable Wet Chemical Kitchen Fire Extinguisher for Class A and Class K Fires for use in case of fire to ensure effective suppression of fire. Kitchen staff is aware not to use deep fat fryer to cook.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		

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K 069	Continued From page 10 with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the kitchen ansul system as evidenced by the fire suppression system being inoperable. This deficient practice could result in the lack of extinguishment in the event of a fire. This affected 4 of 4 smoke compartments. Findings: During the facility tour with the Administrator and Maintenance staff on 11/7/13, the kitchen ansul system was observed. At 12:14 p.m., the ansul system pull device was red tagged as non-compliant. The red tag was dated 7/29/13. The red tag note stated that the gas valve was not connected. Upon interview, the Administrator stated the ansul system had been installed on 3/14/13, and the gas valve installation was included on the original work order. The Administrator provided numerous email correspondences with the vendor regarding the gas valve completion, and requesting to know when the technician would install the gas valve. The Administrator stated the vendor had been paid for the entire job, and was wafting for the vendor to complete the project.	K 069	**How the facility plans to monitor its performance to make sure that solutions are sustained?** Administrator will report any findings to the QA Committee during its monthly meeting for review and intervention as needed. **When will corrective action be completed?** Corrective action will be completed by 12/07/2013.	12/07/2013
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	**K 147** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. A cover will be placed on a light fixture in the Staff Lounge.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055715	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2013

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K 147	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their electrical wiring and equipment as evidenced by the facility's failure to prohibit the use of a multi-outlet adapter as a substitute for fixed wiring, and by two light fixtures that had no cover. This deficient practice could result in an electrical shock or electrical fire, and affected 2 of 4 smoke compartments. NFPA 101, 2000 Edition 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, 1999 edition 400-8 Unless specifically permitted in Section 400-7, flexible cord and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code Findings:	K 147	2. The Belkin six plug multi-outlet adapter in Room 34 Bed B will be removed. 3. A cover will be placed on the light fixture in the Utility closet near the Laundry. **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 ensure that all light fixtures have a cover and to remove any multi-outlet adapters. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Maintenance staff will conduct weekly rounds to ensure compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained?** Maintenance staff will present and discuss findings of inspections and interventions during monthly QA Committee meeting for review and appropriate action if needed **When will corrective action be completed?** Corrective action will be completed by 12/07/2013.	12/07/2013

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K 147	Continued From page 12 During the facility tour with the Administrator and Maintenance staff on 11/7/13, the electrical equipment and wiring were observed. 1. At 11:24 a.m., the light fixture in the Staff Lounge located on the second floor had no cover. 2. At 11:41 a.m., there was a Belkin six plug multi-outlet adapter plugged into the electrical outlet in Room 34, Bed B, located on the first floor. 3. At 12:09 p.m., the light fixture in the Utility closet near the Laundry located on the first floor had no cover.	K 147		