STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555466	A. BUILDING _____ B. WING _____	09/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY CARE CENTER	2270 ASHBY AVENUE BERKELEY, CA 94705

(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)	(XS) COMPLETION DATE
F000	INITIAL COMMENTS	F 000		

The following reflects the findings of the California Department of Public Health during the annual recertification visit conducted from 9/18/17 to 9/20/17.

Representing the Department:
Health Facilities Evaluator Nurses: 38296 and 36891.

The resident census at the time of survey was 30.

F 309 SS=D 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services,

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F 309 Resident has a tendency to draw attention to the fact that she has painful and swollen legs. The Resident stated, "that the nurses had not applied high compression stockings on her legs since April of 2017. This has totally been misinterpreted by the Resident and facility does not agree. The Resident does wear compression stockings, which has been ordered by the Physician, however, a few days prior to the survey, the Resident threw her compression stockings away stating, "they had holes in them and no longer needed them". The facility has taking measures i.e., to purchase new compression stockings and encourage the Resident to wear them during the day and off at night per Physician's order. The Resident's Care Plan has been up-dated to reflect the process for compression stockings worn by the Resident. The Director of Nurses

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: George Robertson
TITLE: Administrator
(XS) DATE: 11/8/17

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

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F 309	Continued From page 1 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, for one of 13 sampled residents (Resident 5), the facility failed to ensure Resident 5 maintained her highest possible level of functioning and well-being when thigh high compression stockings were not applied to Resident 5 legs to prevent edema (fluid collection to the legs). These failures resulted in worsening edema and pain in Resident 5's. Findings: Review of Resident 5's Admission Face Sheet (a document that provides resident specific information at a quick glance), dated 10/20/15, indicated Resident 5 was admitted to the facility on 5/22/12 with multiple diagnoses that included dependent edema (fluid collection in lower legs). The MDS also indicated Resident 5 was able to clearly think, reason, and remember. In a concurrent observation and interview on 9/18/17, at 8:30 a.m., Resident 5 was sitting on the side of her bed complaining of red, painful, and swollen legs. Resident 5 was not wearing	F 309	and Charge Nrses wi." mnitor for compliance, with phys1c1an s orders, to prevent this deficiency from re-occurrence. It is identified that other residents in the facility have phyic'.an's orers to use Medical and Ass1st1ve Devices. To ensure that all residents who have orders for asistive devices have them availabe and ready for use. A list was onstructed for all residents who have assigned devices. The list is located at the Nursing Station on 10/18/17. This list will be checked with the Charge Nurse/Director of Staff Development and Certified Nursing Assistants. Each shift, Social Service Director can also assist with locating and ensuring itmes are available. If Assistive Devices is missing and need replacement, the Social Services Director will find means to replace the item immediately. This system will prevent the re-occurrence of this deficiency.	10/18/17

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F 309	Continued From page 2	F 309		

thigh high compression stockings. Resident 5 stated the nurses had not applied the thigh high compression stockings on her legs since April 2017.

In an observation and concurrent interview on 9/18/17, at 12 p.m. Resident 5 walked from her room to the activity room and was not wearing thigh high compression stockings. Resident 5 complained of pain and swollen legs and ankles.

Review of Resident 5's physician's order, dated 3/7/14, indicated Resident 5 had a physician's order to wear "Compression stockings, thigh high, worn during the day and off at night."

Review of Resident 5's care plan,dated 6/2/17, indicated Resident 5 was supposed to wear "Ted hose (compression stockings) used to prevent edema."

In an interview on 9/18/17, at 12:30 p.m., Licensed Vocational Nurse (LYN) stated the facility could not provide compression stocking to Resident 5.

In an interview on 9/18/17 at 9:40 a.m. the Director of Nurses (DON) stated Resident 5 had her old compression stockings.

In a joint interview on 9/19/17, at 9:45 *a:m.,* the Director of Staff Development (DSD) asked Resident 5 to look for her old compression stockings in her room. Resident 5 told the DSD that her old compression stockings were torn, so she threw them away on 4/1/17. Resident 5 also told the DSD that she had not worn the compression stocking since April 2017. The DSD was not able to locate Resident 5's old

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F 309	Continued From page 3 compression stocking in Resident S's room.	F 309		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal. state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to store, prepare, and serve food under sanitary conditions when there was one expired container of special soup base in the refrigerator and there was pink residue the freezer. These failures had the potential to result in food	F 371	The Beef Soup Base opened and deficiency, was an over-sight by the Dietary Department Personnel. A new refrigerator was purchased and brought into place and during the process of placing the items for transfer, was over-looked and placed into the new refrigerator. The Dietary Personnel & Administrator will monitor for compliance to prevent this deficiency from re-occurrence. Refrigerator storage items will be arranged in the refrigerator so that the older items will be used first. Dietary Supervisor, Dietary Personnel and Administrator will monitor for compliance to prevent this deficiency from re-occurrence. Maintaining a clean refrigerator and freezer has always been the Policy of Ashby Care Center. The Dietary Personnel and Administrator will monitor for compliance to prevent this deficiency from re-occurrence. We are attaching our Refrigerator and Freezer Policy for Maintaining a clean refrigerator and freezer.	

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F 371	Continued From page 4 borne illness. Findings: During a concurrent observation in the presence of the Dietary Cook (DC1) on 9/18/17, at 6:15 a.m., there was one container of special beef flavor soup base was opened and expired in 5/17 (4 months prior). During an interview with the DC1 on 9/18/17, at 7 a.m., DC1 stated if a food item was expired, it should not be used. Review of the facility's undated policy and procedure titled "Procedure for Refrigerated Storage," undated, indicated "...9.food items should be arranged so that older items will be used first. ..." During an observation in the presence of the DC1 on 9/18/17, at 6:25 a.m., there was pink residue on the back end of the upper shelf surface and bottom shelf surface of the inside of the freezer. During an interview with the DC1 on 9/18/17, at 6:25 a.m., the DC1 stated the freezer needed to be cleaned. DC1 was unable to provide a policy and procedure for freezer cleaning and maintenance.	F 371	The corrective actions that will be monitored to ensure the deficient practices will not recure is that the Dietary Suprvisor, Administrator & Dietary Personnel will monitor on a consistent basis. The Quality Assurance Committee will also include any deficiencies noted for review and recommendations for this deficiency from re-occurrence.	9/20/17
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	Our Pharmacist Consultant has monthly visits to the facility to monitor the Injectable Emergency Kit for expiration dates. She will check each month for any expiration dates on medications for the Emergency Kit and will follow through for compliance. The Monthly Consultant Reports will	

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F 425	Continued From page 5 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure emergency medications were readily available for residents' needs when one Injectable Emergency Kit was expired and also contained nine expired medications. This failure had the potential to result in residents receiving expired medications that were less effective. Findings: In an observation on 9/18/17, at 7:35 a.m., there was an Injectable Emergency Kit with an expiration date of 7/1/17 was observed containing the following medications: a. two vials of Diphenhydramine (anti-allergy) with an expiration date of Aug 2017; b. one vial of Haloperidol (anti-psychotic) with an expiration date of 9/1/17; c. one vial of Gentamycin (anti-biotic to treat infections) with an expiration date of July 2017; d. one box of Glucagon (to treat low blood sugar) with an expiration date of 9/1/17; e. one vial of Vitamin K (prevent excessive bleeding) with an expiration date of 7/1/17; f. . one vial of Solu-medrol (an anti-inflammatory) with an expiration date of 9/1/17; and g. two vials of Naloxone HCL [to rapidly reverse	F 425	reflect that the Emergency Kit has been monitored for full compliance. The The Pharmacist Consultant and Omnicare will monitor for compliance to keep this deficiency from re-occurrence. The Director of Nurses will monitor of Compliance.	9/20/17

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F 425	Continued From page 6 opioid (chemical substance to treat pain) overdose] with an expiration date of Aug 2017. In an interview on 9/18/17, at 7:40 a.m., the Director of Staff Development (DSD) stated the Injectable Emergency Kit was expired. In an interview on 9/19/17, at 10:30 a.m., the Pharmacist (RPH) stated she visited the facility once a month to conduct medication audits and to discuss issues with the nursing staff. The RPH added that somehow, she missed the Injectable Emergency Kit that expired on 7/1/17.	F 425		
F 431 SS=E	483.45(b){2}{3}{g)(h) DRUG RECORDS, LABEUSTORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431	The facility has established a system in place to monitor for expired drugs and medications in the storage room. The system was not followed through by the License Personnel as set forth by the Director of Nurses. Charge Nurses will be assigned to check for expired drugs and these drugs eliminated from the storage area. The Pharmacy Consultant will monitor on the Monthly Viists and reflect her findings of expired drugs & biologicals in her reports.The Director of Nurses will monitor for full compliance. The expired drugs which was noted in this deficiency has been eliminated. The Director of Nurses and Assistant Director of Nurses will monitor Monthly to prevent this deficiency from re-occurrence. The Pharmacist Consultant on her month! visits will monitor any discrepancies	

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F 431	Continued From page 7 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. **(1) In accordance with State and Federal laws,** the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain safe storage of medications and biologicals (products to prevent or test for diseases) when there were multiple expired medications and biologicals in the medication storage room. This failure had the potential to result in residents receiving expired medications or the use of	F 431	on expired medications noted. The Quality Assurance Committee will make any recommendations needed to prevent this deficiency from re-occurrence.	9/21/17

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F 431	Continued From page 8	F 431		

expired biologicals in the testing for diseases in residents.

Findings:

During the medication room inspection and concurrent interview on 9/18/17 at 6:50 a.m., expired medications and biologicals were observed in the medication room:

a. seven Bisacodyl (stool softener) suppositories that expired in 10/16;
b. one Bisacodyl that expired in 2/17;
c. three Bisacodyl that expired in 1/17;
d. nine ES Swab for Aerobic and Anaerobic Fastidious Bacteria (used to test for bacteria in wounds) that expired in 5/17;
e. two Influenza Virus laboratory test kits that expired in 4/17;
f. two boxes of 200 lancets (sharp pointed instrument used to make small incisions) that expired in 7/14;
g. two diabetic control test kits with an expiration date of 5/17
h. one box containing 6 expired xeroforms (an occlusive dressing which means the dressing prevents air from reaching the wound) that expired in 12/12;
i. one Polyethylene Glycol Osmotic Laxative that expired 6/17; and
j. four Wal-Phed nasal decongestant that expired 7/17.

In an interview on 9/18/17, at 6:50 a.m., the Director of Staff Development (DSD) stated the above listed medications and biologicals were expired.

A review of the facility's policy titled, "Disposal of

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F 431	Continued From page 9 Medications", dated Sep 2010, indicated outdated medications, contaminated or deteriorated medications, and the contents of containers with no label shall be destroyed.	F 431		
F 441 SS=D	483.80{a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (!PCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility: (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441	The Director of Staff Development has given an "Infection Control Program In-Service' for the Nursing Assistants . The Program consisted of, "Understanding Necessary Precautions to Prevent Infections" Hand Hygiene, Glove Use, Universal Precautions, Standard Precautions, Preventative gear to prevent spread of infection, Vaccines, do not come to work sick. Report cough, Drainage, Diarrhea, Loose stool, Congestion. Wounds etc. Gopy of Lesson Plan and In-Service Attached . The Director of Staff Development will monitor for compliance. The Director of Staff Development gave an In-Service on, "Hand Hygiene". Staff must properly perform Hand Hygiene according to the Hand Washing Policy and Procedure i.e., when to wash hands, when to wash hands between Residents, direct and indirect contact, soap and water vs hand sanitizer and how to wash hands. The Director of Staff Development will monitor for compliance.	10/13/17 - 10/19/17 9/19/17 - 9/27/17

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F 441	Continued From page 10 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and records review, the facility failed to maintain an infection control program when Certified Nurse Assistant (CNA) 1 and the Maintenance Manager (MM) did not practice hand hygiene after a direct contact	F 441	The Director of Staff Development/ Infection Control Officier has conducted compliance rounds on weekly bases to identify Resident Handling, specifically for identification of potential spreads of infection. This will help identify residents who are at most risk for infections as well as staff who need more in-service training for Hand-hygiene or infection control practice. Documentation of findings is written on a form. The findings will identify re-occurring issues and will be corrected immediately through in-services. Issues will be brought up during the Quarterly Assurance Meetings.	9/19/17

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F 441	Continued From page 11	F 441		

This deficient practice had the potential to result in the spread of nosocomial (an infection acquired in a health care facility through person to person contact from unclean hands) infections.

Findings:

Review of Resident 11's Admission Face Sheet (a document that provides resident specific information at a quick glance), dated 8/14/17, indicated Resident 11 was admitted to the facility on 4/27/17.

During the dining observation on 9/19/17, at 8:05 a.m., CNA 1 and MM entered Room 6, put on gloves and repositioned Resident 11 while he was in bed. Then, CNA 1 and the MM removed their gloves and left Room 6. CNA 1 and the MM and did not perform hand hygiene (wash hands or use an alcohol based hand rub) after they repositioned Resident 11.

During an interview with MM, on 9/19/17 at 9:05 a.m., the MM stated he did not perform hand hygiene after he assisted Resident 6.

Review of the facility's undated policy and procedure, titled "Handwashing" indicated handwashing must be performed after resident contact. The use of gloves does not replace handwashing.

F 458 SS=B	483.90(e)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT (e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;	F 458	A separate letter was sent to the Dept of Public Health requesting a Waiver on the room measurement sizes.	9/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555466	A. BUILDING _____ B. WING _____	09/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY CARE CENTER	2270 ASHBY AVENUE BERKELEY, CA 94705

(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)	(XS) COMPLETION DATE
F 458	Continued From page 12	F 458		

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility had six resident rooms (Rooms 1, 3, 5, 7, 8, and 9) with multiple beds that provided less than 80 square feet 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.

Findins: .

During an observation on 9/18/17 at 8:10 a.m., the following rooms and corresponding square footage (sq.ft) per bed were identified:

Room	Activity and Room Size	Floor Area
1	Pt Room 299.63 sq.ft	74.9 sq.ft/bed
3	Pt Room 293.25 sq.ft	73.32 sq.ft/bed
5	Pt Room 299 sq.ft	74.75 sq.ft/bed
7	Pt Room 299 sq.ft	74.75 sq.ft/bed
8	Pt Room 299 sq.ft	74.75 sq.ft/bed
9	Pt Room 299 sq.ft	74.75 sq.ft/bed

During random observations of care and services from 9/18/17 to 9/20/17, 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 consequences attributed to the decreased space and/or safety concerns in the six rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555466	A. BUILDING _____ B. WING _____	09/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY CARE CENTER	2270 ASHBY AVENUE BERKELEY, CA 94705

(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
F458	Continued From page 13 Recommend granting room size waiver.	F458		