

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Ashby Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Ashby Avenue Berkeley, CA 94705	

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>31403</p> <p>Based on observation, interview, and record review, the facility did not provide the necessary pain medication for one of three sampled residents (Resident 3) Resident 3 required wound dressing changes, three times per week, which were painful and required premedication. The licensed nursing staff did not administer the required pain medication before wound care.</p> <p>This caused unnecessary pain and distress for Resident 3.</p> <p>Findings:</p> <p>Review of the Admission Record showed the facility admitted Resident 3 on 3/11/2023. The diagnoses included dementia (memory difficulty). Resident 3 received hospice services (end-of-life comfort care) while at the facility.</p> <p>During an interview on 12/18/2023 at 10:35 a.m., the facility's Director of Nursing (DON) stated Resident 3's dressings were being changed three times per week and the hospice agency, Calls us ahead of time so we know when they are coming. DON stated licensed staff would then pre-medicate Resident 3 with pain medication prior to hospice's arrival so that Resident 3 felt minimal to no pain during the wound dressing changes.</p> <p>During an interview on 12/18/2023 at 10:22 a.m., Resident 3 did not respond to this surveyor's questions and was not interviewable.</p> <p>On 12/18/2023 at 1:45 p.m., the hospice registered nurse (HRN) was observed changing Resident 3's dressings on her leg, knee and foot. Resident 3 was observed moaning in pain as the old dressings were removed.</p> <p>Review of the document (not titled) MD orders (undated), showed Resident 3 had orders from the doctor for Morphine (pain medication) 5 mg (milligram) every 4 hours as needed for shortness of breath or pain. The start date was 9/12/2023.</p> <p>Review of the Charts/Clinical Notes (not dated), showed hospice had visited Resident 3 on 11/6/2023. Resident 3 was yelling Ouch now stop that during wound care. The wounds were described as Significantly worse.</p> <p>(continued on next page)</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
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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Hospice Home Instructions, dated 11/6/2023, showed facility staff were to Pre-medicate with morphine prior to dressing change. Hospice nurses would call the facility ahead of time to let staff know when they were coming and to administer the pain medication before arrival.</p> <p>Review of the document Hospice Routine Visit, dated 11/13/2023, showed Resident 3 had .Pain with wound care. Multiple rapidly worsening wounds with purulent (pus), malodorous drainage (foul smelling).</p> <p>Review of the Medication Administration Record (MAR), dated November 2023, showed the facility had not administered Morphine to Patient 3 on 11/13/2023 (prior to the wound dressing changes).</p> <p>Review of the Controlled Drug Record (not dated) showed no Morphine had been signed out of the narcotic drawer for Resident 3 on 11/13/2023. In a concurrent interview, DON confirmed there had not been any Morphine administered to Resident 3 on 11/13/2023 prior to the wound dressing change.</p> <p>Review of the Charts/Clinical Notes, dated 11/20/2023, showed the hospice nurse visited Resident 3 on 11/20/2023 at 4 p.m. Patient 3 was found to have mild to moderate pain and had not been pre-medicated with Morphine prior to the visit.</p> <p>Review of the MAR dated November 2023 showed Resident 3 had not been given Morphine on 11/20/2023.</p> <p>Review of the Controlled Drug Record (not dated) showed Resident 3 had received Morphine at 5 p.m. on 11/20/2023, one hour after the start of the hospice visit.</p> <p>Review of the Charts/Clinical Notes (not dated), showed the hospice agency Registered Nurse (RN) visited Resident 3 on 11/30/2023 at 12:30 p.m. for a wound dressing change. The visit note showed, Attempted wound care - pt developed severe pain, screaming, stating no stop do not touch me repeatedly. Pt was medicated with Morphine 5 mg around 11:30-12 per DON and wound care occurred one hour later at 12:30-1.</p> <p>Record review of the MAR dated November 2023 showed no Morphine had been administered to Resident 3 on 11/30/2023.</p> <p>Review of the Controlled Drug Record showed Morphine was signed out for Resident 3, on 11/30/23 at 7 p.m. , six hours following the wound dressing change.</p> <p>Review of the Supplemental Order, dated 12/11/2023, showed the Morphine had been increased to 30 mg and was to be given one hour prior to Resident 3's dressing changes. Review of the MAR dated 12/20/23 showed Resident 3 had not received the Morphine 30 mg since the order was written on 12/11/2023. During a concurrent interview, with DON, DON confirmed Resident 3 had not been receiving the Morphine 30 mg and was Not sure why.</p> <p>Review of the Controlled Drug Record (not dated) showed Resident 3 had received Morphine 5 mg on 12/9/2023 and 30 mg on 12/18/2023 (date of investigation).</p> <p>During an interview on 12/18/2023 at 1:15 p.m., DON stated the hospice agency staff had Never discussed pain control problems with me. They just send over the orders.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/18/2023 at 2:15 p.m., HRN stated she discussed the plan of care with DON regarding pre-medicating Resident 3 with Morphine. HRN stated DON had reported she helps to control Resident 3's pain, More gently by asking Resident 3 to Count down while doing the dressing change instead of administering the medication. HRN said she made a plan with DON to meet on 12/8/2023 to discuss the plan (pain control), but DON was a No show. HRN said she then wrote DON a letter discussing the importance of the plan since Resident 3 was in Tremendous pain.</p> <p>During an interview on 12/18/2023 at 2:26 p.m., HRN stated she became concerned that Resident 3 was not receiving the pain medication as ordered. HRN stated Resident 3 should have received the increased dosage to 30 mg on 12/14/23, 12/16/23, and 12/18/2023.</p> <p>During an interview on 1/26/2024 at 1:55 p.m., the hospice Social Worker (HSW) stated she had talked with the facility's DON regarding the need to keep Resident 3 comfortable. HSW stated DON agreed this was the goal. DON reported to HSW that she Didn't need to pre-medicate Resident 3 because she could get her to, Count backwards from 100 to calm her down before the dressing change. HSW stated she was concerned about how a hospice patient could be expected to count backwards from 100 and how that could be effective in controlling the pain. HSW had suggested DON speak with the hospice doctor regarding the importance of pre-medication. HSW stated DON told her that she (DON) did not require a doctor's opinion. HSW asked DON if she was committed to following the plan of care for Resident 3 and DON Would not commit. HSW further stated she had seen Resident 3 be pre-medicated during previous dressing changes and she was still yelling out, Please stop. Help Me! HSW stated Resident 3 had fragile skin and knew it was very important for her to be effectively pre-medicated.</p> <p>During an interview on 12/18/2023 at 1:10 p.m., DON stated the potential consequence of not giving the prescribed amount of premedication prior to Resident 8's dressing changes was Pain.</p> <p>Review of the Policy and Procedure, Pain Assessment/Management, (not dated) showed it was the facility's policy to, Respect and support every patient's right to optimal pain relief through education, initial and ongoing assessment, and effective and appropriate pain management.</p> <p>Review of the Skilled Nursing Facility Memorandum of Understanding Routine Level of Care, dated 2/23/2023, showed the facility, Shall comply with Hospice Patient's Plan of Care and shall ensure Hospice Patients are kept comfortable, clean, well-groomed and protected from negligent and intentional harm including, but not limited to, accident, injury and infection.</p>		