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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashby Care Center	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44823 The facility failed to ensure proper medication storage when: 1. Medication refrigerator was not padlocked 2. Medication room dry storage temperature log did not have entries for December 2 and 3, 2024 3. Medication room refrigerator had nutritional supplements along with food items that were not labeled with names and dates 4. The medication room had a staff's clothing item hanging on the door. This failure can potentially result in unsafe medication storage practices and impact the safety and well-being of all 29 residents. Findings: 1. During a concurrent observation and interview on 12/4/24, at 10:15 a.m., with Licensed Vocational Nurse (LVN) 1, the medication refrigerator in the medication room was found not padlocked. During a concurrent observation and interview on 12/4/24, at 11:10 a.m., with Administrator (ADM), ADM stated the medication refrigerator should have been padlocked. During an interview on 5/8/25, at 9:30 a.m., with Director of Nursing (DON), the DON stated the medication refrigerator should have been padlocked as it had E-kit (emergency kit containing medications) in it. The DON further stated the danger of the refrigerator not being padlocked is that medications can be touched by any staff. 2. During a concurrent observation and interview on 12/4/24, at 10:15 a.m., with LVN 1, the medication room dry storage temperature log did not have day and evening entries for 12/2/24 and 12/3/24 under the columns Storeroom and Nursing Sig (signatures). (continued on next page)

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25, at 9:30 a.m., with DON, the DON stated the temperature log should be completed, otherwise it (refrigerator) may not be meeting temperature requirements. Per the DON, licensed nurse is responsible for keeping the temperature log. 3. During a concurrent observation and interview on 12/4/24, at 10:15 a.m., with LVN 1, the dry storage refrigerator, which had a label Medication Only contained non-medication food items. On the inside door of the refrigerator, the top shelf had nutritional supplements. On the bottom shelf were the following four items: a bag of whole mixed olives, an unmarked half-full jar of green marmalade-like item, a half-full container of creamed honey, and a half full bottle of apple cider vinegar vinaigrette. These four items were not labeled with names or dates. During an interview on 5/8/25, at 9:30 a.m., with the DON, the DON stated she did not know what these items were. Per DON, food items inside the refrigerator should have names, covered, and dated. DON further stated she did not know who the items belonged to. 4. During a concurrent observation and interview on 12/4/24, at 10:15 a.m., with LVN 1, a white vest was found hanging on the door of the medication room. LVN 1 stated the clothing item belonged to an employee. During an interview on 12/4/24, at 11:10 a.m., with ADM, the ADM stated the white vest belonged to the DON. ADM stated it was the medication room and not the DON's closet and the clothing item should not have been stored there. During a review of the facility's policy and procedure titled, Medication Storage, dated 2007, the P&P indicated, Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access . A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits . Refrigerated medications should be kept in closed and labeled containers . segregated from fruit juices, applesauce, and other foods used in administering medications. Any other foods such as employee lunches and activity department refreshments should not be stored in this refrigerator.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44823 The facility failed to ensure infection control measures were followed when: 1. Outside resident room [ROOM NUMBER] was an open lid bin which contained a used yellow gown. Next to this open bin was a container of unused personal protective equipment (PPE) supplies 2. Inside the medication room, a bag of adult brief pads was found on the floor 3. Inside the medication room, under the sink was a half-full container of water and located next to two containers of chemical agents, one of which was perineal wash. 4. Biohazard door was unlocked. This failure can potentially result to cross contamination of clean product items and impact the physical health, safety and well-being of all 29 residents. Findings: 1. During a concurrent observation and interview on 12/4/24, at 10:15 a.m., with Licensed Vocational Nurse (LVN) 1, in the hallway was an open lid bin with used yellow gown was noted outside of resident room [ROOM NUMBER]. Next to this open lid bin was a container with unused PPE supplies. LVN 1 stated the lid should have been closed for infection control. During an interview on 5/8/25, at 9:30 a.m., with Director of Nursing (DON), the DON stated the open lid bin containing used PPE should have been closed for infection control, as clean PPEs could be contaminated. 2. During a concurrent observation and interview on 12/4/24, at 10:15 a.m., with LVN 1, a bag of Presto Pads, 15 count XL (extra-large), was noted to be on the floor in the medication room. During an interview on 5/8/25, at 9:30 a.m., with DON, the DON stated the bag of briefs should not have been on the floor due to infection control. 3. During a concurrent observation and interview on 12/4/24, at 10:15 a.m., with LVN 1, a half-full container of water was found under the sink in the medication room. LVN 1 stated water was used by residents. During an interview on 5/8/25, at 9:30 a.m., with DON, the DON stated the water should not be next to chemicals as it could be missed and swallowed by anyone. 4. During a concurrent observation and interview on 12/4/24, at 10:15 a.m., with LVN 1, the Biohazard door was unlocked. LVN 1 stated door should be locked. LVN 1 left the door unlocked. During an interview on 5/8/25, at 9:30 a.m., with DON, DON stated Biohazard room should be locked as the room had used needles and someone could go in the room.