STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225640	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkeley Retirement Home,the	150 Berkeley Street Lawrence, MA 01841

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48671 Based on record review and interview, the facility staff failed to inform one out of one resident reviewed, and their representatives with potential liability for payment for non-covered services including estimated cost of services. Findings include: The Advanced Beneficiary Notice (SNFABN) is a form which provides information to Residents and/or their beneficiaries so that they can decide if they wish to continue receiving the skilled services they are receiving at the facility that may not be paid for by Medicare and assume financial responsibility for these services. Review of the facility's SNFABN form failed to include the cost of rehab services for one resident. During an interview on 5/14/24 at 10:55 A.M., the Administrator said the cost indicated on the form was for room and board and did not include skilled services, such as rehab.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 44095 Based on record review and interview, the facility failed to ensure that Minimum Data Set (MDS) assessments were coded accurately for one Residents (#5) out of a total sample of 11 residents. Specifically, for Resident #5, the MDS was accurately coded relative to a.) anticoagulation use, b.) antiplatelet use, and c.) hypoglycemic medication use. Findings include: Review of Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2023, indicated the following: - N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). - N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). - N0415J1. Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). Resident #5 was admitted to the facility in August 2018 with diagnoses including anxiety, depression, heart failure, and paroxysmal atrial fibrillation. Review of the Minimum Data Set (MDS) assessment, dated 4/20/24, indicated Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 which indicated he/she was cognitively intact. The MDS indicated: E. Anticoagulant, coded yes. I. Antiplatelet, coded no. J. Hypoglycemic, coded no. Review of the nurse practitioner progress note, dated 4/4/24, indicated Resident #5 unable to have anticoagulation due to gastrointestinal bleed. Review of the Medication Administration Record, dated April 2024, failed to include Resident #5 was ordered or prescribed an anticoagulant medication. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the physician's order, dated 4/26/19, indicated: -clopidogrel (antiplatelet medication) 75 milligram (mg), give one tablet by mouth every day. Review of the Medication Administration Record (MAR), dated April 2024, indicated nursing administered clopidogrel on 4/14/24 to 4/20/24. Review of the physician's order, dated 5/3/23, indicated: - metformin (hypoglycemic medication) 500 mg, give one tablet by mouth every day. Review of the MAR, dated April 2024, indicated nursing administered metformin (hypoglycemic) 4/14/23 to 4/20/24. During an interview on 5/14/24 at 2:32 P.M., the Director of Nursing (DON) said the MDS was not coded correctly.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on observation, record review, and interviews, the facility failed to ensure care plans were reviewed with the interdisciplinary team (IDT) as required for two Residents (#5 and #15), out of a total sample of 11 residents. Specifically, 1.) the facility failed to review and revise Resident #5's fall care plan with the IDT after each Minimum Data Set (MDS) assessment. 2.) the facility failed to revise and update Resident #15's Activities of Daily Living (ADL) care plan. Findings include: Review of the facility policy, Care Plans- Comprehensive, dated as revised December 2010, indicated an individualized comprehensive care plan that includes measurable objectives and time tables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 9. The Care Planning/ Interdisciplinary Team is responsible for the review and updating of care plans: d. At least quarterly. 1.) Resident #5 was admitted to the facility in August 2018 with diagnoses including anxiety, depression, heart failure, and paroxysmal atrial fibrillation. Review of the Minimum Data Set (MDS) assessment, dated 4/20/24, indicated Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 which indicated he/she was cognitively intact. The MDS indicated the resident has not had any falls since the previous assessment. Review of the plan of care related to falls, dated as revised on 5/5/22, indicated: - brace left lower extremity (LLE) on in morning and off at bedtime, skin check before and after application (currently not using brace, working with therapy). Review of the are plan conference summary, dated 5/6/24, indicated Resident #5's care plan was reviewed. On 5/13/24 at 7:26 A.M., the surveyor observed Resident #5 not wearing a brace to his/her left lower extremity. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/24 at 1:36 P.M., Certified Nurse Assistant (CNA) #1 said Resident #5 had not worn a leg brace for over a year. During an interview on 5/13/24 at 1:51 P.M., Nurse #1 said Resident #5 has not worn a brace in over a year. Nurse #1 said the Director of Nursing will update care plans during care plan meetings. During an interview on 5/14/24 at 2:37 P.M., the Director of Nursing (DON) said care plans should be reviewed quarterly during the care plan meeting. 43807 2.) Resident #15 was admitted to the facility in July 2023 with diagnoses including Dementia and a history of falling. A review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident requires supervision or touching assistance while walking 10 feet, 50 feet with 2 turns, and 150 feet. On 5/14/24 at 10:34 A.M., the surveyor observed Resident #15 ambulating with a walker to an outside activity, the Activities Director was assisting the Resident, the Resident was wearing a gait belt. On 5/14/24 at 1:40 P.M., the surveyor observed Resident #15 ambulating with a walker back into the facility from the outside activity, Certified Nurse's Assistant (CNA) #1 was assisting the Resident, the Resident was wearing a gait belt. During an interview on 5/14/24 at 1:26 P.M., the Activities Director said the Resident ambulates with supervision with a rolling walker and has to have a gait belt on. She said the Resident is not able to ambulate independently. During an interview on 5/14/24 at 1:45 P.M., CNA #1 said that the Resident ambulates with a rolling walker with supervision, she said the Resident wears a gait belt and staff have to guide him/her while walking. A review the Resident's ADL care plan initiated on 8/23/23 and revised on 10/13/23 indicated the following: -Transfer-Independent, remind to use rolling walker -Ambulation-Independent using rolling walker -Locomotion-Independent using rolling walker During an interview on 5/14/24 at 1:47 P.M., Nurse # 1 said the Resident does not ambulate independently with a rolling walker, he/she needs supervision and assistance from staff, she said the Resident also needs to be wearing a gait belt while ambulating. Nurse #1 said the ADL care plan should be revised to reflect that. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/24 at 2:27 P.M., the Director of Nurses said Resident #15 requires supervision while ambulating with a rolling walker, she said the Resident should also have a gait belt on while ambulating, the Director of Nurses said the ADL care plan should be updated and revised to reflect the current Resident's ambulation status.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44095 Based on review of the facility's licensed nurse staff schedules, employee punch cards, and interviews, the facility failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. Specifically, the facility failed to provide at least eight consecutive hours of RN services in the facility over one, 24-hour period, when no nurse staffing waivers were in place. Findings include: Review of the PBJ Staffing Data Report, dated Quarter One (1) 2024 (October 1 to December 31), indicated there was no RN on the following date: - 10/21/23 Review of the nursing punch cards indicated a RN finished her shift on 10/20/23 at 11:15 P.M., and there was no RN scheduled until 10/22/23 at 2:45 P.M., consisting of approximately 39 hours without consecutive RN coverage. During an interview 5/14/24 at 11:07 A.M., the Administrator confirmed there was no RN on 10/21/23, the Administrator said she is aware of the requirement for RN coverage. During an interview on 5/14/24 at 1:39 P.M., the Scheduling Coordinator said there should be at least eight consecutive hours of RN services a day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 48671 Based on observation, record review and interview, the facility failed to ensure a water management program was implemented to minimize the risk of Legionella and other opportunistic pathogens in building water systems by having a documented water management program. Findings include: Review of the facility policy titled, Legionella Surveillance and Detection, dated 9/2018, indicated the following: - Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaire's disease will be included as part of our infection surveillance activities. Review of the facility policy titled, Legionella Water Management Program, dated 9/2018, indicated the following: -As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. -The purpose of the water management program are to identify areas in the water system wherever Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. -The water management program includes the following elements: an interdisciplinary water management team, a Legionella Risk Assessment completed at least annually. -The identification of areas in the water system that could encourage growth and spread of Legionella or other waterborne bacteria. -Identification of situations that can lead to Legionella growth. -Specific measures used to control the introduction and/or spread of Legionella. -The control limits, or parameters that are acceptable and that are monitored. -A diagram of where control measures are applied. -A system to monitor limits and the effectiveness of control measures. -A plan for when control limits are not met and/or control measures are not effective. -Documentation of the program. -The water management program will be reviewed at least once a year, or sooner if any of the following occur: There are changes in laws, regulations, standards, or guidelines. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/14/24 at 1:59 P.M., the Maintenance Director said the facility has not implemented it's water management program, implemented measures, or conducted any water assessments. The Maintenance Director said he started working at the facility four months ago and was unable to locate any documented water management program and has not initiated a water management program. During an interview on 5/14/24 at 2:00 P.M., the Administrator said the facility has not implemented it's water management program to monitor for Legionella and that the facility should have a program in place. The Administrator was unable to locate any documentation of a water management program prior to starting at the facility in December of 2023.