

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/22/2025
NAME OF PROVIDER OR SUPPLIER  Berkshire Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Berkshire Road West Babylon, NY 11704	

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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and staff interviews during an abbreviated survey (NY002604352) initiated on 09/03/2025, the facility failed to ensure residents received treatment and care according to professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for three (3) of (5) residents reviewed. Specifically, 1) Resident #1 had no bowel movements eight (8) consecutive days from (07/19/2025 through 07/26/2025 and again for nine (9) consecutive days from 07/28/2025 through 08/05/2025. 2) Resident #2 had no bowel movements for eight (8) consecutive days from (08/15/2025 through 08/22/2025 and again for (8) consecutive days from 08/24/2025 through 08/31/2025. 3) Resident #3 had no bowel movements for eight (8) consecutive days from 06/06/2025 through 06/13/2025 and again for 11consecutive days from 06/15/2025 through 06/25/2025. There was no documented evidence the physician was notified or that the facility staff were aware of the resident's need for interventions to facilitate regular bowel movements. Subsequently, Resident #1 was hospitalized for bowel impaction. This resulted in actual harm to Resident #1 and the likelihood of serious harm for Resident #2 and Resident #3 that is Immediate Jeopardy and Substandard Quality of Care to three out of five residents' health and safety. The findings are:The facility's policy titled Bowel Management dated June 2025 documented that every shift the nurses will check bowel movement pattern via the Electronic Medical Record and staff/resident interview to verify if resident had a bowel movement and notify the medical doctor accordingly. Nurses document on the Electronic Medical Record for this check. The nurses will monitor resident for any signs of pain, discomfort or complaints of constipation; medical doctor will be notified for further bowel management as needed. Resident #1 was admitted with diagnoses including spinal stenosis spondylosis (a degenerative condition of the spine that affects the intervertebral disc), and constipation (a gastrointestinal condition characterized by infrequent or difficult bowel movements and constipation. The admission Minimum Data Set a resident assessment tool dated 07/17/2025 documented a Brief Interview for Mental Status score of 15 indicating the resident has intact cognitive function. Resident #1's Certified Nursing Aide Documentation Record dated July 2025, and August 2025 documented no bowel movements from 07/19/2025 through 07/26/2025 eight (8) consecutive days and 07/28/2025 through 08/05/2025, nine (9) consecutive days. Resident #1's Physician Order dated 07/10/2025 documented to check bowel movement pattern every shift. If there was no bowel movement in 48 hours, report to the medical doctor. There was no documented evidence in the medical record dated 07/17/2025 through 08/05/2025 that the medical doctor was notified that Resident #1 had no bowel movement for eight (8) consecutive days from 07/19/2025 through 07/26/2025 and for nine (9) consecutive days from 07/28/2025 through 08/05/2025. Resident #1 was discharged to the hospital on [DATE] related to a fall. A computed tomography (CT) scan was completed on 08/13/2025 in the hospital and the impression documented fecal impaction of the rectum with stercoral proctitis (a condition where inflammation of the rectum occurs due to prolonged fecal impaction. The resident did not return to the facility. During an interview with Certified Nursing Aide #2 on 09/03/2025 at 3:29 PM they stated Resident # 1 fell out of their wheelchair while Resident #1 was self-transferring back to their bed without assistance. Certified Nursing Aide #2 stated they were in the room close to the resident but could not reach them in time. Resident #1 stated to them they were constipated. Certified Nursing Assistant #2 stated they called the nurse because the resident fell. During an interview with Certified Nursing Aide #3 on 09/04/2025 at 12:25 PM they stated Resident#1 told them that they did not feel well because they were constipated and had received an enema earlier today 09/04/2025. There is no documented evidence in Resident #1's Medication Administration Record that the resident had an order for an enema. During an interview with Licensed Practical Nurse #2 on 09/04/2025 at 2:03 PM they stated they are to check the computer for a bowel report every shift to see when the residents have a bowel movement. Licensed Practical Nurse #2 they stated they were not sure how to check the computer for a bowel report. During an interview with Registered Nurse #1 on 09/04/2025 at 2:37 PM they stated they do not run the bowel report unless licensed practical nurse reports to them that a resident did not have a bowel movement in 48 hours. During an interview with Medical Doctor #1, who is the primary care physician for Resident #1, on 09/04/2025 at 5:01PM they stated the nurses are supposed to monitor the residents for bowel movements every shift. The nurses should notify them if the residents do not have a bowel movement for 48 hours. A resident could experience nausea, vomiting and abdominal pain. They also stated prolonged periods of no bowel movements place the residents at risk for obstruction and rupture of</p>		