STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335083	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkshire Nursing & Rehabilitation Center	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on record review and interviews conducted during a Recertification Survey and Abbreviated Survey (Complaint #NY 00322088) initiated on [DATE] and completed on [DATE], the facility did not have evidence that all alleged violations were thoroughly investigated in response to allegations of abuse, neglect, and mistreatment. This was identified for one (Resident #360) of eight residents reviewed for Accident. Specifically, Resident #360 with impaired cognition was found on the floor on [DATE]. The incident was reported to the facility staff by the resident's roommate. The facility did not obtain a statement from the resident's roommate to identify the root cause of the incident. Additionally, the Accident and Incident investigation summary indicated Licensed Practical Nurse #5 observed the resident on the floor; however, the written statement provided by the Licensed Practical Nurse indicated they were caring for another resident at the time of the incident and the inconsistency was not addressed by the facility. The finding is: The facility's undated policy titled Accident/Incident Investigation Management documented that statements, when appropriate, will be obtained from witnesses and others who may have knowledge of the event, for example, other residents. When possible, statements must be written and signed by the person involved. The Supervisor should review for sufficient detail. Resident #360 was admitted with diagnoses including Alzheimer's Disease, Chronic Atrial Fibrillation, and Fracture of the Lumbar Vertebra (lower spine). The Admission Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 10 which indicated moderately impaired cognition. The Minimum Data Set assessment documented the resident was usually able to understand others. A Comprehensive Care Plan for Falls dated [DATE] last revised on [DATE] documented that the resident was at risk for falls/injuries secondary to a history of falls, Alzheimer's Disease. and impaired gait. Interventions included to place the call bell within easy reach at all times, encourage the resident to call for assistance, and provide anti-skid socks. The care plan interventions were updated on [DATE] to include toileting every ,d+[DATE] hours and as needed while awake. An Accident and Incident Report dated [DATE] at 12:30 PM documented that Resident #360 fell in their room. Resident #360 stated they were sitting and slid down off their bed. The Accident and Incident Report did not identify who initially reported Resident #360's fall. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated [DATE], written by Registered Nurse #6, documented that at approximately 12:30 PM, Registered Nurse #6 was notified that Resident #360 was found on the floor. Upon assessment, the resident was lying supine on the floor on the left side of their bed with no injuries noted. Resident #360 complained of pain in the left lower posterior (back) leg. The Nurse Practitioner was notified and ordered neuro checks (evaluates brain and nervous system functioning) as per facility protocol and an x-ray of the left tibia and fibula (lower leg bones) related to pain. The summary of the investigation dated [DATE] documented that on [DATE], Resident #360 was observed on the floor on the left side of their bed by staff (Licensed Practical Nurse #5) after the resident's roommate reported that the resident was on the floor. Registered Nurse #6 responded and assessed the resident. Resident #360 stated they slid off the bed. The call bell was within reach and was not activated. Resident #360 requested to be toileted during the nursing assessment. Toileting was provided. The investigation concluded that there was no cause to believe abuse, mistreatment, or neglect had occurred. The facility investigation did not include a written statement from Resident #360's roommate who had initially reported the incident. The written statement from Licensed Practical Nurse #5 dated [DATE] documented that they were assisting another resident at the time of the incident. Resident #360's roommate, who had reported the incident, had expired and therefore was not interviewed. Licensed Practical Nurse #5 was interviewed on [DATE] at 1:21 PM and stated they were the nurse on duty along with Registered Nurse #6 on Unit East B on [DATE]. Licensed Practical Nurse #5 stated that the incident occurred around lunchtime and most of the nursing staff would be in the dining room assisting residents with their meals. Licensed Practical Nurse #5 stated they were in the dining room and did not receive any report from Resident #360's roommate about the resident's fall. Licensed Practical Nurse #5 stated they did not go into Resident #360's room and did not observe the resident on the floor. Licensed Practical Nurse #5 stated they also did not notify Registered Nurse #6 of Resident #360's fall and did not know who did. Licensed Practical Nurse #5 stated that if they had responded to Resident #360's roommate's call for help and had notified the Registered Nurse, they would include that information in their statement. The Accident and Incident investigation report did not include statements from other staff members who allegedly responded to the roommate's call for help and who had notified Registered Nurse #6 to assess Resident #360 on [DATE]. Registered Nurse #6, who no longer works in the facility, was interviewed on [DATE] at 12:43 PM. Registered Nurse #6 stated they were the Unit Manager at the time of the incident related to Resident #360. Registered Nurse #6 stated the unit charge nurses were responsible for initiating Accident and Incident reports. Resident #360's Accident and Incident report was completed by them (Registered Nurse #6) because they were helping the nurse. Registered Nurse #6 stated they did not obtain statements from staff or residents because the Risk Manager was responsible for investigating the Accidents and Incidents and obtaining the statements. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Risk Manager #1, who no longer works at the facility, was interviewed on [DATE] at 2:53 PM. Risk Manager #1 stated they were responsible for investigating Resident #360's fall incident that occurred on [DATE]. Risk Manager #1 stated that if the resident's roommate was mentioned in the investigation summary, then the roommate should have been interviewed and their statement should have been attached to the Accident and Incident report. Risk Manager #1 stated they did not recall if they obtained a statement from Licensed Practical Nurse #5 and if the statement was consistent with the investigation report summary. Risk Manager #1 stated the Director of Nursing Services was ultimately responsible for reviewing the Accident/Incident report for completeness. Risk Manager #2 was interviewed on [DATE] at 4:14 PM. Risk Manager #2 reviewed the Accident and Incident report and stated that an interview with Resident #360's roommate should have been attempted and documented. Risk Manager #2 stated if inconsistency in a staff's statement was identified then a follow-up interview should have been conducted and documented. Risk Manager #2 stated that Resident #360's Accident and Incident was missing a statement from the resident's roommate and Licensed Practical Nurse #5's statement was inconsistent with the investigative summary. The Director of Nursing Services was interviewed on [DATE] at 1:10 PM and stated all Accident and Incident reports should be reviewed and investigated thoroughly. The Director of Nursing Services was unable to locate a statement from Resident #360's roommate and a statement from the staff member who was first notified of the incident, involving Resident #360, by the resident's roommate. The Director of Nursing Services stated they trusted Risk Manager #1 and did not see why it was important to figure out and obtain a statement from the person who first saw the resident on the floor. 10 NYCRR 415.4 (b) (3)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and staff interviews during the Recertification Survey initiated on 8/14/2024 and completed on 8/20/2024, the facility did not ensure that each resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for one (Resident # 95) of two residents reviewed for Pressure Ulcers. Specifically, Resident #95 had a history of a Pressure Ulcer of the Sacral (the portion of the spine between the lower back and tailbone) Region. Resident #95 had a physician's order for an alternating-pressure air mattress. During multiple observations, the adjustable weight setting for the air mattress, which is meant to correspond to the resident's weight, was not set accurately. The finding is: The facility's policy and procedure titled Alternating Pressure/Low Air Loss Mattress, last revised on 10/2023, documented that an alternating pressure/low air loss mattress will be used to maintain adequate circulation to the skin at pressure areas, to prevent the development of skin ulcers in residents with little or no mobility, and to assist in the treatment of skin ulcers. Maintenance will apply the air mattress to the bed frame. Nurses or Maintenance will adjust the pressure control knob to the appropriate setting based on the Resident's weight. The operation manual for the alternating-pressure air mattress documented instructions for setting up the pump with a control knob that adjust the pressure of the mattress with the weight of the resident. Resident #95 was admitted to the facility with Diagnoses including Type 2 Diabetes, Venous Insufficiency, and Chronic History of Stage 4 Pressure Ulcer of the Sacral region (the portion of the spine between the lower region back and tailbone). The Quarterly Minimum Data Set (MDS)assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #95 had intact cognition. The Quarterly Minimum Data Set (MDS) assessment documented that Resident #95 had a Venous (wound caused by a damaged vein) ulcer on the left posterior (back) thigh. A Comprehensive Care Plan (CCP) dated 5/22/2024 and renewed on 8/15/2024 documented that Resident #95 had a skin breakdown on the left posterior thigh and Moisture Associated Skin Damage (MASD) wound over sacral scarring related to impaired mobility and a history of pressure ulcers. Interventions included an air mattress, the use of skin protectant when performing care, providing supplements, and applying treatments as ordered by the Physician. A physician's order dated 8/31/2023 and renewed on 8/13/2024 documented utilizing an Alternating Air Mattress when in bed. A physician's order dated 8/12/2024 documented cleaning the left posterior thigh with normal saline followed by Calcium Alginate (a dressing that absorbs moisture) and abdominal pad dressing twice a day. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 8/15/2024 documented discontinuing the Calcium Alginate and applying Calmoseptine (a moisture barrier ointment) 0.44 percent to 20.6 percent ointment to the left posterior thigh and covering the wound with an abdominal pad every shift. A physician's order dated 8/12/2024 documented cleaning the sacrum with normal saline followed by Collagen (a dressing that breaks inflammation) and Calcium Alginate covered with an abdominal pad and paper tape daily. A review of the electronic medical record indicated that Resident #95's most recent weight dated 7/29/2024 was 176 pounds. A Wound Care Report dated 8/15/2024 documented that Resident #95's wound on the sacrum measured 1 centimeter in length, 2 centimeters in width, and 0.1 centimeters in depth. The wound had serous (yellow or transparent) discharge and a superficial cluster of open areas over scarred tissue. A Wound Care Report dated 8/15/2024 documented that Resident #95's wound on the left posterior (back) thigh had less maceration (softening and breaking down of skin from prolonged exposure to moisture) but remained denuded (exposed raw tissue) and no discharge. The treatment was changed to Calmoseptine ointment after cleaning with normal saline and covering with an abdominal pad every shift. On 8/14/2024 at 9:47 AM, Resident #95 was observed in bed. The air mattress control knob was set at 300 pounds. On 8/14/2024 at 1:45 PM, Resident #95 was observed in bed. The air mattress control knob was set at 300 pounds. Certified Nursing Assistant #1 was interviewed on 8/16/2024 at 2:00 PM and stated they were only responsible for checking if the mattress was deflated. Certified Nursing Assistant #1 stated they would inform the Nurses and Maintenance if there were any problems with the air mattress. Certified Nursing Assistant #1 stated the nurses were responsible for maintaining the air mattress weight setting. Licensed Practical Nurse #1 was interviewed on 8/16/2024 at 2:15 PM and stated they do not check the air mattress weight setting for Resident #95. Licensed Practical Nurse #1 stated the Wound Care Nurse was responsible for checking and monitoring the air mattresses. Registered Nurse #3, the Wound Care Nurse, was interviewed on 8/16/2024 at 3:00 PM and stated when the air mattress is first installed, they set up the air mattress control knob according to the Resident's weight. Registered Nurse #3 stated they do a monthly audit on the air mattress including the weight setting. Registered Nurse #3 stated the Nurses and Certified Nursing Assistants would inform them (Registered Nurse #3) with any malfunction on the air mattress. Registered Nurse #3 stated there is no documentation that a certain discipline monitored the air mattress. The Wound Care Nurse Practitioner was interviewed on 8/19/2024 at 12:03 PM and stated the air mattress should correspond to Resident #95's weight. The Wound Care Nurse Practitioner stated the facility was responsible for monitoring the air mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Staff was interviewed on 8/19/2024 at 2:15 PM and stated they do not have any issues with the air mattress in the facility. The Director of Nursing Services stated the Nurses and Certified Nursing Assistants were aware to inform the Wound Care Nurse and Maintenance of any concerns with the air mattress. The Director of Nursing Staff stated the Nurses should have been aware that monitoring the air mattress was a nursing responsibility. 10 NYCRR 415.12(c)(1)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 8/14/2024 and completed on 8/20/2024, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents. This was identified for one (Resident #71) of eight residents reviewed for Accidents. Specifically, Resident #71 required the assistance of two staff members for bed mobility as per the Rehabilitation Department screening on 1/4/2024 and 4/4/2024. The resident's comprehensive care plan and nursing care instructions for the Certified Nursing Assistants were not updated to reflect the Rehabilitation Department's recommendations. During the morning care on 6/24/2024, Certified Nursing Assistant #5 turned the resident on their side to clean the resident's back and the resident fell out of the bed. Subsequently, Resident #71 was transferred to the hospital and was diagnosed with a fracture of the right leg. This resulted in actual harm to Resident #71 that is not Immediate Jeopardy. The finding is: The facility's policy titled Rehabilitation Evaluations/Screens/Assessments, last reviewed January 2022, documented the purpose is to ensure the resident receives Physical Therapy, Occupational Therapy, and Speech Therapy evaluation upon admission, quarterly, and as necessary to obtain the resident's baseline function, improve or maintain status, and set appropriate goals/outcome to obtain optimal performance. The undated facility's policy titled Activities of Daily Living documented appropriate care and services will be provided for residents who are unable to carry out Activities of Daily Living independently, in accordance with the plan of care, including appropriate support and assistance with hygiene and mobility. For a dependent resident: the helper does all of the effort; the resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity. Resident #71 was admitted with diagnoses including Dementia, Anxiety Disorder, and Hypertension. The 4/6/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 6, indicating the resident had severe cognitive impairment. The Minimum Data Set assessment documented the resident was dependent on staff for rolling from lying on their back to the left or right side. The Rehabilitation Department's quarterly screens dated 1/4/2024 and 4/4/2024 documented the resident required maximum assistance of two people for bed mobility (the ability of the resident to move from their back to the left or right side when in bed). A Comprehensive Care Plan titled Activities of Daily Living All Tasks, effective 8/5/2022 and last updated on 4/4/2024, documented the resident required partial/moderate physical assistance of one staff member for bed mobility (the ability of the resident to move from their back to the left or right side when in bed). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	There was no documented evidence the Rehabilitation Department updated the Activities of Daily Living All Task care plan to include two person assistance for bed mobility. The Resident Nursing Instructions (care instructions provided to Certified Nursing Assistants) from 6/1/2024 through 6/30/2024 documented Resident #71 required one-person partial/moderate physical assistance for bed mobility. The resident had the behavior of yelling and screaming. A review of the Certified Nursing Assistant Accountability Record for June 2024 documented bed mobility was performed by one staff member through 6/24/2024 as indicated by staff signatures. A nursing progress note dated 6/24/2024 at 2:24 PM, written by Registered Nurse #2 (the Risk Manager), documented this writer was called to assess the resident who was on the floor. While Certified Nursing Assistant #5 was providing care to the resident (at 11:15 AM), the resident began reaching for their stuffed animal, which was on the nightstand table near the bed. The resident reached too far and rolled out of bed onto the floor before Certified Nursing Assistant #5 could reach the resident. Upon assessment, the resident was observed with a deformity to their right lower extremity and was complaining of pain. A Nurse Practitioner who was present in the building, assessed the resident and observed obvious deformity to their right lower extremity. Resident complained of pain from the right hip to the right ankle. 911 was called and the resident was transferred to the hospital. A nursing progress note dated 6/24/2024 at 3:16 PM documented the resident was admitted to the hospital with a diagnosis of a fracture of their right lower extremity. A review of the Accident and Incident Investigation dated 6/24/2024, prepared by Registered Nurse #2 (the Risk Manager) concluded the resident was reaching for a stuffed animal. The resident reached too far and rolled out of bed onto the floor before the Certified Nursing Assistant could prevent the fall. All care plan interventions were investigated to have been in place. The interdisciplinary team and medical services are in agreement that there was no evidence of any abuse, mistreatment, neglect, or exploitation. The hospital discharge summary dated 6/27/2024 documented the resident was admitted to the hospital on 6/24/2024 with a fracture of their right tibia/fibula (lower leg bones). A Nurse Practitioner readmission note dated 6/27/2024 at 4:06 PM documented the resident was readmitted from the hospital with a right tibia/fibula fracture and the right lower extremity had a cast from mid-femur (bone in thigh) to mid-foot. During an observation on 8/19/2024 at 12:15 PM, Resident #71 was in the day room waiting for lunch. The resident had a cast on their right leg. The resident stated they had a fall; however, could not remember how. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Rehabilitation Director on 8/19/2024 at 1:44 PM, the Rehabilitation Director stated Rehabilitation Department screens are completed quarterly and as needed. The quarterly screens dated 1/4/2024 and 4/4/2024 for Resident #71 documented the resident required maximum assistance of two staff members for bed mobility. The care that the Certified Nursing Assistants provide is based on the Rehabilitation Department assessment. The Therapist completing the assessment should update the resident's All-Task Activities of Daily Living care plans based on their assessment. Once the care plan is updated, the recommendations and instructions are automatically documented on the Resident Nursing Instructions. During an interview with Certified Nursing Assistant #5 on 8/19/2024 at 2:22 PM, they stated the resident was dependent on them for bed mobility. On 6/24/2024 they were providing morning care alone for the resident, which included washing their face, changing their brief, combing their hair, and getting them dressed. Resident #71 reached for their stuffed animal on the bedside table when they (Certified Nursing Assistant #5) turned the resident to their left side to clean the resident's back. Certified Nursing Assistant #5 stated they tried to support the resident, but the resident fell out of bed. Certified Nursing Assistant #5 stated the resident required one person's assistance for the bed as per the Resident Nursing Instructions. Certified Nursing Assistant #5 stated they worked with the resident prior to the fall on 6/24/2024 and always provided care by themselves. During an interview with Physical Therapist #1 on 8/19/2024 at 2:30 PM, stated they completed the quarterly Rehabilitation screening for Resident #71 on 1/4/2024 and 4/4/2024. According to their assessment, the resident required the maximum assistance of two staff members for bed mobility. Physical Therapist #1 stated the resident's care plan should have reflected the resident required two persons for the bed mobility as per the recommendations made on the Rehabilitation screens. Physical Therapist #1 stated their recommendation to use two staff for bed mobility was based on their assessment and observation of the resident while the resident was in bed. Physical Therapist #1 stated they were supposed to update the All-Task Activities of Daily Living care plan to reflect their recommendations to use two staff members for bed mobility. Physical Therapist #1 stated they screen many residents a day and try to make sure that everything matches; however, they could not remember why the care plan for Resident #71 was not updated in January 2024 and April 2024 after they completed the Rehabilitation screen. Physical Therapist #1 stated when the Activities of Daily Living care plan is updated, the recommendations are automatically updated on the Resident Nursing Instructions. During a re-interview with the Rehabilitation Director on 8/20/2024 at 8:45 AM, the Rehabilitation Director stated following Resident #71's Rehabilitation screens on 1/4/2024 and 4/4/2024, there was a conversation among the Interdisciplinary Team, which consisted of all Department Heads, during the morning report. The Rehabilitation Director stated even though Physical Therapist #1 documented the resident required two-person assistance for bed mobility, it was not based on the resident's physical needs but because of the resident's behaviors, so the team decided one person was appropriate for bed mobility. The Rehabilitation Director was unable to state the behaviors exhibited by the resident. The Rehabilitation Director stated they were part of the Interdisciplinary Team and were not sure where the discussion regarding the Interdisciplinary Team's decision not to implement the screen findings was documented. The Rehabilitation Director further stated nurses were responsible for updating the care plan related to the Interdisciplinary Team decision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with Licensed Practical Nurse #5, the unit charge nurse, on 8/20/2024 at 9:57 AM, they stated they attended Interdisciplinary Team meetings for Resident #71 and did not recall any discussions regarding not following the Rehabilitation Department screen assessment recommendation for Resident #71's bed mobility status. Licensed Practical Nurse #5 stated the All-Task Activities of Daily Living care plan is a Rehabilitation Department care plan and only the Rehabilitation Department can update that. Resident #71's medical record review revealed no documentation regarding the Interdisciplinary Team's decision to not implement the Rehabilitation screen assessment recommendations/findings. During a re-interview with Physical Therapist #1 on 8/20/2024 at 10:29 AM, when they completed the resident's Rehabilitation screen in January and April 2024, the resident was exhibiting behaviors of reaching out for things, grabbing, and trying to pinch the staff. Physical Therapist #1 stated the resident's behavior was one of the reasons they recommended two-person assistance with bed mobility for Resident #71. During an interview with Certified Nursing Assistant #6 on 8/20/2024 at 11:31 AM, they stated during the 11:00 PM - 7:00 AM shift, Resident #71 did not help in turning from their back to the left or right side. Certified Nursing Assistant #6 stated they always needed help to turn the resident in bed. During an interview with Certified Nursing Assistant #7 on 8/20/2024 at 12:07 PM, stated during the 3:00 PM - 11:00 PM shift, they always used two people to turn the resident from their back to the left or right side because the resident had a behavior of hitting the staff during care and the resident did not help with turning. During an interview with Physician #1 on 8/20/2024 at 1:00 PM, Physician #1 stated Resident #71's right leg fracture was the result of the fall from bed on 6/24/2024. During an interview with the Director of Nursing Services on 8/20/2024 at 1:38 PM they stated the Rehabilitation Department is responsible for updating the All-Task Activities of Daily Living care plan. The Director of Nursing Services stated based on the Rehabilitation screening evaluation, the resident required two staff members for bed mobility and if there was a discussion by the Interdisciplinary Team to not implement the assessment findings, the reasons should have been documented in the resident's medical record. They stated Certified Nursing Assistant #5 followed the instructions written on the Resident Nursing Instructions and cared for the resident alone on 6/24/2024. 10 NYCRR 415.12(h)(2)