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	02/18/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility did not ensure each resident received preadmission screening for individuals with a mental disorder. This was identified for one (1) (Resident #9) of 32 residents reviewed for Preadmission Screening and Resident Review (PASRR). Specifically, Resident #9 with diagnosis of schizophrenia (a chronic, severe brain disorder that distorts how a person thinks, feels, acts, and perceives reality) was originally admitted to the facility on [DATE]; there was no documented evidence that a Preadmission Screening and Resident Review was completed for Resident #9, prior to their admission to the facility. Additionally, the Preadmission Screening and Resident Review screen form completed on 07/18/2025 was incomplete and did not assess the need for a Level II referral.The finding is:The facility's policy titled Preadmission Screening and Resident Review (PASRR), last reviewed December 2025, documented all residents have a screen upon admission to the facility and thereafter, when there is a significant change that has a bearing on the resident's specialized service needs. The screen assesses residents' mental illness, dementia, and intellectual disability/developmental disability and ensures that they are placed in the least restrictive setting and receive recommended interventions to improve their quality of life. Upon admission, a Preadmission Screening and Resident Review screen is either sent with the Patient Review Instrument (PRI- a mandatory clinical assessment tool in New York State used to determine a person's medical, physical, and cognitive condition for admission to a skilled nursing facility) or completed by a qualified Preadmission Screening and Resident Review screener.Resident #9 was admitted with diagnoses including schizophrenia, Parkinson's disease, and diabetes mellitus. The 01/23/2026 quarterly Minimum Data Set assessment documented no Brief Interview for Mental Status as the resident had severely impaired cognitive skills for daily decision making. The Minimum Data Set assessment documented the resident was receiving antipsychotic medications.A physician's order dated 02/12/2026 documented Seroquel (antipsychotic medication) 25 milligram tablet, give one (1) tablet by oral route once daily at bedtime, for diagnosis of schizoaffective disorder, bipolar type; and major depressive disorder, recurrent, severe with psychiatric symptoms.Review of the resident's electronic medical record revealed that the resident was originally admitted to the facility on [DATE]. There was no initial Preadmission Screening and Resident Review screen form in the medical record.The facility provided a Preadmission Screening and Resident Review screen form dated 07/18/2025 that was completed by Social Work Director #1 upon Resident #9's readmission to the facility on [DATE] from the hospital. This form documented that the resident had a serious mental illness (Yes to Question 23); however, this form was incomplete because the directions were not followed for the steps to be taken if question 23 was marked as Yes to determine if the resident required a Level II referral.During an interview on 02/13/2026 at 11:10 AM, Social Work Director #1 stated the Preadmission Screening and Resident Review screen form is supposed to be provided by the hospital and the Preadmission Screening and Resident Review form was not received from the hospital on [DATE]. Social Work Director #1 stated they initiated the Preadmission Screening and Resident Review screen for the Resident #9 on 07/18/2025 as they were a qualified Preadmission Screening and Resident Review screener. The 07/18/2025 Preadmission Screening and Resident (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review screen form was not completed correctly and would have to be re-done. Social Work Director #1 stated they could not find the initial Preadmission Screening and Resident Review screen when the resident was first admitted to the facility in 2023.On 02/13/2026 at 11:36 AM, Social Work Director #1 provided a revised Preadmission Screening and Resident Review screen form dated 02/13/2026 for Resident #9. Social Work Director #1 stated the new screen indicated the resident was receiving the appropriate services at the facility and did not require a Level II referral.During an interview on 02/13/2026 at 1:15 PM, Social Work Director #1 stated they have not been able to find the Preadmission Screening and Resident Review screen form for the 04/25/2023 admission.During an interview on 02/13/2026 at 2:00 PM, the Administrator stated they were unable to find the Preadmission Screening and Resident Review screen for Resident #9. The facility should receive the Preadmission Screening and Resident Review screen form from the hospital upon resident's admission to the facility. If the screen form is not provided during the admission process by the hospital, Social Work Director#1 should complete the Preadmission Screening and Resident Review screen as they are a qualified screener.10 NYCRR 415.11(e)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey, the facility did not ensure that a comprehensive person-centered care plan was implemented for one (1) (Resident #13) of three (3) residents reviewed for skin integrity. Specifically, Resident #13 was assessed to have fragile skin and required use of the Geri sleeves according to the Comprehensive Care Plan. During multiple observations, Resident #13 was observed without the use of the Geri sleeves.The finding is: A facility policy and procedure titled Comprehensive Care Plan, last reviewed 06/2025, documented the Person-Centered Care Plan is developed to include information necessary to properly care for the residents. The Comprehensive Care Plan will be implemented by qualified members of the facility staff. Resident #13 was admitted with diagnoses including non-Alzheimer's dementia, diabetes mellitus, and depression. A quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, indicating the resident was cognitively intact. Resident #13 did not exhibit behaviors of rejection of care and required partial/moderate assistance for upper body dressing. The comprehensive care plan titled Skin Integrity: Risk for Skin Breakdown, effective 05/06/2025, documented the resident was at risk for skin breakdown secondary to fragile skin and diabetes mellitus. The interventions included using Geri sleeves and providing protective/preventative skin care. A physician's order dated 12/10/2025 documented to monitor skin integrity each shift. During an observation on 02/10/2026 at 9:59 AM, Resident #13 was wearing a shortˆsleeved shirt and did not have the Geri sleeves on their arms. During an observation on 02/12/2026 at 9:27 AM, Resident #13 was in bed wearing a gown and had no Geri sleeves on their arms. During an observation on 02/12/2026 at 2:08 PM, Resident #13 was in bed wearing a shortˆsleeved shirt and had no Geri sleeves on their arms. During an observation on 02/13/2026 at 10:30 AM, Resident #13 was wearing a shortˆsleeved shirt and had not Geri sleeves on their arms. During an interview on 02/13/2026 at 11:01 AM, Certified Nursing Assistant #1 stated they refer to Certified Nursing Assistant Accountability Record to determine required care and receive updates from the Charge Nurse. Certified Nursing Assistant #1 stated the Activities of Daily Living (ADL) instructions on the Certified Nursing Assistant Accountability Record did not indicate Geri sleeves as one of the interventions for Resident #13. During an interview on 02/13/2026 at 11:27 AM, Registered Nurse Charge Nurse #3 stated that registered nurses were responsible for initiating the care plans and copying the care plan interventions into the Certified Nursing Assistant Accountability Record. Registered Nurse Charge Nurse #3 reviewed the Certified Nursing Assistant Accountability Record and confirmed that Geri sleeves were not listed as an intervention for Resident #13. During an interview on 02/13/2026 at 11:34 AM, the Assistant Director of Nursing stated the intervention for using the Geri sleeves are documented on Resident #13's care plan; however, these interventions were not documented on the Certified Nursing Assistant Accountability Record, therefore Certified Nursing Assistant #1 likely did not apply the Geri sleeves. During an interview on 02/18/2026 at 11:04 AM, the Director of Nursing Services stated that care plan interventions should be carried over to the Certified Nursing Assistant Accountability Record for the staff to implement appropriate interventions according to each resident's plan of care. The Director of Nursing Services stated Resident #13 should have been provided with the Geri sleeves according to their care plan to prevent any skin damage. 10 NYCRR 415.11 (c)(1)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility did not ensure that each resident who needs respiratory care is provided care in accordance with the professional standards of practice and the comprehensive person-centered care plan. This was identified for one (1) (Resident #128) of four (4) residents reviewed for Respiratory Care. Specifically, Resident #128 indicated they use the Continuous Positive Airway Pressure machine (CPAP- a machine used for obstructive sleep apnea: a condition with temporary pauses in breathing during sleep) that was observed on their nightstand. Resident #128 did not have a physician's order or a Comprehensive Care Plan (CCP) with goals and interventions for the use of the Continuous Positive Airway Pressure machine. The finding is:The facility policy titled, Non-Invasive Ventilation Devices last revised on 09/2025 documented that a Physician, Physician Assistant, or Nurse Practitioner order is required for the use of the Non-Invasive ventilation devices. The order is to include initiation of the device, diagnosis, pressure settings, and oxygen requirements. Non-invasive ventilation devices will be utilized for nocturnal (nighttime) use. The settings may not be adjusted without a provider order. The tubing and masks will be kept in a bag, when not in use. A Pulmonology consult is to be ordered as indicated. The device will be applied and monitored by the licensed Nurses.Resident #128 was admitted with diagnoses including chronic obstructive pulmonary disease (COPD, progressive lung disease that restricts airflow and causes breathing difficulties), heart failure (a chronic condition where the heart muscle cannot pump blood efficiently) and hypertension (high blood pressure). The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated that Resident #128 had intact cognition. The Minimum Data Set assessment documented that Resident #128 had shortness of breath or trouble breathing when lying flat and was receiving continuous oxygen therapy.A review of Resident #128's electronic medical record revealed that Resident #128 did not have a physician's order or a care plan developed for the use of the Continuous Positive Airway Pressure (CPAP).A physician's order dated 01/07/2026 documented continuous supplemental oxygen therapy via nasal cannula at two (2) liters per minute, every shift.A Comprehensive Care Plan (CCP) titled, Respiratory Disorders: Chronic Obstructive Pulmonary Disease (COPD) and Chronic Respiratory Failure dated 12/12/2025 documented interventions including monitoring respiratory status, administering oxygen as per physician's order, and administering medications as per physician's order. The care plan did not include the use of the Continuous Positive Airway Pressure machine.During an observation on 02/10/2026 at 12:12 PM, Resident #128 was sitting in a wheelchair in their room. A Continuous Positive Airway Pressure (CPAP) machine was observed on Resident #128's nightstand. The machine was not connected to the oxygen concentrator. Resident #128 stated that the Continuous Positive Airway Pressure machine did not have to be connected to an oxygen source and worked on room air.During an observation on 02/10/2026 at 2:11PM, Resident #128 was lying in bed. A Continuous Positive Airway Pressure (CPAP) machine was observed on Resident #128's nightstand.During an interview on 02/10/2026 at 12:39 PM, Resident #128 stated they had used the Continuous Positive Airway Pressure (CPAP) machine at times since they have been at the facility. Resident#128 stated that they were familiar with the use of the Continuous Positive Airway Pressure machine and did not need a nurse to set it up.During an observation on 02/11/2026 at 8:15 AM, Resident #128 was lying in bed. A Continuous Positive Airway Pressure (CPAP) machine was observed on Resident #128's nightstand.During an interview on 02/11/2026 at 1:38PM, Licensed Practical Nurse #1, the Medication Nurse, stated that they had seen the Continuous Positive Airway Pressure machine on Resident #128's nightstand. They did not check if there was a physician's order for the use of the machine because they only work during the 7:00 AM-3:00 PM shift and the Continuous Positive Airway Pressure was used during the evening shift.During an interview on 02/11/2026 at 1:59 PM, Registered Nurse #1, the Charge Nurse, stated Resident #128 did not have a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's Order for the use of the Continuous Positive Airway Pressure machine. Registered Nurse #1stated they did not know who brought the Continuous Positive Airway Pressure machine to the resident's room. Registered Nurse #1 stated that there should have been a physician's order if Resident #128 was using the machine. During an interview on 02/13/2026 at 8:15AM, the Pulmonologist stated if Resident #128 was utilizing the Continuous Positive Airway Pressure machine at the facility, there should have been a physician's order for the proper setting, frequency of use, and the care of the Continuous Positive Airway Pressure machine.During an interview on 02/17/2026 at 8:58 AM, the Director of Nursing Services stated that they did not know who had brought the Continuous Positive Airway Pressure machine for Resident #128. The Director of Nursing Services stated that they expect the staff to be aware of their surroundings and report any observations including equipment found in the resident's room.10NYCRR 415.12(k)(6)

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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. Based on observation, record review, and interviews, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and include the appropriate instructions and the expiration date to facilitate considerations of precautions and safe administration of medications. This was identified on one (1) (East A unit) of three (3) nursing units. Specifically, on 02/10/2026, a medication cart on the East A nursing unit was observed with a vial of Insulin lispro (fast acting insulin to be administered pre-meal based on a sliding scale to prevent blood sugar from spiking after the meal) with an open date of 01/03/2026. The insulin vial was not discarded after 28 days as per the manufacturer's guidelines.The finding is:The facility's policy titled Insulin Administration, last reviewed 10/2025, documented under Procedure: Check and verify physician order; check blood glucose levels as per physician order; verify insulin type, dose, timing, and expiration date. The policy did not indicate when to discard the open insulin.The facility's policy titled Medication Storage, reviewed 10/2025, documented medications must be stored in accordance with manufacturer's specifications and secured in locked storage areas in compliance with State and Federal requirements and accepted professional standards of practice. Multiple dose vials of medications that are opened shall have the start (opening) date indicated on them.The Food and Drug Administration data sheet for Humalog (insulin lispro) documented in-use vials, cartridges, pens should be stored at room temperature and must be used within 28 days or be discarded, even if they still contain insulin.Resident #167 was admitted with diagnoses including diabetes mellitus, cerebrovascular accident, and seizure disorder. The 01/10/2026 quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact, and the resident received insulin injections for seven days prior to 01/10/2026.A physician's order dated 10/10/2025 and renewed on 02/04/2026 documented Insulin Sliding Scale, insulin lispro 100 unit/milliliter subcutaneous solution, inject by subcutaneous (delivers medication into the fatty tissue layer between the skin and muscle) route three (3) times per day before meals and at bedtime as needed, every day at 11:30 am; 4:30 pm; 6:30 am; and 9:00 pm; if blood sugar equals 200-250 administer 2 Units; 251 - 300 administer 4 Units; 301 - 350 administer 6 Units; 351 - 400 administer 8 Units; If greater than 400 or below 60, call physician; for diagnosis of diabetes mellitus with other specified complications.During an observation of a medication cart with Licensed Practical Nurse #1 on 02/10/2026 at 1:35 PM, an opened vial of insulin lispro insulin was kept in a box with an open date of 01/03/2026 written on the box which was stored in a plastic bag. The plastic bag had a label with Resident #167's name. Licensed Practical Nurse #1 confirmed the insulin vial was first opened on 01/03/2026 and should have been discarded after 28 days from the opening date. There were no other vials of insulin lispro in the cart for Resident #167.During an interview on 02/11/2026 at 9:37 AM, Assistant Director of Nursing Services/Nursing Education #1 stated, I think it is just good practice to discard the insulin after 28 days. I am not aware of anything that happens to the insulin.During an interview on 02/11/2026 at 9:45 AM, the Director of Nursing Services stated the standard is to discard the insulin after 28 days from opening. The nurses should know that. The Director of Nursing Services stated the Pharmacist would know what happens to the insulin after 28 days. I am not sure.During an interview on 02/11/2026 at 2:20 PM, Pharmacist #1 stated the insulin lispro should be discarded after 28 days of being opened; this is the manufacturer's guideline. Insulin loses its potency and may not be as effective in controlling the blood sugar levels. 10 NYCRR 415.18(d)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not maintain medical records on each resident that are complete and accurately documented. This was identified for one (1) (Resident #174) of three (3) residents reviewed for Urinary Catheter. Specifically, Resident #174 was admitted with a foley catheter. Primary Physician #2 initiated documentation of an admission History and Physical evaluation on 02/09/2026, prior to the resident's arrival to the facility and did not complete the documentation until 02/10/2026. The evaluation inaccurately documented Resident #174 was continent, had no foley catheter, and had no diagnosis related to urinary tract. The finding is: The facility's policy titled, Physician Visits, last reviewed 1/2026, documented the Medical Staff shall provide for a medical history and physical examination to be done within 48 hours after admission to the facility. The Medical Staff shall record, date, and sign the significant findings of the history and physical examination in the appropriate form in the chart including, but not limited to: a complete medical history, physical examination, a complete list of diagnoses and problems, and admission orders to include, but not limited to: medications, consultations, diagnostic tests, and monitoring. Medical History should be obtained from the resident, family, and transfer forms. During the Physical Examination particular attention should be paid to include but not limited to: presence of urinary or fecal incontinence. Resident #174 was admitted to the facility with diagnoses which included hypothyroidism (a condition which happens when the thyroid gland makes too much thyroid hormone) and hypertension (abnormally high blood pressure). The resident was admitted on [DATE] and a comprehensive Minimum Data Set was not available. The physician's order dated 02/09/2026, ordered by Primary Physician #1 and signed by Primary Physician #2, documented for the resident to have a Foley Catheter #16 French with a 10 cubic centimeter (cc) balloon related to diagnosis of stress incontinence. Review of the resident's Hospital Discharge summary dated [DATE] revealed under the active problem list a diagnosis of acute urinary retention and under the past medical history a diagnosis of urinary disorder and stress incontinence. The Medical Doctor Examination - Comprehensive admission History and Physical dated 02/09/2026 and completed on 02/10/2026 by Primary Physician #2 documented the resident had no urinary incontinence, no urinary retention, and no foley catheter. In addition, there was no documented past or present history of the resident having a diagnosis of neurogenic bladder or Parkinson's disease. The Physician's Order dated 02/13/2026 at 09:32 AM, entered by Assistant Director of Nursing #2, ordered by Primary Physician #1, and signed by Primary Physician #2 at 11:46 AM, documented for the resident to have a Foley Catheter #16 French with a 10 cubic centimeter (cc) balloon related to diagnosis of neurogenic bladder. During an interview on 02/13/2026 at 11:00 AM, Primary Physician #1 stated Primary Physician #2 completed the admission History and Physical and did not document the resident had a foley catheter. During an interview on 02/13/2026 at 12:15 PM, Primary Physician #2 stated they may have started the resident's admission History and Physical template before seeing the resident. Primary Physician #2 stated upon examining the resident, they saw the resident had a foley catheter and just forgot to go back and update the admission History and Physical in the medical record. During an interview on 02/13/2026 at 1:40 PM, the Medical Director stated some Physician's do begin to fill out a resident's Medical Doctor Examination - Comprehensive admission History and Physical before they see the resident and then adjust it accordingly after seeing the resident. The Medical Director stated Primary Physician #2 should have updated the medical record to indicate the presence of the foley catheter after they examined the resident. 10 NYCRR 415.15(b)(1)(i)(ii)