

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER Berkshire Place		STREET ADDRESS, CITY, STATE, ZIP CODE 455 Douglas Avenue Providence, RI 02908	
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>42907</p> <p>Based on record review and staff interview, it has been determined that the facility failed to notify the resident and the resident's representative(s) of a transfer or discharge and the reasons for the move in writing and in a language and manner they understand for 1 of 1 resident who was transferred to the hospital and discharged from the facility, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to The Rhode Island Department of Health on 1/15/2025, alleged that Resident ID #1 was not permitted to return to the facility, and s/he was not given a 30 day notice, as required.</p> <p>Record review revealed that the resident was admitted to the facility in July of 2019 with diagnoses of violent behaviors and dementia.</p> <p>Record review revealed a Quarterly Minimum Data Set Assessment, dated 12/2024, revealed a Brief Interview for Mental Status Score could not be completed as the resident has severe cognitive impairment.</p> <p>Record review further revealed that s/he was transferred to the emergency room for evaluation following an alleged resident to resident interaction on 1/14/2025 at 1:32 PM.</p> <p>Further record review revealed that the resident was documented as being discharged from the facility on 1/14/2025.</p> <p>Record review failed to reveal evidence that the facility notified the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.</p> <p>During a surveyor interview with the Administrator and the Director Of Nursing on 1/17/2025 at approximately 1:10 PM, they were unable to provide evidence that the resident and the resident's representative(s) were notified of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.</p> <p>Cross Reference F 625 and F 626</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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>42907</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide evidence that written notification was provided to the resident or resident representative(s) regarding a bed hold. Additionally, at the time of transfer the facility failed to provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy for 1 of 1 resident who was transferred to the hospital, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to The Rhode Island Department of Health on 1/15/2025, alleged that Resident ID #1 was not permitted to return to the facility, and s/he was not given a 30 day notice, as required.</p> <p>Record review revealed that the resident was admitted to the facility in July of 2019 with diagnoses of violent behaviors and dementia.</p> <p>Record review revealed a Quarterly Minimum Data Set Assessment, dated 12/2024, revealed a Brief Interview for Mental Status Score could not be completed as the resident has severe cognitive impairment.</p> <p>Record review further revealed that s/he was transferred to the emergency room for evaluation following an alleged resident to resident interaction on 1/14/2025 at 1:32 PM.</p> <p>Further record review revealed that the resident was documented as being discharged from the facility on 1/14/2025.</p> <p>Record review failed to reveal evidence that written notification was provided to the resident or resident representative(s) regarding a bed hold that specifies the duration of the state bed-hold policy during which the resident is permitted to return and resume residence in the nursing facility, the reserve bed payment policy in the state plan and the nursing facility's policies regarding bed-hold periods.</p> <p>Additionally, record review failed to reveal evidence that at the time of resident's transfer from the facility that the resident and the resident representative(s) were provided with written notice of the duration of the bed-hold policy.</p> <p>During a surveyor interview with the Administrator and the Director of Nursing on 1/17/2025 at approximately 1:10 PM, they were unable to provide evidence that the facility provided written information to the resident or resident representative(s) regarding a bed hold. Additionally, they were unable to provide evidence that at the time of transfer the resident or the resident representative was provided with written notice of the duration of the bed-hold policy.</p> <p>Cross Reference F 623 and F 626</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>42907</p> <p>Based on surveyor observation, record review and staff interview, it has been determined that after a resident was transferred to the hospital, the facility failed to allow the resident to return to facility where s/he resided for several years for 1 of 1 resident reviewed who was transferred to the hospital, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to The Rhode Island Department of Health on 1/15/2025, alleged that Resident ID #1 was not permitted to return to the facility, and s/he was not given a 30 day notice, as required.</p> <p>Record review revealed that the resident was admitted to the facility in July of 2019 with diagnoses of violent behaviors and dementia.</p> <p>Record review further revealed that s/he was transferred to the emergency room for evaluation following an alleged resident to resident interaction on 1/14/2025 at 1:32 PM.</p> <p>Further record review revealed that the resident was documented as being discharged from the facility as of 1/14/2025.</p> <p>Record review failed to reveal evidence that the resident was allowed to return to the facility following a hospitalization or therapeutic leave.</p> <p>Surveyor observation on 1/17/2025 at 11:50 AM revealed the resident's room prior to his/her hospital transfer was vacant.</p> <p>During a surveyor interview with the Administrator and the Director of Nurses (DON) on 1/17/2025 at approximately 10:25 AM, they indicated that they sent the resident out to the hospital for a psychological evaluation due to his/her behaviors and that the hospital diagnosed the resident with Covid and a urinary tract infection (a urinary tract infection in the elderly population can commonly cause agitation).</p> <p>During a surveyor interview with the Administrator and the DON on 1/17/2025 at approximately 1:10 PM, they revealed that they are not allowing the resident to return to the facility.</p> <p>Cross Reference F 623 and F 625</p>		