STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415119	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkshire Place	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to provide appropriate treatment and services for 1 of 1 resident reviewed with a foley catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag), Resident ID #1, and for 2 of 2 residents with a suprapubic catheter (SP tube, a medical device that drains urine from the bladder through a small incision in the abdomen) Resident ID #s 2 and 3.Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health on 4/1/2026 alleges that on 3/31/2026, Resident ID #1 arrived to the emergency room and was observed to have a foley catheter that was crusted and had evidence of erosion to the urinary meatus [the opening where urine exits during urination]. Additionally, the resident had significant urinary retention and the foley catheter needed to be replaced. The report further documented that his/her urine was foul smelling. 1. Record review revealed that Resident ID #1 was admitted to the facility in December of 2025 with diagnoses including, but not limited to, urinary retention and neurogenic bladder (a condition where nerve damage disrupts communication between the brain, spinal cord, and bladder, leading to loss of bladder control).Further record review revealed that the resident was admitted to the hospital on [DATE] with diagnoses of septic shock and acute respiratory failure.Review of a care plan last revised on 1/30/2026 revealed that Resident ID #1 requires a foley catheter related to a diagnosis of neurogenic bladder. Interventions include, but are not limited to, changing the foley catheter per the physician's orders.Record review revealed the following physician's orders:1/1/2026: Change the resident's foley catheter monthly and as needed.2/4/2026: Change the resident's foley catheter monthly and as needed.2/24/2026: Primary team to determine if foley catheter is to be exchanged out by urology for discoloration of urine.Record review of the January, February, and March 2026 Treatment Administration Records (TAR) revealed the following:1/4/2026: Change the resident's foley catheter monthly and as needed was documented as NA [not applicable].2/4/2026: Change the resident's foley catheter monthly and as needed was documented as refused change.2/24/2026: Primary team to determine if foley catheter is to be exchanged out by urology for discoloration of urine signed off as completed.3/4/2026: Change resident's foley catheter monthly and as needed was documented as n.Record review of progress note authored by the on-call provider dated 2/24/2026 states in part, .urine noted to be cloudy, and blood tinged .Determine if foley should be exchanged out if so, the patient prefers urology to exchange.Record review failed to reveal evidence that urology was contacted, or an appointment was scheduled for a foley catheter exchange. Further record review revealed the last time the foley catheter was exchanged was on 12/31/2025 at the hospital.During a surveyor interview on 4/2/2026 at 12:26 PM with the Nurse Practitioner, she revealed that it is her practice to have foley catheters exchanged monthly and as needed which could be completed at the facility or with a urologist. She further revealed that it would be her expectation that if the resident is refusing to have it exchanged in the facility that the nursing staff would call urology, per the physician's order on 2/24/2026 for an appointment.During a surveyor interview on 4/2/2026 at 2:18 PM with the Assistant Director of (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing (ADNS), she was unable to provide evidence that the resident's foley catheter was exchanged as ordered by the physician or that urology was contacted for an appointment.2. Record review revealed that Resident ID #2 was readmitted to the facility in December of 2025 with diagnoses including, but not limited to, external genitalia, head, and neck malignancies (cancer).Review of a care plan dated 10/28/2025 revealed that Resident ID #2 requires an SP catheter related to a terminal condition. Interventions include but are not limited to, changing the SP catheter per the physician's order.Record review revealed a physician's order dated 10/14/2025 to call to set up the resident's appointment with urology for an SP catheter exchange.Record review of the January, February, and March 2026 TARs revealed the above order was signed off as completed daily.Record review of a continuity of care document, Consultation and Referral form dated 12/2/2025 revealed that the resident was seen by urology and had a SP catheter exchanged, further review revealed that s/he requires an SP exchange in 4 weeks at the facility.Record review failed to reveal evidence that the resident's SP catheter was exchanged since 12/2/2025.During a surveyor interview on 4/2/2026 at 12:26 PM with the resident's Nurse Practitioner, she revealed that it would be her expectation that the SP catheter would be exchanged in the facility if s/he was not going to urology.During a surveyor interview on 4/2/2026 at 2:18 PM with the ADNS, she revealed that the nursing staff at the facility all have competencies to exchange SP tubes in the facility. She further revealed that there may have been confusion if s/he was having it exchanged at the urologist office. She was unable to provide evidence that Resident ID #2's SP catheter had been exchanged since 12/2/2025. 3. Record review revealed that Resident ID #3 was admitted to the facility in June of 2025 with a diagnosis including, but not limited to, flaccid neuropathic bladder (the inability of the bladder muscles to contract effectively leading to urinary retention).Review of a care plan last revised on 6/13/2025 revealed that Resident ID #3 requires an SP catheter. Interventions include, but are not limited to, changing the SP catheter per the physician's order.Record review revealed a physician's order dated 6/11/2024 that the resident SP catheter exchange is completed at urology.Record review of a continuity of care document, Consultation and Referral form dated 11/6/2025 revealed that the resident was seen by urology and had his/her SP catheter exchanged. Further review revealed s/he had a follow-up appointment with urology for an annual check-up and SP catheter exchange scheduled for 12/15/2025.During a surveyor interview on 4/2/2026 at 12:56 PM with the above Urology receptionist, she revealed that the resident did not show up for his/her 12/15/2025 appointment and has not had an appointment since 11/6/2025.During a surveyor interview on 4/2/2026 at 2:18 PM with the ADNS, she was unable to provide evidence that Resident ID #3 has had a urology appointment since 11/6/2025 and that his/her SP tube has been exchanged per the physician's order.