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| 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 07/26/2024 |
| 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.

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37158</p> <p>Based on record review and staff interview, it has been determined that the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 5 residents reviewed relative to smoking, Resident ID #186.</p> <p>Findings are as follows:</p> <p>According to the facility policy titled Smoking Policy reviewed and revised in 2/2024, states in part, . PROCEDURE .</p> <p>3. Residents who are identified as smokers are to have a Comprehensive Care Plan for smoking developed by the Interdisciplinary Care Team .</p> <p>Record review revealed the resident was admitted to the facility in May of 2024 with a diagnosis including, but not limited to, nicotine dependence, cigarettes.</p> <p>Record review revealed a smoking assessment dated [DATE] was completed upon admission to the facility which indicated the resident is a smoker.</p> <p>Record review revealed a smoking assessment dated [DATE] was completed upon re-admission to the facility which indicated the resident is a smoker.</p> <p>Further record review failed to reveal evidence that a comprehensive care plan was developed and implemented for smoking.</p> <p>During a surveyor interview on 7/26/2024 at 8:35 AM with the Director of Nursing Services, she acknowledged that the resident was a smoker. Additionally, she acknowledged that a comprehensive care plan was not developed relative to smoking.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>37158</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice relative to following physician's orders for 1 of 3 residents reviewed for obtaining laboratory results, Resident ID #162, and 1 of 1 resident reviewed for obtaining a psychiatric consult and daily weights, Resident ID #241.</p> <p>Findings are as follows:</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, .The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients .</p> <p>1. Record review revealed Resident ID #162 was admitted to the facility in July of 2022 with a diagnosis including, but not limited to, seizure disorder.</p> <p>Record review revealed an order dated 10/26/2023 for Valproic Acid (medication to treat seizures) 250 milligrams per 5 milliliters (mL), give 10 mL by mouth three times a day for seizures.</p> <p>Record review revealed an order with a start date of 6/12/2024, to obtain bloodwork; a CMP (comprehensive metabolic panel-tests the body's chemical balance and metabolism), and Valproic Acid level (measures the amount of valproic acid level) every 6 months.</p> <p>Record review of the June 2024 Laboratory Administration Record revealed the order to obtain a CMP and a Valproic Acid level every 6 months was transcribed with a start date of 6/12/2024. Further record review revealed the order was not signed off as completed on 6/12/2024.</p> <p>Record review failed to reveal evidence of the laboratory results for the CMP or Valproic Acid levels.</p> <p>During a surveyor interview with the Director of Nursing Services (DNS) on 7/26/2024 at 1:41 PM, she was unable to provide evidence of the laboratory results for the CMP and the Valproic Acid levels. Additionally, she would expect the laboratory work would be obtained, as ordered.</p> <p>2. Record review revealed Resident ID #241 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, cirrhosis of the liver (a condition in which the liver is scarred and permanently damaged), ascites (fluid accumulation in the abdomen), and a history of depression.</p> <p>a. Record review revealed a physician's order dated 7/12/2024 with a start date of 7/13/2024 to obtain daily weights.</p> <p>Record review of the documented weights revealed the resident's weights were not obtained daily as ordered on 7/18/2024 and 7/19/2024.</p> <p>(continued on next page)</p> |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>b. Record review revealed a physician's order dated 7/12/2024 to obtain a psychiatric consult for a history of psychosis (a mental disorder that affects a person's ability to recognize reality and relate to others). Further review revealed a subsequent physician's order dated 7/22/2024 to obtain a psychiatric consult for a history of depression.</p> <p>Record review failed to reveal evidence that the resident was seen and evaluated by psychiatric services.</p> <p>During a surveyor interview with the resident's physician, Staff A, on 7/26/2024 at 12:30 PM, she indicated that she wanted the resident to be evaluated by psychiatric services before implementing any medications.</p> <p>During a surveyor interview with the DNS on 7/26/2024 at 8:35 AM, she was unable to provide evidence that the resident was seen and evaluated by psychiatric services. Additionally, she acknowledged the resident was not weighed daily on the above-mentioned dates, as ordered.</p> <p>47279</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41729</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide necessary services to a resident who is unable to carry out activities of daily living relative to scheduled showers for 1 of 1 resident reviewed who had concerns regarding shower provision, Resident ID #111.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in June of 2023 with diagnoses including, but not limited to, severe morbid obesity and generalized muscle weakness.</p> <p>Record review of a Quarterly Minimum Data Set assessment dated [DATE] revealed the resident is dependent with bathing and showering, and s/he requires staff assistance to complete these tasks.</p> <p>Record review of a care plan dated 1/8/2024 revealed the resident requires assistance with self-care and mobility and is dependent with showers and bathing.</p> <p>Record review of a physician's order dated 7/4/2024 revealed an order for biweekly showers scheduled on Mondays and Thursdays during the day shift.</p> <p>During a surveyor observation of the resident on 7/24/2024 at 8:56 AM and on 7/25/2024 at 9:26 AM, s/he was observed in bed, upon entering the room, a strong odor of urine was noted.</p> <p>During a surveyor interview on 7/24/2024 at 8:58 AM and on 7/25/2024 at 9:28 AM, with the resident s/he indicated that s/he had not had a shower since s/he moved onto the unit in May of 2024. Staff B further indicated to have a shower. The resident indicated that s/he was told by the staff that s/he could not get a shower because the shower chair was broken.</p> <p>During a surveyor interview on 7/25/2024 at approximately 9:36 AM with Nursing Assistant (NA), Staff B, she indicated that she is the resident's primary NA. She indicated has not given the resident a shower since she started providing care to the resident when s/he moved onto the unit in May of 2024. Staff B further indicated that she was the resident's NA on 7/22/2024 and on 7/25/2024 and had not given the resident a shower on both dates, as ordered. Additionally, Staff B acknowledged that the shower chair is not broken and could not provide evidence the resident has received showers, as ordered.</p> <p>During a surveyor interview on 7/25/2024 at 9:47 AM, with the unit manager, Licensed Practical Nurse, Staff H, he could not provide evidence that the resident received showers, as ordered.</p> <p>During a surveyor interview on 7/25/2024 at 1:45 PM, with the Director of Nursing Services, she was unable to provide evidence the resident received showers, as ordered.</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41729</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 2 residents reviewed for respiratory care, Resident ID #159.</p> <p>Findings are as follows:</p> <p>According to Lippincott Manual of Nursing Practice 10th Edition, 2014, page 240, states in part, . Administering Oxygen by Nasal Cannula [a device that is used to deliver oxygen through a tube to your nose] .1. Record flow rate used and immediate patient response .</p> <p>Record review of a facility policy titled, Oxygen Administration states in part, .Documentation .2. Document the date, time, amount, and method of oxygen administration. 3. Document the resident's condition before and after the initiation of therapy. 4. Ensure that there is evidence of oxygen administration for the duration of the therapy .</p> <p>Record review revealed the resident was admitted to the facility in September of 2022 and readmitted in July of 2024 with diagnoses including, but not limited to, lung cancer, shortness of breath, and pneumonia.</p> <p>Record review of a physician's order dated 6/17/2024 states in part, Oxygen 2-4L [liters] via Nasal Cannula Titrate [to evaluate your oxygen needs at rest or during exercise] as able, keep POX [pulse oximetry, a method of measuring the saturation of oxygen in a person's blood] > [greater than] 88 r/a [room air] every 1 hour as needed .Document liters and POX .</p> <p>Record review of the vital report on the following dates and times revealed the resident was administered oxygen but failed to reveal evidence of the amount/liters of oxygen administered to the resident, as per the facility's policy:</p> <ul style="list-style-type: none"> - 7/25/2024 at 11:35 AM - 7/24/2024 at 3:49 PM - 7/24/2024 at 1:08 PM - 7/23/2024 at 8:06 AM - 7/19/2024 at 9:49 AM - 7/14/2024 at 10:13 PM <p>During a surveyor observation on the following dates and times, the resident was observed on 2 liters of oxygen:</p> <ul style="list-style-type: none"> - 7/25/2024 at 10:56 AM <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>- 7/25/2024 at 12:04 PM</p> <p>- 7/26/2024 at 9:15 AM</p> <p>Further record review of the Treatment Administration Record for July 2024 failed to document that the resident received oxygen on 7/25/2024 and 7/26/2024, per the facility's policy.</p> <p>During a surveyor interview on 7/26/2024 at 11:21 AM, with the resident's physician, Staff A, she indicated that she would expect the staff to document the date, time, and amount of oxygen that is being administered to a resident each time when oxygen is administered.</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>37158</p> <p>41729</p> <p>47279</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 4 of 9 residents reviewed for medication administration, Resident ID #s 111, 136, 162, and 186.</p> <p>Findings are as follows:</p> <p>1. Record review revealed Resident ID #111 was admitted to the facility in June of 2023 with diagnoses including, but not limited to, hypertension (high blood pressure) and acute kidney failure.</p> <p>Record review revealed a physician's order dated 3/12/2024 for furosemide (Lasix - diuretic) 20 milligrams (mg), give 1 tablet at 7:00 AM for heart failure.</p> <p>Review of a progress note dated 7/22/2024 at 4:04 PM revealed the Nurse Practitioner (NP), Staff C, ordered the Lasix to be held for 3 days based on the resident's laboratory results.</p> <p>Review of the July 2024 Medication Administration Record (MAR) revealed that his/her Lasix was not held as ordered, and the resident received Lasix on 7/23, 7/24, and 7/25/2024 in error.</p> <p>During a surveyor interview on 7/25/2024 at 9:31 AM, with Staff C, she acknowledged that the resident's Lasix was not held as ordered on the above-mentioned dates and would have expected the medication to be held.</p> <p>2. Record review revealed Resident ID #136 was admitted to the facility in November of 2021 with diagnoses including, but not limited to, gastric ulcer (open sore in your stomach lining) and diabetes mellitus.</p> <p>2a. Review of a document titled, ORDER LOG FOR PCC [Point Click Care] dated 7/8/2024 revealed a physician's order for Resident ID #136 to start metronidazole (an antibiotic) 250 mg, give four times daily for 14 days.</p> <p>Review of the July 2024 MAR revealed that the order was incorrectly transcribed as metronidazole 500 mg twice daily and not 250 mg four times daily, as ordered. The resident received the incorrect dose and frequency of the medication for 14 days from 7/9/2024 through 7/22/2024.</p> <p>During a surveyor interview on 7/26/2024 at 12:33 PM with the resident's physician, Staff A, she revealed that the resident should have received the metronidazole as prescribed.</p> <p>2b. Review of a document titled, ORDER LOG FOR PCC dated 7/8/2024 revealed a physician's order for metformin (medication to help lower blood sugar) 500 mg, twice daily.</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record review failed to reveal evidence that the above-mentioned order for metformin was transcribed, resulting in the resident failing to receive 34 doses of the medication.</p> <p>During a surveyor interview on 7/25/2024 at 9:36 AM, with the Unit Manager, Staff D, after the medication errors were brought to Staff D's attention, she acknowledged that she failed to transcribe the order for metformin. Additionally, she acknowledged that she transcribed the order for metronidazole as 500 mg twice daily in error, and not the ordered 250 mg four times daily.</p> <p>3. Record review revealed Resident ID #162 was admitted to the facility in July of 2022 with a diagnosis including, but not limited to, seizures.</p> <p>Record review revealed a physician's order dated 10/26/2023 for Valproic Acid 250 mg per 5 milliliters, give 500 mg at 6:00 AM, 2:00 PM, and 9:00 PM for seizures.</p> <p>Review of the July 2024 MAR failed to reveal evidence that the resident received his/her Valproic Acid on 7/16 and 7/21 at 6:00 AM, or that the provider was notified that the resident did not receive his/her medication, as ordered.</p> <p>During a surveyor interview on 7/26/2024 at 1:18 PM with Licensed Practical Nurse, Staff E, she acknowledged that the medication was not administered to the resident on the above-mentioned dates and times.</p> <p>During a surveyor interview with NP, Staff C, on 7/26/2024 at 1:31 PM, she revealed that she was unaware that the resident did not receive the Valproic Acid on the above-mentioned dates and times, as ordered. Additionally, she would expect medication orders to be followed and to be notified of any missed doses.</p> <p>4. Record review revealed Resident ID #186 was admitted to the facility in May of 2024 with diagnoses including, but not limited to, abnormal findings of blood chemistry and heart failure (a condition when the heart pumps inadequately).</p> <p>Review of a nursing progress note dated 7/18/2024 at 12:41 PM, revealed a new order to hold Lasix 20 mg for 3 days, and start 40mg of Lasix for 3 days.</p> <p>Review of a provider progress note dated 7/18/2024 at 3:17 PM, authored by NP, Staff C, states in part, .HF: [heart failure] Lasix 40mg for 3 days, ctm [continue to monitor] for fluid overload .</p> <p>Record review revealed the following physician orders:</p> <p>-7/12/2024 Lasix 20 mg give 1 tablet once daily for fluid retention, hold from 7/18/2024 to 7/21/2024.</p> <p>-7/19/2024 Lasix 40 mg give 1 tablet in the morning for 3 days, start 7/19/2024.</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the July 2024 MAR failed to reveal evidence that the Lasix 20mg was held on 7/21, as ordered. Additionally, the Lasix 20 mg was signed off as administered on 7/21 by Certified Medication Technician, Staff F. Further review of the MAR revealed that the Lasix 40mg order was also signed off as administered by Staff F, indicating the resident received a total dose of Lasix 60 mg, instead of the ordered dose of Lasix 40mg.</p> <p>During a surveyor interview on 7/25/2024 at 2:02 PM with Staff F, she acknowledged that she administered Lasix 60 mg to the resident on 7/21/2024.</p> <p>During a surveyor interview on 7/26/2024 at 8:45 AM with the DNS, she was unable provide evidence the resident's Lasix order followed.</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>41729</p> <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain medical records that are accurately documented in accordance with professional standards and practices for 1 of 1 resident reviewed for showers and 1 of 4 residents reviewed for non-pressure wound treatments, Resident ID #111, and 1 of 1 resident reviewed for psychiatric evaluations, Resident ID #241.</p> <p>Findings are as follows:</p> <p>1. Record review revealed Resident ID #111 was admitted to the facility in June of 2023 with diagnoses including, but not limited to morbid obesity and generalized muscle weakness.</p> <p>Record review revealed the following physician's orders:</p> <ul style="list-style-type: none"> - Weekly shower schedule: Monday 7-3 and Thursday 7-3 every day shift - Apply calazime (skin protectant cream) to left posterior thigh twice daily every day and evening shift, document refusals of treatment <p>Additional record review revealed a Nursing Assistant assignment log which indicated the resident is schedule for showers on Tuesdays and Fridays on the first shift.</p> <p>Record review of the July 2024 Treatment Administration Record revealed that Registered Nurse, Staff G, signed off that the resident had received a shower and that his/her wound treatment to the left posterior thigh had been completed on 7/25/2024.</p> <p>During a surveyor interview on 7/25/2024 at 9:36 AM, with Nursing Assistant (NA), Staff B, she revealed that she is the resident's primary NA and was the assigned NA to provide care including shower to the resident on 7/25/2024. She further acknowledged that she had not given a shower to the resident on 7/25/2024, as documented.</p> <p>During a surveyor interview on 7/25/2024 at 10:14 AM, with Staff G, he acknowledged he had inaccurately documented that Resident ID #111 had received a shower and his/her wound treatment had been completed on 7/25/2024.</p> <p>During a surveyor interview on 7/25/2024 at 1:45 PM, with the Director of Nursing Services (DNS), she could not provide evidence that the resident's record was accurately documented to reflect the care and services s/he received on 7/25/2024.</p> <p>2. Record review revealed Resident ID #241 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, cirrhosis of the liver (a condition in which the liver is scarred and permanently damaged), ascites (fluid accumulation in the abdomen), and a history of depression.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of the physician's orders revealed an order dated 7/12/2024 which states in part, Psych consult for h/o [history of] psychosis .</p> <p>Record review of a Behavioral Health Visit Request/Follow Up form indicated the consulting psychiatric provider signed off that she had completed the psychiatric consult for the resident on 7/13/2024.</p> <p>Additional record review failed to reveal evidence that the resident was seen by psychiatric services on 7/13/2024.</p> <p>During a surveyor interview on 7/26/2024 at 8:35 AM, with the DNS, she was unable to provide evidence that the resident was seen and evaluated by the consulting psychiatric provider as ordered.</p> <p>After it was brought to the facility's attention by the surveyor, the Assistant Director of Nursing Services provided an email correspondence with the consulting psychiatric provider, dated 7/26/2024 at 11:37 AM, revealing that the provider did not complete a psychiatric evaluation for the resident.</p> <p>47279</p> <p>37158</p> | | |