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	09/04/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and staff interview, it has been determined that the facility failed to ensure that services provided meet professional standards of quality relative to following the parameters for a physician's order for Metoprolol Succinate Extended Release (a medication prescribed to treat various heart conditions), for one of one resident reviewed, Resident ID #125. Findings are as follows:According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients.Record review revealed the resident was admitted to the facility in July of 2025 with diagnoses including, but not limited to, high blood pressure and heart failure (a condition where the heart is unable to pump blood effectively).Record review revealed a physician's order dated 7/3/2025 for Metoprolol Succinate Extended Release, give 50 milligrams (mg) by mouth daily. Further review of the order revealed parameters to hold the medication for a systolic blood pressure (the top number of a blood pressure reading) of less than 100 and/or a heart rate of less than 60. Record review of the July and August 2025 Medication Administration Records failed to reveal evidence that the resident's heart rate was obtained prior to the Metoprolol Succinate being administered.During a surveyor interview on 8/28/2025 at 9:47 AM with Registered Nurse, Staff E, she acknowledged that the Metoprolol order did not include documentation of the resident's heart rate. Additionally, she was unable to provide evidence that the resident's heart rate was obtained prior to the administrations of Metoprolol for July and August of 2025.During a surveyor interview on 8/28/2025 at 11:00 AM with the Director of Nursing, she revealed that she would expect that the Metoprolol order would be followed, and that the resident's heart rate would be obtained prior to the medication being administered.

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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(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 - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 2 of 7 residents reviewed with pressure ulcers (a localized injury to the skin and/or underlying skin usually over a boney prominence), Resident ID #s 4 and 99. Findings are as follows:1.Record review revealed Resident ID #4 was admitted to the facility in May of 2022 with diagnoses including, but not limited to, fracture of the neck, dementia with psychotic disturbance, and stage 4 pressure ulcer (full thickness tissue loss extending into muscle, tendon, or bone) of the right buttockRecord review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident has one or more unhealed pressure ulcers or injuries.Record review of a progress note dated 6/21/2025 states in part, During care, CNA [certified nursing assistant] reported that resident had an open area. Upon assessment, the resident was noted to have redness and an open area in the right trochanter [upper buttocks/hip, where the femur meets the hip socket] area.NP [Nurse Practitioner] .was notified.who gave the order to clean the area with normal saline, cover with a dry dressing off-load pressure every 2 hours. Further record review revealed the wound was assessed by the Wound Nurse on 6/23/2025 and a new treatment implemented to cleanse the wound with wound cleanser, pat dry, apply calcium alginate to the base of the wound, and cover with a bordered foam dressing daily and as needed.Record review of the following wound provider progress notes revealed the following: -6/26/2025, states in part, .wound consult requested for resident with wound to right inferior buttock. Slough [dead yellow or white tissue that accumulates on the surface of the wound] noted to wound- unable to determine depth. Will treat with Santyl [a topical medication used to remove dead skin tissue from wounds].pressure ulcer of right buttock, unstageable [a full-thickness pressure injury where the base of the wound is obscured by dead or leathery tissue].ASSESSMENT/PLAN: All recommendations will remain in effect until discontinued, revised, or replaced.Optimize Nutrition - Registered Dietician [RD] consultation. -7/10/2025, states in part, .Right inferior buttock wound measurements increased. Slough and small amount of granulation tissue [a type of connective tissue that forms on the surface of the wound during the healing process] noted. Odor, erythema [redness], and purulent [pus] drainage noted.wound.right inferior, buttock.unstageable.Optimize Nutrition - Registered Dietician consultation.-7/17/2025, states in part, .wound.right, inferior, buttock.unstageable. ASSESSMENT/PLAN: Optimize Nutrition - Registered Dietician consultation.-7/31/2025, states in part, . wound.right, inferior, buttock.unstageable.ASSESSMENT/PLAN: Optimize Nutrition - Registered Dietician consultation.-8/7/2025, states in part, .wound.right, inferior, buttock.unstageable.ASSESSMENT/PLAN: Optimize Nutrition - Registered Dietician consultation.-8/14/2025, states in part, Right inferior buttock wound measurements and slough improving. Fascia [muscle tissue] noted .wound.right, inferior, buttock.stage 4. ASSESSMENT/PLAN: Optimize Nutrition - Registered Dietician consultation.-8/21/2025, states in part, wound.right, inferior, buttock.stage 4.ASSESSMENT/PLAN: Optimize Nutrition - Registered Dietician consultation.Record review failed to reveal evidence that the RD completed a nutritional consult after the Wound Provider made repeated recommendations for a dietary consult, until 8/26/2025 which was 2 months after the wound was identified.Record review revealed the following dietary recommendations were approved by the provider and orders were implemented for wound healing on 8/27/2025:- Ascorbic acid tablet 250 milligrams (mg), 1 tablet by mouth one time a day- Zinc oral tablet 50 mg, one tablet by mouth one time a day- Prostat Extra Protein, 30 milliliters, one time a day During a surveyor interview with RNP, Staff G, on 8/28/2025 at 9:43 AM, she revealed that the resident's pressure ulcer was originally identified on 6/26/2025 and treatment recommendations were made by the Wound Provider. Additionally, she revealed she would have expected the RD to complete a dietary consult for the resident's wound when the wound was identified.During a surveyor interview with the RD, Staff F, in the presence of RD, Staff H, on 8/28/2025 at 10:43 AM, she revealed she was aware that the resident had a stage 4 pressure ulcer as this was discussed at the weekly interdisciplinary meetings, however, she acknowledged that she failed to complete a nutritional assessment for the resident until 8/26/2025.During a surveyor interview with the Director of Nursing Services (DNS) on 8/28/2025 at 12:49 PM, she was unable to provide evidence that a dietary consult for Resident ID #4's pressure wound was completed until 8/26/2025.2. Record review revealed Resident ID #99 was admitted to the facility in February of 2023 and readmitted in August of 2025 with diagnoses including, but

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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 0688 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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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 0688 Level of Harm - Actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, family member, and staff interview, it has been determined that the facility failed to ensure that a resident who was admitted to the facility without a limited range of motion does not experience a reduction in range of motion for 1 of 2 residents observed with contractures (the shortening of muscles, tendons, skin, and nearby soft tissues that cause the joints to become very stiff, which prevent normal movement), Resident ID #99. Findings are as follows:Record review revealed the resident was admitted to the facility in February of 2023 and readmitted in August of 2025 with diagnoses including, but not limited to, dementia, left sided hemiplegia (paralysis that affects only one side of the body), left sided hemiparesis (muscle weakness on one side of the body) and bilateral lower leg contractures.Record review revealed the resident's functional abilities from the following Minimum Data Set (MDS) Assessments: Quarterly MDS dated [DATE]:Sit-stand: and bed mobility: dependentChair/bed-to-chair transfer: supervision or touching assistance-helper provides verbal cues or touching/steadying assistance as resident completes activity.Walk 10 feet (ft)= independentWalk 50 ft: supervision or touching assistance-helper provides verbal cues or touching/steadying assistance as resident completes activity.Walk 150 ft: independent- Resident completes the activity by him/herself with no assistance from helper.Quarterly MDS dated [DATE]: Sit-stand: and bed mobility: dependentChair/bed-to-chair transfer: dependent-helper does all of the effort. Resident does none of the effort to complete activity.Walk 10 ft= supervision or touching assistanceWalk 50 ft: not attempted due to medical condition or safety concernsWalk 150 ft: not attempted due to medical condition or safety concerns Quarterly MDS dated [DATE]:Sit to stand/ Bed mobility/transfers: dependentChair/bed-to-chair transfer: dependent-helper does all of the effort. Resident does none of the effort to complete activity.Walk 10 ft: supervision or touching assistanceWalk 50 ft: independent-Resident completes the activity by him/herself with no assistance from helperWalk 150 ft: independent-Resident completes the activity by him/herself with no assistance from helper Annual MDS dated [DATE]:Bed mobility/transfers: DependentSit to stand/ Bed mobility/transfers: dependentChair/bed-to-chair transfer: dependent-helper does all of the effort. Resident does none of the effort to complete activity.Walk 10 ft: supervision or touching assistanceWalk 50 ft: supervision or touching assistance-Helper provides verbal cues touching/steadying assistance as resident completes activity.Walk 150 ft: not applicable Quarterly MDS dated [DATE]:Bed mobility/transfers: DependentSit to stand/ Bed mobility/transfers: dependentChair/bed-to-chair transfer: dependent-helper does all of the effort. Resident does none of the effort to complete activity.Walk 10 ft: not attempted due to medical condition or safety concernsThe above findings indicate that the resident has experienced a progressive decline in ambulatory status over time. In September of 2024, the resident was able to ambulate up to 150 feet. However, by December of 2024, the resident was no longer able to ambulate that distance. As of April 2025, the resident was unable to ambulate any distance.Record review of a Quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status score of 00 which indicates the resident is unable to complete the assessment and has severe cognitive impairment. Additional review of this assessment revealed the resident is non-ambulatory and s/he is dependent with bed mobility. Record review of the resident's care plan revised on 8/13/2025 revealed the resident has impaired mobility and that the resident is dependent with bed mobility, transfers, ambulating and all activities of daily living. Record review revealed a Physical Therapy (PT) Discharge summary dated [DATE] states in part:- .Functional Skills Assessment:- Transfers: sit to stand=supervision or touching assistance. Chair/bed-to-chair transfer=supervision or touching assistance- Ambulation: Walk 10 feet=supervision or touching assistance- Ambulation: Walk 50 feet with Two Turns=Supervision or touching assistance.Record review of a progress note authored by Registered Nurse Practitioner (RNP), Staff S, dated 10/2/2024 states in part, .Plan: Order Physical Therapy Evaluation and Treatment.Starting to have contractures.Record review failed to reveal evidence that the resident had a PT evaluation or treatment as ordered on 10/2/2024. PT did not complete an evaluation until 8/27/2025 which was after the surveyor brought this to the facility's attention, which is approximately 10 months after the evaluation was ordered. Review of a PT document titled Evaluation Only dated 8/27/2025 states in part, .Musculoskeletal Assessment.LE [lower extremity] ROM [range of motion]=Impaired: LLE [left lower extremity ROM: Impaired. RLE [right lower extremity] ROM: Right Hip= Impaired; Knee= Impaired; Ankle=Impaired, LLE ROM: left Hip=Impaired; Knee=Impaired; Ankle=Impaired, RLE, LLE: Strength=patient with poor tolerance to PROM

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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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 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure residents maintain acceptable parameters of nutritional status, such as usual body weight, for 1 of 9 residents reviewed for weight loss, Resident ID #4.Findings are as follows:Review of a facility policy titled, Weight Loss/Gain Protocol and Heights states in part, POLICY: All residents are to be weighed upon admission and at least monthly; so as to monitor for weight loss or gain, to assess for underlying causes for weight loss or gain, to intervene accordingly and timely to allow for an optimal level for well-being.PROCEDURE:.a significant weight discrepancy is defined as: 1. A weight change of 3 pounds or more in one week (if resident on weekly weights); 2. A loss/gain of 5% or greater within one month.When a significant weight loss/gain is noted.the following must occur.a. Reweigh all residents who are reported to have a significant weight discrepancy in order to assess the accuracy of the weight. The reweigh shall be done within 48 hours of the initial weight. b. If the re-weigh is accurate and there has been a significant weight loss/gain, nursing must notify the; Physician, Dietician, DNS [Director of Nursing Services], Resident Representative.c. Review the resident's current diet for appropriateness. d. Start weekly weights, if not already on.II. For any resident who tolerates less than 50% of any meal, the resident(s) will be offered a nutritional supplement (the house supplement). 1a. Record review revealed Resident ID #4 was admitted to the facility in May of 2022 with diagnoses including, but not limited to, fracture of the neck, dementia with psychotic disturbance, and stage 4 pressure ulcer (full thickness tissue loss extending into muscle, tendon, or bone) of the right buttock.Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident has a Brief Interview for Mental Status score of 4, indicating s/he has severe cognitive impairment. Additionally, it revealed the resident experienced a weight loss of 5% or more in the last month without being on a physician-prescribed weight loss regimen.Record review revealed the resident weighed 164.8 pounds (lbs.) on 1/2/2025 and 161.9 lbs. on 3/2/2025.Record review revealed a physician's order dated 1/30/2024, for a house supplement, 4 ounces, two times per day.Additional record review revealed a nutrition note dated 4/11/2025 which states in part, Weight is stable at this time with overall good intake, recommend reducing supplementation at this time to QD [once daily], RD [Registered Dietitian] to follow up and provide additional recommendations as warranted.Additional record review revealed a physician's order dated 4/12/2025 to decrease the house supplement, of 4 ounces, from twice daily to once a day. Record review revealed s/he consumed 100% of the ordered supplement for 26 out of 28 opportunities in August of 2025.Record review revealed the following documented weights:4/1/2025- 160. 4 lbs.5/2/2025 - 158.2 lbs.6/2/2025 - 154.6 lbs. 7/2/2025 - 142.1 lbs.7/8/2025 - 143.0 lbs.8/4/2025 - 142.3 lbs.This indicates that the resident lost 18.3 lbs. from 4/1/2025 to 7/2/2025, which is a severe weight loss of 11.4%.Record review failed to reveal evidence that a reweight was obtained following the weight loss on 7/2/2025, per the facility policy.Record review failed to reveal evidence that the RD, Staff F, assessed the resident for his/her weight loss on 7/2/2025 until 8/26/2025. Further review failed to reveal evidence that new interventions were implemented for Resident ID #4's severe weight loss.During a surveyor interview with the Nurse Practitioner (NP), Staff G, on 8/28/2025 at 9:43 AM, she revealed that she was aware of Resident ID #4's weight loss in July and thought that dietary was following [him/her]. Additionally, she acknowledged that there were no interventions in place to mitigate his/her weight loss, and she would have increased the house supplement back to twice per day and ordered Remeron (a medication to stimulate appetite) to improve his/her intake.During a surveyor interview with the RD on 8/28/2025 at 10:43 AM, she revealed she is made aware of any significant changes in weight through the weight exceptions report in the medical record. She indicated that she would expect a reweight to be obtained when there is a difference of 5 lbs. or more from the previous weight. She also indicated that she was aware of Resident ID #4's weight loss, however, she acknowledged that she did not recommend any additional interventions to address it.Record review failed to reveal evidence that a subsequent weight was obtained after the weight loss was brought to the facility's attention by the surveyor.1b. Record review of a wound progress note dated 6/26/2025, states in part, .wound consult requested for resident with wound to right inferior buttock.pressure ulcer of right buttock, unstageable [a full-thickness pressure injury where the base of the wound is obscured by dead or leathery tissue].ASSESSMENT/PLAN: All recommendations will remain in effect until discontinued, revised, or replaced.Optimize Nutrition - Registered Dietician consultation. Additional record review revealed the wound was diagnosed as a stage 4 pressure ulcer Record review

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and staff interview, it has been determined that the facility failed to obtain laboratory services to meet the needs of its residents for 1 of 4 residents reviewed, Resident ID #2.Findings are as follows:Record review revealed the resident was readmitted to the facility in April of 2025 with a diagnosis including, but is not limited to, sepsis (a life-threatening emergency caused by the body's response to an infection).Review of the resident's physician orders revealed an active order, with a start date of 4/11/2025, for a Complete Blood Count (CBC) and a Complete Metabolic Panel (CMP) every Thursday.Record review of the resident's lab work failed to reveal evidence that the CBC and CMP were obtained on the following dates: 7/3, 7/10, 7/17, 7/25, 7/31, 8/7 and 8/21/2025. This indicates that the resident did not receive his/her ordered lab work for 7 of 9 opportunities. During a surveyor interview on 8/27/2025 at 10:43 AM with Registered Nurse, Staff I, she revealed that the order was put into the electronic medical record incorrectly so that it didn't alert the nurse to fill out the lab slip. This caused the CBC and CMP not to be obtained as ordered.During a surveyor interview on 8/27/2025 at approximately 12:48 PM, with the Director of Nursing Services, she acknowledged that the lab work was not obtained as ordered on the above dates.

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (continued on next page)

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on surveyor observation and staff interview, it has been determined that the facility failed to employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services relative to the testing of the water temperature of the main dishwashing machine to ensure proper sanitization. Findings are as follows:Record review of a facility policy titled, OnTray Dietary Policies and Procedures Mechanical Ware Washing (Dish Machine) reveals in part, . The proper cleaning and sanitizing of dishes in the dietary department is extremely important to the health and safety of residents. It is especially important to follow the guidelines noted below and the requirements of the dish machine.The dietary Manager should ensure that the staff know where the requirements are located on the machine, and where the temperature logs and test strips or thermometer, for high temp machines.are located. It is advisable to use a test strip or thermometer for high temp machines instead of relying on the outside thermometer.The internal temperature of the sanitizing cycle (if a high-temperature machine).should be tested and logged before washing dishes from each meal to ensure the dish machine is properly sanitizing dishes.Follow the manufacturer's directions for checking temperature and sanitizer.According to the dish machine manual titled American Dish Services Installation Instructions states in part, .TESTING FOR TEMPERATURE- for high temp sanitizing. The measurements taken at the manifold for a minimum of 180 Fahrenheit (F).if color changing tapes are used to verify temperature, then only 165 F labels should be used. this is according to the National Sanitation Foundation (NSF)/American National Standards Institute (ANSI) Standard 3 test health protocol [a standard of minimum public health and sanitation requirements for commercial dishwashing machines] .During a surveyor observation of a test dishwashing cycle on 8/25/2025 at 9:15 AM, the Assistant Food Service Director (AFSD) was observed placing a bowl on a dish rack through the dish machine. When the cycle was finished, the AFSD then took the temperature of the water collected in the bowl with a thermometer which read 164 F. On the machine's gauge, the wash cycle was observed to reach a temperature of 161 F and the final rinse cycle reached a temperature of 175 F. When prompted by the surveyor, he ran a second test cycle to which the gauge read a temperature of 182 F for the final rinse. During a surveyor interview at the time of the above observation with the AFSD, he revealed he obtains the water temperature by dipping a thermometer into a cup of water collected from the wash cycle. Additionally, he indicated that since he didn't see any chemicals, the dish machine was probably a high temperature machine. Further, he was unaware that he needed to use temperature test strips in the manifold to ensure the machine was sanitizing properly.During a surveyor interview on 8/25/2025 at 9:20 AM with the following staff revealed that they do not test the water temperatures of the dish machine, and they are unaware of how to perform the procedure:-Dietary Aide (DA), Staff J-DA, Staff K-DA, Staff LDuring a surveyor interview on 8/25/2025 at approximately 9:30 AM with Dietary Cook, Staff M, she revealed that the DA's are responsible to test the dish machine's water temperatures.Record review of the instructions for using the temperature test strips indicated that a single-use label should be applied directly to a dry dish or bin before it is loaded into the machine. The label has an adhesive backing to ensure it stays securely in place. These stickers utilize a thermochromatic color-change band that shifts from blue to orange when the appropriate temperature for sanitization is reached.During a surveyor observation and interview with the AFSD on 8/25/2025 at 9:52 AM, the AFSD was seen dipping a temperature test strip into a cup containing water collected from the dish machine cycle. He explained that this was the method he used when testing the dish machine's temperature. This indicated that the AFSD to was unaware of how to test the dish machine to ensure proper sanitization. Additionally, he revealed that the machine has an external gauge which he uses to record water temperatures.During a surveyor observation and simultaneous interview with the AFSD on 8/25/2025 at 9:56 AM, he was observed twice unsuccessfully attempting to place a test sticker to a wet plate. The surveyor then prompted the AFSD to place the self-adhesive test strip on a dry plate and run that through the dish machine cycle to accurately test the temperature at the manifold to ensure the minimum temperature of 180 F is reached at the final rinse. Additionally, the AFSD acknowledged that he did not know the proper procedure to test the water temperature.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that food is stored and distributed in accordance with professional standards for food service safety, relative to the main kitchen and 4 of 4 kitchenettes observed.Findings are as follows:1. Record review of Rhode Island Food Code, 2022 Edition, Section 3-501.17 states in part, .READY -TO-EAT-TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and help in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees Celsius or 41 degrees Fahrenheit or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 .During the initial tour of the kitchen in the presence of the Assistant Food Service Director (AFSD), on 8/25/2025 at 8:37 AM, the following was observed:In the walk-in refrigerator: - three containers of fresh strawberries, approximately 1 pound each, observed with white fuzzy matter, without a discard date - one container of fresh blueberries, approximately 1 pint, observed with white fuzzy matter, without a discard date In the walk-in freezer: - one bag of sausage patties, containing approximately 20 patties, open without a label or discard date. During a surveyor interview with the AFSD immediately following the above observations, he acknowledged the container of strawberries and blueberries should have been thrown away. Additionally, he acknowledged that the bag containing sausage patties should have been labeled and included a discard date.During a surveyor observation of the 1st floor kitchenette on 8/28/2025 at approximately 9:52 AM, revealed a large bag of a rice crispy type cereal, approximately 32 ounces, was observed to be 1/4 full, opened, without a label or discard date.During a surveyor interview immediately following the above observation with Nursing Assistant, Staff N, she acknowledged the cereal did not contain a label or discard date and should have.During a surveyor observation of the 2nd floor kitchenette on 8/28/2025 at approximately at 8:00 AM, a large bag of a rice crispy type cereal approximately 32 ounces, was observed to be 2/3 full, opened, without a label or discard date.During a surveyor interview immediately following the above observation with the Food Service Director, Staff O, she acknowledged the cereal did not contain a label or discard date and should it have.During a surveyor observation of the 3rd floor kitchenette on 8/27/2025 at 10:13 AM, revealed a large bag of a corn flake type cereal approximately 32 ounces, was observed to 1/2 full, opened, without a label or discard date.During a surveyor interview immediately following the above observation with Medication Technician, Staff P, acknowledged it did not contain a label or discard date and should have.During a surveyor observation of the 4th floor kitchenette on 8/28/2025 at 9:35 AM, revealed in an upper cabinet above the top shelf, a covered warmer plate containing 2 biscuits, an egg omelet and two fried eggs wrapped in a napkin, along with a cup 2/3 full of oatmeal.During a surveyor interview immediately following the above observation with Nursing Assistant, Staff Q, she acknowledged the plate of food and indicated that it should not have been placed there.2. Record review of the Rhode Island Food Code, 2022 Edition, Section 3-501.15 states in part, FOOD EMPLOYEES shall clean their hands in a HANDWASHING SINK OR APPROVED automatic handwashing facility and may not clean their hands in a sink used for FOOD preparation or WAREWASHING, or in a service sink.Record review of a facility policy titled Hand Washing, indicates that staff should wash their hands before handling food (even between tasks), before handling clean dishes and upon arrival and returning to the kitchen. During a surveyor observation of the main kitchen on 8/25/2025 at approximately 10:00 AM, Dietary Aide, Staff R, was observed scraping food off of a dirty dish into the trash barrel using her bare hands, she was observed with visible food debris on her hands as she walked over to the 3-bay sink that is used to wash pans. She then placed a metal bin in the wash sink and proceeded to rinse her hands off in the 3-bay sanitizer sink. She then touched the outside of a clean stack of bins and resumed scraping dirty dishes.During a surveyor interview with Staff R immediately following the above observations she acknowledged that she rinsed her hands in the sanitizing sink and indicated that she should have used the handwashing sink.

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	09/04/2025

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review and staff interview, it has been determined that the facility failed to maintain documentation and demonstrate evidence of its ongoing Quality Assurance and Performance Improvement (QAPI) program relative to a performance improvement project (PIP) involving significant weight loss. Findings are as follows:Review of the QAPI binder for 2025 revealed that the facility had a PIP in place for significant weight loss. Further record review failed to reveal evidence of documentation demonstrating the plan implementation, and evaluation of corrective actions or performance improvement activities relative to the significant weight loss PIP.During a surveyor interview on 8/28/2025 at 1:00 PM with the Administrator and Director of Nursing, they were unable to provide evidence of documentation that includes the monitoring and auditing of data relative to their QAPI plan for significant weight loss.