

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/22/2022
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2022
NAME OF PROVIDER OR SUPPLIER Berkshire Rehabilitation & Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Sandisfield Road Box 216 Sandisfield, MA 01255	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, and interview, the facility failed to ensure one Resident (#39) had access to his/her call light, out of a total of 15 residents sampled. Findings include: Resident #39 was admitted to the facility in May 2012. Review of the Minimum Data Set (MDS) assessment, dated 3/24/22, indicated Resident #39 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated he/she was cognitively intact. During an observation and interview on 8/03/22 at 9:32 A.M., the surveyor and Certified Nurses Aide (CNA) #1 observed Resident #39 in bed with no call light accessible. CNA #1 was initially unsure where the call light was or how it worked. She followed the cord from the wall and located the Resident's call light cord on the floor, in between the two beds. She said the Resident did not have access to the call light and should have.		

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure its staff correctly code a Minimum Data Set (MDS) assessment for one Resident (#17), out of a total of 15 sampled residents. Findings include: Resident #17 was admitted to the facility in June 2019 with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of the Resident's MDS assessments, dated 2/17/22 and 5/19/22, Section N - Medications, indicated the Resident received antipsychotic medications on an as needed (PRN) basis only. Review of the Resident's clinical record included physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] [MEDICATION(S)], 20 milligrams (mg), give one tablet by mouth at bedtime, initiated 2/8/20. [MEDICATION(S)], 5 mg, give one tablet twice daily, initiated 11/10/21. Review of the Medication Administration Records (MAR) for February 2022 and May 2022 indicated [MEDICATION(S)] was given scheduled three times per day at 8:00 A.M., 2:00 P.M., and 8:00 P.M. daily, as ordered. During an interview on 8/04/22 at 2:41 P.M., the MDS Nurse said the MDS assessments for 2/17/22 and 5/19/22 were coded incorrectly and should have reflected the Resident received antipsychotic medications on both a scheduled and PRN basis.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation and interview, the facility failed to use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week. Findings include: Review of the facility's weekly nursing schedule, dated 6/26/22 through 7/30/22, indicated an RN was not scheduled for 8 consecutive hours on 6/26/22, 7/9/22, 7/10/22, 7/23/22, and 7/24/22. During an interview on 8/05/22 at 1:03 P.M., the Administrator said there should be an RN scheduled for eight hours for each 24-hour period and there was not.		

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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. Based on observation, interview, and policy review, the facility failed to 1.) Maintain sanitary conditions relative to the cleanliness of kitchen equipment and proper cleaning and sanitizing of cookware; and 2.) Properly store an ice scoop used for the ice chest in the kitchenette, on the resident care unit, as an appropriate infection control practice when dispensing ice. Findings include: 1. Review of the facility's policy titled Manual Warewashing and Sanitizing, with a review date of 2/05, indicated the following: Pot Washing and Sanitizing -Procedure: to manually wash and sanitize: after scraping, wash with an approved detergent mixed according to manufacturer's specifications. Rinse with potable water. Sanitize pre-cleaned items by preparing a solution of an approved sanitizing agent mixed according to manufacturer's specifications, at not less than 75 degrees Fahrenheit . -The approved Warewashing detergent for this facility is: (facility left blank) -The approved sanitizing agent for this facility is: (facility left blank) Review of the facility's policy titled pH Testing (pH is used to measure the acid and alkaline present in various fluids) in manual Warewashing with a review date of 2/05, indicated the following: -Procedure: Sanitize all pre-cleaned items using an accepted food grade sanitizing solutions, following the manufacturer's directions for use. -Test with pH strips that there is 200 parts per million (ppm) active quaternary solution in the mixture Review of the facility's policy titled Cleaning Schedule, revised on 2/05, indicated the following: -A cleaning schedule will be posted weekly, followed by staff, and monitored by the Director of Dining Services. During an initial walk through of the kitchen with the Lead Cook on 8/03/22 at 7:26 A.M., the surveyor observed the following: -Debris build up on top of the oven (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A dark, thick layer of grease build up around and in the grease drain, located on the bottom right corner of the stove top. -Coating of thick dust located on the underside of the stovetop and above the oven doors -Burnt food and white dust located inside of the oven The lead cook said that the cleaning is done whenever the staff had time and was not able to provide a cleaning schedule. During a follow up visit to the kitchen on 8/04/22 at 1:06 P.M., the following was observed: -Dietary Aide #1 running pots and pans through the dishwasher. -A two compartment sink (the sink on left had water in it for sanitizing, the sink on the right was empty with food debris) At the time of the observation, Dietary Aide #1 provided the surveyor with a step-by-step process of how the two-compartment sink is utilized. He was unable to demonstrate how the water was tested to ensure the cookware was properly sanitized. Additionally, he was unable to provide evidence that the water was being tested daily. The Regional Food Service Director additionally said that he was unable to locate any test strips to test the water. The surveyor's observations from the previous day indicated the oven and stove top remained dirty: -Debris build up on top of the oven -Dark and thick grease build up around and, in the grease drain located on the bottom right corner of the stove top -Coating of dust located on the underside of the stovetop and above the oven doors -Burnt food and white dust located inside of the oven At the time of the observation the Regional Director of Food Services said that the expectation is that the oven would be cleaned daily (inside and outside), and it does not appear that it has been. 2. Review of the 2013 Food Code (model for safeguarding public health and ensuring food is safe for consumption) indicated to store ice scoops outside of the ice machine in a clean, protected location to avoid contaminating the ice. During an observation with interview on 8/4/22 at 12:45 P.M., Certified Nurse's Aide (CNA)#1 and the surveyor observed an ice scoop resting on top of the ice in the ice chest, located in the kitchenette on the resident care unit. CNA #1 said the ice scoop should not be in there as the handle was resting in the ice and that is not sanitary.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to identify and control the potential spread of infection, including COVID-19 within the facility. Specifically, the facility failed to ensure staff monitored residents' temperatures daily and monitored residents for signs and symptoms of COVID-19 every shift during a COVID-19 outbreak for three Residents (#10, #11, and #36), out of three total residents sampled, per the facility's policy and Centers for Disease Control (CDC) and Massachusetts Department of Public Health (DPH) guidance. Findings include: Review of the facility's policy, Coronavirus (Covid-19), revised 3/16/20, included the following: - The facility follows the professional standards and recommendations set forth by the Centers for Disease Control (CDC) and state health care agencies regarding Coronavirus. - The facility will monitor resident temperatures every shift and monitor for respiratory symptoms. - All residents will have a temperature taken every shift. Review of the CDC guidance titled, Interim Infection Prevention Control Recommendations to prevent [CONDITION(S)]-CoV-2 (Covid-19) Spread in Nursing Homes, updated 2/2/22 indicated the following: - When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. - A single new case of [CONDITION(S)]-CoV-2 infection in any health care provider or a nursing home onset of infection in a resident should be evaluated as a potential outbreak. - Consider increasing monitoring all residents from daily to every shift to more rapidly detect those with new symptoms. Review of the Massachusetts Department of Public Health (DPH) guidance titled, Updates to Long-Term Care Surveillance and Outbreak Testing, dated 1/3/22 and updated 6/10/22, indicated the following: - On unit(s) conducting outbreak testing, a long-term care facility should assess residents for symptoms of COVID-19 during each shift. Symptoms include cough, shortness of breath, sore throat, myalgia (muscle aches), chills, new onset loss of taste or smell, and a fever. Runny nose, sore throat and headache have been identified as more common symptoms in individuals infected with the Omicron variant of COVID-19. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/5/22 at 11:45 A.M., the Director of Nursing (DON) said the facility followed the guidance of the CDC and DPH relative to COVID-19 and the facility was in the middle of a COVID-19 outbreak during the month of May 2022. She further said that during an outbreak, the residents were to be monitored for signs and symptoms of COVID-19 every shift and their temperatures should have been monitored at least daily. a. Resident #10 was admitted to the facility July 2021 and according to his/her medical record, tested positive for COVID-19 on 5/17/22. Review of the Resident's clinical record indicated the facility staff did not monitor Resident #10's temperature daily, as required, on the following dates in May 2022: - 5/12, 5/15-5/20, 5/29. Further review of the Resident's clinical record indicated the facility staff did not monitor for signs and symptoms of COVID-19 every shift, as required, during the entire month of May 2022. b. Resident #11 was admitted to the facility in November 2017. Review of the Resident's clinical record indicated the facility staff did not monitor Resident #11's temperature daily, as required, on the following dates in May 2022: - 5/22 and 5/23 Further review of the Resident's clinical record indicated the facility staff did not monitor for signs and symptoms of COVID-19 every shift, as required, on the following dates in May 2022: - 5/1-5/2, 5/4-5/6 and 5/11-5/31 c. Resident #36 was admitted to the facility in December 2010. Review of the Resident's clinical record indicated the facility staff did not monitor Resident #36's temperature daily, as required, on the following dates in May 2022: 5/1, 5/15-5/19 and 5/29 Further review of the Resident's clinical record indicated the facility staff did not monitor for signs and symptoms of COVID-19 every shift, as required, during the entire month of May 2022. During an interview on 8/5/22 at 1:57 P.M., the DON said Resident #10 tested positive for COVID-19 on 5/17/22, he/she did not have temperatures evaluated daily and was not monitored for signs and symptoms of COVID-19 every shift, as required. She further said that if Resident #10 refused any assessments, it should have been documented in the progress notes. She further said that both Resident #11 and Resident #36 did not have temperatures monitored daily and were not assessed for signs and symptoms of COVID-19 every shift, as required.		