

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/07/2026
NAME OF PROVIDER OR SUPPLIER  Craneville Rehabilitation and Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  265 Main Street Dalton, MA 01226	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose physician's orders included the need to notify family member of changes, the facility failed to ensure nursing notified the family/resident representative when he/she developed an injury to his/her foot and when he/she was referred to Hospice. Findings include: Review of the facility policy titled, Change in Resident Condition, dated 6/2024, indicated that unless otherwise instructed by the resident, the Nurse will notify the resident's representative when the resident is involve in any accident or incident that results in an injury including injuries of an unknown source and that a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments. Review of the facility policy titled, Incidents and Accidents, dated 10/2017, indicated that the date and time the injured person's family was notified, and by whom, will be documented on the Report of Incident/Accident form. During a telephone interview on 04/03/26 at 8:22 A.M., Family Member (FM) #1 said that the facility had received instructions in the past that he was to be notified when Resident #1 has a change in condition or an injury. FM #1 said that he had not been notified by the facility when Resident #1 sustained an injury to his/her foot, and that he had also not been notified by the facility when Resident #1 had been referred for Hospice services. FM #1 said he received a telephone call from a Hospice Nurse on 04/01/26, and that is when he became aware. Resident #1 was admitted to the facility June 2020, with diagnoses including anoxic brain damage, epilepsy, bipolar disorder, depression, end-stage renal (kidney) disease with dependence on dialysis and osteoarthritis. Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 02/27/26, indicated he/she had moderate cognitive impairment and was dependent on staff assistance for activities of daily living (bathing, dressing, eating, transferring, mobility and toileting). Review of Resident #1's current Physician's Orders for the Month of April 2026, indicated the following: -05/01/24 (effective date of order and remains current) -Notify resident's family [Family Member #1] if resident has a change in condition, any incidents/accidents happen, if he transfers to the hospital and any pertinent appointments. Review of Resident #1's Alteration in Neurological Status care plan, reviewed and renewed with his/her 02/27/26 MDS assessment indicated interventions included to discuss with him/her and family any concerns, fears, issues regarding diagnoses or treatment. Review of Resident #1's Incident Report, dated 03/09/26, indicated a dark purple bruise had been observed on his/her left foot involving three toes, the bottom and the side of the foot. Further review of the Incident Report indicated there was no documentation to support that Family Member #1 had been notified of the injury. Review of Resident #1's Nurse's Note, dated 03/09/26, indicated a bruise was observed on his/her left outer foot and bottom of foot measuring five inches by four inches and involving the tops and bottoms of three toes. Further review of the Note indicated there was no documentation to support that Family Member #1 had been notified of the injury. During an interview on 04/07/26 at 8:40 A.M., Resident #1 said he/she wanted Family Member #1 notified of his/her medical changes or injuries. During an interview on 04/07/26 at 4:15 P.M., Nurse #1, who had performed the initial assessment and measurement of Resident #1's bruise on 03/09/26, said she should have notified Resident #1's family member (FM #1) of the new bruise on 03/09/26, but had not. During an interview (continued on next page)</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>on 04/07/26 at 2:55 P.M., the Director of Nurses (DON) said Nursing staff are responsible for notifying family members when injuries have occurred to residents. The DON said Nurse #1 should have notified Resident #1's family (FM #1) of the injury on 03/09/26 but had not, as required. Review of Resident #1's Provider Progress Note, dated 03/31/26, indicated he/she expressed an interest in a hospice evaluation. Review of Resident #1's Social Service Note, dated 03/31/26, indicated a Hospice RN would be at the facility the following day at 10:00 A.M. to assess Resident #1. Review of Resident #1's medical record indicated there was no documentation to support Family Member #1 had been notified by the Facility of the Hospice consultation. During a telephone interview on 04/08/26 at 12:00 P.M., the Nurse Practitioner said that when a Hospice consult has been recommended it is her expectation that facility staff contact the family prior to the Hospice evaluation and if they agree to hospice services, a order for hospice will be given. During a telephone interview on 04/08/26 at 11:10 A.M., the Director of Social Services (DSS) said that Nursing staff are responsible for notifying the family when there is a recommendation for a Hospice evaluation. The DSS said that the Hospice Nurse told her that nursing staff had not notified the family (Family Member #1) prior to Resident #1's evaluation or prior to her calling Family Member #1 to discuss Hospice services. The DSS said Nursing staff should have notified Family Member #1 of the recommendation for Resident #1's Hospice evaluation but said that this had not been done as required. During a telephone interview on 04/09/26 at 12:00 P.M, the Director of Nurses (DON) said nursing staff are responsible for notifying family members when recommendations for Hospice evaluations are made. The DON said there was no documentation in Resident #1's medical record to support that nursing had notified Family Member #1 of Resident #1's Hospice evaluation.</p>		