STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225771	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkshire Rehabilitation & Skilled Care Center	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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was newly admitted , was unfamiliar with the facility, the staff, and was having difficulty adjusting to his/her admission, the Facility failed to ensure he/she was free from abuse, when on 05/01/25 at approximately 1:30 P.M., Director of Nurses (DON) #1 engaged in a verbally and physically abusive altercation with Resident #1. DON #1 with the assistance of Certified Nurse Aide #1, physically restrained Resident #1 to retrieve a bottle of medication he/she had in his/her possession, they pinned him/her up against the wall, blocked him/her from exiting the area, held him/her by his/her arms, pried open his/her hand to check for pills and searched his/her pockets, which only served to escalate Resident #1's resistive and combative behaviors. Findings include: Review of the Facility Abuse, Neglect and Exploitation Policy, implemented February 2023, indicated that it was the policy of the Facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. The Policy indicated that the definition of abuse included unreasonable confinement. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/11/25, indicated they reported an allegation of physical abuse that occurred on 05/01/25, involving the Former Director of Nurses (hereby referred to as DON #1) and Certified Nurse Aide (CNA) #1, which included the following: Resident #1 arrived at the Facility at 9:15 A.M. by taxi, carrying only a bag of medications. Resident #1 was unaware of his/her admission to the Facility, having been informed by the Assisted Living Facility he/she was discharged from, that he/she was going on a medical appointment. Upon arrival, Resident #1 appeared agitated due to the unexpected nature of the admission, the realization that he/she would be residing at the Facility, and the bag of medications was taken by a nurse for inventory. Later that afternoon, Nurse #1 observed Resident #1 take pills from a medication bottle that was in his/her pocket, and that Resident #1 told Nurse #1 that they were his/her pain pills and refused to give her the bottle of medication. The Report indicated that when Nurse #1 told Nurse #2 that Resident #1 had taken pain pills from a medication bottle in his/her pocket, she surmised that DON #1 had overheard the exchange. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	DON #1 then quickly approached Resident #1 and there was a brief physical altercation when she attempted to retrieve the bottle of medication from Resident #1's possession, and that he/she was agitated, uncooperative, and attempted to hit DON #1. DON #1 yelled out to staff call 911 and Nurse #2 responded by telephoning the police. The Report further indicated that DON #1 pried the medication from Resident #1's fingers, that CNA #1 helped hold Resident #1 while she (DON #1) searched his/her pockets, pulling out change and a lighter. DON #1 informed the Substance Use Disorder (SUD) Counselor that Resident #1 had a bottle of prescription medication in his/her possession, and that she was searching for other items. Resident #1 was sent to the Hospital Emergency Department (ED) for evaluation, due to his/her combativeness and the staff's inability to determine how many pills he/she had taken. The Report indicated that upon interview, Resident #1 had no recollection of the altercation. Based on the reasonable person concept, it would be more likely than not, that Resident #1 would have experienced psychosocial harm, recurrent fear, anxiety or anger as a result of the unreasonable confinement since there is an expectation that he/she would not be restrained and searched by a provider that had been entrusted to care for him/her. Resident #1 was admitted to the Facility in May of 2025, diagnoses included alcohol dependence with alcohol-induced persisting amnesic disorder (a chronic memory disorder caused by severe deficiency of vitamin B-1), opioid abuse, major depressive disorder and post-traumatic stress disorder. Review of Resident #1's Medical Record indicated that he/she was alert and oriented and could make his/her needs known. Further review of the Record indicated that his/her Health Care Proxy (HCP) was activated prior to admission. During an interview on 05/20/25 at 2:59 P.M., Resident #1 was unable to speak to the events of 05/01/25 and did not have any recollection of the altercation with staff. During a telephone interview on 05/21/25 at 11:22 A.M., Director of Nurses (DON) #1 said that on 05/01/25, Resident #1 had been agitated all morning, and had been yelling and swearing in the hallway because he/she was upset about being tricked into admission to the Facility that morning. DON #1 said that she was called to the first floor at approximately 1:30 P.M. because Resident #1 had a bottle of oxycodone (opioid, used for the treatment of moderate to severe pain) in his/her possession. DON #1 said that when she approached Resident #1, across from the nurses' station, he/she tried to hit her with his/her cane. During a telephone interview on 05/21/25 at 12:45 P.M., Certified Nurse Aide #1 said that on 05/01/25, Resident #1 had been agitated all morning, yelling, swearing and threatening to leave the Facility. CNA#1 said Resident #1 was upset about his/her admission to the Facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/20/25 at 2:05 P.M., Nurse #1 said that on 05/01/25 during the early afternoon, Resident #1 approached her medication cart and asked for a cup of water. Nurse #1 said she observed Resident #1 dispense three pills from a prescription medication bottle into the palm of his/her hand. Nurse #1 said that when she asked Resident #1 What have you got there? he/she said that they were his/her pain pills, oxy. Nurse #1 said she asked Resident #1 if she could see the medication bottle and when she reached for it, he/she put the medication bottle back in his/her jacket pocket and said no, they are mine. Nurse #1 said she notified Nurse #2 that Resident #1 had a bottle of pain medication in his/her possession and asked for her help because she wanted to closely monitor Resident #1 until she could reapproach him/her, in attempt to avoid confrontation. Nurse #1 said that DON #1 may have overheard the conversation between herself and Nurse #2, because shortly thereafter, DON #1 appeared suddenly and approached Resident #1 loudly and in a rapid manner, causing the situation to quickly escalate. Nurse #1 said that Resident #1 refused to hand over the medication to DON #1 and verbally threatened to punch someone. Nurse #1 said that DON #1 loudly instructed someone nearby to call 911. Nurse #1 said that at the time of the altercation, Resident #1 was standing in an alcove across from the nurses' station with his/her back against the wall. Nurse #1 said that CNA #1 responded to the situation and positioned himself on Resident #1's left side, while DON #1 was positioned on Resident #1's right side, going through his/her pockets. Nurse #1 said that Resident #1 could not go anywhere because his/her movements were blocked by DON #1 and CNA #1. Nurse #1 said that Resident #1 was yelling and swearing and that DON #1 was responding to him/her with the same level of volume. Nurse #1 said It was out of control, like a street fight. Nurse #1 said the altercation lasted a few minutes. During an interview on 05/20/25 at 2:34 P.M., Nurse #2 said that Nurse #1 notified her that Resident #1 had a bottle of oxycodone in his/her possession and that she (Nurse #1) saw him/her consume two pills from the bottle. Nurse #2 said that she assumed DON #1 overheard her discussion with Nurse #1, because she (DON #1) rushed over to Resident #1 and engaged in a verbal altercation with him/her. Nurse #2 said that when Resident #1 became physical toward DON #1, she (DON #1) yelled, Call 911, and she did as DON #1 directed. Nurse #2 said that there was so much yelling between DON #1 and Resident #1, that the police dispatcher on the other end of the telephone asked who was yelling in the background. Nurse #2 said the altercation between DON #1, CNA #1 and Resident #1 lasted less than five minutes. During a telephone interview on 05/22/25 at 12:01 P.M., Nurse #3 said that she went downstairs to tell DON #1 that Resident #1 had a bottle of oxycodone in his/her possession and would not relinquish it. Nurse #3 said DON #1 went upstairs immediately to address the situation. CNA #1 said he/she was at the nurses' station around 1:30 P.M., when the altercation between DON #1 and Resident #1 began. CNA #1 said that upon seeing Resident #1 lunge toward DON #1, as if he/she was going to hit her, he intervened and positioned himself close to Resident #1's left side, preventing him/her from pulling his/her arm away from the wall. CNA #1 said that when DON #1 tried to get Resident #1 to hand over what he/she was holding, he/she kept his/her hand closed. CNA #1 said that when Resident #1 didn't respond when asked to open his/her hand, he stepped in to block Resident #1's movement and physically pried open his/her hand. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 05/22/25 at 10:07 A.M., the Finance Assistant said that sometime during the afternoon of 05/01/25, she went upstairs to the unit after hearing a situation was unfolding. The Finance Assistant said she went with the intent to help redirect residents as needed. The Finance Assistant said that from her position at the back of the nurses' station, she observed that DON #1 and CNA #1 held Resident #1 against the wall. The Finance Assistant said that DON #1 was positioned on Resident #1's right side, holding his/her right arm while CNA #1 was on his/her left side, holding his/her left arm. The Finance Assistant said that Resident #1 was yelling, swearing and resisting what was going on. The Finance Assistant said that the altercation lasted less than five minutes. During a telephone interview on 05/22/25 at 10:15 A.M., Certified Nurse Aide (CNA) #3 said that on 05/01/25 at approximately 1:30 P.M., she witnessed Resident #1 being cornered by DON #1 and CNA #1, that Resident #1 had his/her back against the wall in an alcove area across from the nurses' station. CNA #3 said Resident #1 was visibly upset while DON #1 went through his/her pockets, and when he/she refused to open his/her hand. CNA #3 said she heard DON #1 tell CNA #1 to pull back Resident #1's thumb and pry open his/her hand. CNA #3 said CNA #1 held Resident #1's arm, pulled back his/her thumb, and pried open his/her hand. During an interview on 05/20/25 at 1:00 P.M., the Substance Use Disorder (SUD) Counselor said that sometime during the afternoon of 05/01/25, the Social Worker asked him to come inside to assist with a situation involving Resident #1. The SUD Counselor said he observed Resident #1 in the alcove across from the nurses' station with his/her back against the wall. The SUD Counselor said that DON #1 was standing on Resident #1's right side, holding his/her right arm with her left hand, while she used her right hand to go through his/her pockets. The SUD Counselor said that CNA #1 was holding Resident #1 against the wall with his hands on Resident #1's left upper arm. The SUD Counselor said that during the altercation, Resident #1 resisted being held, was visibly upset, and repeated, No! and Leave me alone! The SUD Counselor said the altercation was already underway when he arrived and that he only saw the last 20-30 seconds. The SUD Counselor said the altercation ended after DON #1 pulled a lighter from Resident #1's pocket and then released him/her. Nurse #3 said that she witnessed Resident #1 standing against the wall in an alcove across from the nurses' station. Nurse #3 said that DON #1 was on Resident #1's right side and CNA #1 was on his/her left side, and they each held one of Resident #1's arms. Nurse #3 said she witnessed the altercation for about 30 seconds before it broke up. Nurse #3 said that once the altercation was over, DON #1 went into her office with the items she had found in Resident #1's possession: a bottle of oxycodone, two lighters, and a box of cigarettes. Nurse #3 said she counted the oxycodone with DON #1. During an interview on 05/20/25 at 12:30 P.M., the current Director of Nurses (hereby referred to as DON #2) said that DON #1 was asked to go upstairs to address an issue with Resident #1 and that when she did not come back downstairs, she went to the unit and saw DON #1 walking from the nurses' station to her office. DON #2 said that DON #1 had a bottle of oxycodone, a box of cigarettes and two lighters that had been in Resident #1's possession. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	DON #2 said she counted the oxycodone with DON #1 and Nurse #3, and that when they could not determine how much of the medication Resident #1 had ingested, the physician gave an order to send him/her to the Hospital Emergency Department to be evaluated. During her interview, DON #1 denied restraining Resident #1 against the wall and denied going through his/her pockets for the bottle of medication. DON #1 said Resident #1 eventually handed over the bottle of medication. DON #1 said she could not recall whether CNA #1 was present during the altercation and did not remember finding two lighters inside a box of cigarettes in Resident #1's possession. During an interview on 05/20/25 at 3:23 P.M., the Administrator said that DON #1 should have cleared the area and attempted to diffuse Resident #1's agitation, monitor him/her closely and reapproach him/her later. The Administrator said that DON #1 and CNA #1 should not have pushed the issue when Resident #1 was agitated. The Administrator said that the outcome of the Facility's internal investigation into the allegations of abuse against DON #1 and CNA #1, was that they did not find their actions to include willful intent. The Administrator said the Facility decided to separate employment with both CNA #1 and DON #1 out of an abundance of caution based on poor customer service.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews and records reviewed, for one of three sampled residents (Resident #1), and for two of three sampled employees (Certified Nurse Aide #1 and the Substance Use Disorder [SUD] Counselor), the Facility failed to ensure staff implemented and followed their abuse policy related to reporting of abuse allegations and employment requirements. 1) On 05/01/25, although several employees witnessed the Director of Nurses #1 and Certified Nurse Aide #1 physically restrain Resident #1 against the wall while they searched his/her pockets and pried open his/her hand, no one reported the physically abusive altercation immediately to the Administrator or Director of Nurses, who were not made aware until four days later, and 2) prior to working at the facility, a Criminal Offender Record Information (CORI) check was not conducted on Certified Nurse Aide (CNA) #1, and a Massachusetts Nurse Aide Registry (NAR) check was not conducted on the SUD Counselor, as required. Findings include: 1) Review of the Facility Abuse, Neglect and Exploitation Policy, implemented February 2023, indicated it was the policy of the Facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The Policy also indicated that the facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified time frames: -immediately but not later than two hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury or, -not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/11/25, indicated an allegation of physical abuse that occurred on 05/01/25, involving the Former Director of Nurses (hereby referred to as DON #1) and Certified Nurse Aide (CNA) #1, was reported. The Report indicated that during the afternoon of 05/01/25, Nurse #1 observed Resident #1 take pills from a medication bottle that was in his/her pocket. The Report indicated that Resident #1 told Nurse #1 that they were his/her pain pills and refused to give her the bottle of medication. The Report indicated that DON #1 quickly approached Resident #1 and there was a brief physical altercation when she attempted to retrieve the bottle of medication from Resident #1's possession. The Report indicated that Resident #1 was agitated, uncooperative, and attempted to hit DON #1. The Report indicated that DON #1 yelled, call 911 and Nurse #2 responded by telephoning the police. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Report indicated that DON #1 pried the medication from Resident #1's fingers and that CNA #1 helped hold Resident #1 while she (DON #1) searched his/her pockets, pulling out change and a lighter. The Report indicated that DON #1 told the Substance Use Disorder (SUD) Counselor that Resident #1 had a bottle of prescription medication in his/her possession, and that she was searching him/her for other items. The Report indicated that Resident #1 was sent to the Hospital Emergency Department (ED) for evaluation, due to his/her combativeness and the staff's inability to determine how many pills he/she had taken. The Report indicated that upon interview, Resident #1 had no recollection of the altercation. Resident #1 was admitted to the Facility in May of 2025, diagnoses included alcohol dependence with alcohol-induced persisting amnesic disorder (a chronic memory disorder caused by severe deficiency of vitamin B-1), opioid abuse, major depressive disorder and post-traumatic stress disorder. Review of Resident #1's Medical Record indicated that he/she was alert, oriented and could make his/her needs known. Further review of the Record indicated that his/her Health Care Proxy (HCP) was activated prior to admission. During an interview on 05/20/25 at 1:00 P.M., the Substance Use Disorder (SUD) Counselor said that sometime during the afternoon of 05/01/25, the Social Worker asked him to come inside to assist with a situation involving Resident #1. The SUD Counselor said he observed Resident #1 in the alcove across from the nurses' station with his/her back against the wall. The SUD Counselor said that DON #1 was standing on Resident #1's right side, holding his/her right arm with her left hand, while she used her right hand to go through Resident #1's pockets. The SUD Counselor said that CNA #1 was holding Resident #1 against the wall with his hands on his/her left upper arm. The SUD Counselor said that during the altercation, Resident #1 resisted being held, was visibly upset, and repeated No! and Leave me alone! The SUD Counselor said the altercation was already underway when he arrived and that he only saw the last 20-30 seconds. The SUD Counselor said the altercation ended after DON #1 pulled a lighter from Resident #1's pocket and then they (DON #1 and CNA #1) released him/her. The SUD Counselor said that several other employees had witnessed the altercation as well. The SUD Counselor said he did not report the abuse allegation until 05/05/25, four days later, and that he should have reported it immediately to the Administrator. During an interview on 05/20/25 at 3:23 P.M., the Administrator said that although he was notified on 05/01/25 that Resident #1 had a bottle of oxycodone in his/her possession and was sent out to the ED for evaluation, he was unaware of the allegation of abuse involving DON #1 and CNA #1, until it was reported to him on 05/05/25 by the SUD Counselor. The Administrator said the allegation of abuse should have been reported immediately. 2) Review of the Facility Abuse, Neglect and Exploitation Policy, implemented February 2023, indicated that potential employees would be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. The Policy further indicated that background reference and credential checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. The Policy indicated the facility will maintain documentation of proof that the screening occurred. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNA #1's Employee File indicated his first date of employment at the Facility was on 02/10/25. Further review of CNA #1's Employee File indicated a CORI check was not obtained until 04/23/25, over two months after CNA #1 started working at the Facility. There was no documentation to support that a CORI check had been conducted prior to his employment at the Facility. Review of the SUD Counselor's Employee File indicated his first date of employment at the Facility was on 10/07/24. Further review of the SUD Counselor's Employee File indicated that there was no documentation to support that a Massachusetts NAR check had been conducted prior to his employment at the Facility. The Administrator said the Facility had no documentation to support that an NAR check had been conducted for the SUD Counselor or that a CORI check had been conducted on CNA #1, before they started working at the Facility. The Administrator said that CORI checks and NAR checks should be run on all employees prior to working at the Facility.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure that on 05/05/25, after Facility Administration was made aware of an allegation of physical abuse of a resident (Resident #1) by Director of Nurses (DON) #1 and Certified Nurse Aide (CNA) #1, that they reported the allegation to the Department of Public Health (DPH) within two hours as required, when it was not reported to DPH until 05/11/25, (six days later). Findings include: Review of the Facility's Policy titled, Abuse, Neglect and Exploitation, dated as revised February 2023, indicated reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time frames: -Immediately but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or -Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted 05/11/25, indicated an allegation of physical abuse occurred on 05/01/25, involving the Former Director of Nurses (hereby referred to as DON #1) and Certified Nurse Aide (CNA) #1. The Report indicated that during the afternoon of 05/01/25, Nurse #1 observed Resident #1 take pills from a medication bottle that was in his/her pocket. The Report indicated that Resident #1 told Nurse #1 that they were his/her pain pills and refused to give her the bottle of medication. The Report indicated that DON #1 quickly approached Resident #1 and there was a brief physical altercation when she attempted to retrieve the bottle of medication from Resident #1's possession. The Report indicated that Resident #1 was agitated, uncooperative, and attempted to hit DON #1. The Report indicated that DON #1 yelled, call 911 and Nurse #2 responded by telephoning the police. The Report indicated that DON #1 pried the medication from Resident #1's fingers and that CNA #1 helped hold Resident #1 while she (DON #1) searched his/her pockets, pulling out change and a lighter. The Report indicated that DON #1 told the Substance Use Disorder (SUD) Counselor that Resident #1 had a bottle of prescription medication in his/her possession, and that she was searching him/her for other items. The Report indicated that Resident #1 was sent to the Hospital Emergency Department (ED) for evaluation, due to his/her combativeness and the staff's inability to determine how many pills he/she had taken. The Report indicated that upon interview, Resident #1 had no recollection of the altercation. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Written Report, dated 05/05/25, given to the Administrator by the SUD Counselor, alleged that on 05/01/25, DON #1 and Certified Nurse Aide (CNA) #1 held Resident #1 against the wall by his/her arms, searched him/her, then removed coins and a lighter from his/her pockets. The Report alleged that DON #1 said that Resident #1 had a bottle of prescription medicine in his/her pocket and that she was also searching for other items. Resident #1 was admitted to the Facility in May of 2025, diagnoses included alcohol dependence with alcohol-induced persisting amnesic disorder (a chronic memory disorder caused by severe deficiency of vitamin B-1, opioid abuse, major depressive disorder, recurrent, and post-traumatic stress disorder. Review of Resident #1's Medical Record indicated that he/she was alert and oriented and could make his/her needs known. Further review of the Record indicated that his/her Health Care Proxy (HCP) was activated prior to admission. During an interview on 05/20/25 at 1:00 P.M., the Substance Use Disorder (SUD) Counselor said that on the morning of 05/05/25, he reported an allegation of physical abuse involving Resident #1 to the Administrator, that occurred on 05/01/25 during an altercation with DON #1 and CNA #1. The SUD Counselor said he reported the allegation both verbally and in writing. During an interview on 05/20/25, the Administrator said he was unsure why the allegation of physical abuse was not submitted to DPH within the required two hours. The Administrator said he would need to verify when the current Director of Nurses (hereby referred to as DON #2) reported the physical abuse allegation via HCFRS. During an interview on 05/20/25 at 4:20 P.M., DON #2 said that she started to report the abuse allegation on 05/05/25 to DPH via HCFRS, but did not submit the information until 05/11/25 because she misunderstood and thought she had five days to submit the allegation.