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	10/16/2025

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. (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had moderate cognitive impairment, the Facility failed to ensure he/she was free from abuse from a staff member, when on 08/09/25, while Nurse #1 was assisting Resident #1, he/she grabbed and squeezed Nurse #1's hand, and in response she struck Resident #1 on the back and pulled his/her hair in attempt to release his/her grip. Nurse #1 admitted to engaging in a physical altercation with Resident #1 and the incident was witnessed by another staff member, and an alert and oriented resident. A cognitively intact person would likely experience pain, anger and emotional distress if struck and had their hair pulled by a caregiver. 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 includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/09/25, indicated that at 6:04 P.M. Nurse #2 reported that Nurse #1 engaged in physical contact with Resident #1 after he/she grabbed her (Nurse #1). The Report indicated that Resident #1 was calling out for help, stood from his/her wheelchair, and that Nurse #2 responded along with Nurse #1 to prevent him/her from falling. The Report indicated that Resident #1 pinched Nurse #1 on the buttocks and that when she went to push his/her hand away, he/she grabbed Nurse #1's closed hand and squeezed, causing her pain. The Report indicated that Nurse #1 said that she pulled Resident #1's hair to get him/her to release his/her grip and when that did not work, she pinched his/her arm. The Report indicated that Nurse #2 witnessed Nurse #1 slap Resident #1's back and pull his/her hair, and that she (Nurse #2) grabbed Nurse #1's hand and said, No, you can't do that! The Report indicated that when Resident #1 released Nurse #1's hand, she pulled away and yelled, I am done with this fucking place, let him/her fall, I will send him/her out!The Report further indicated that Resident #2 witnessed the physical altercation between Resident #1 and Nurse #1, and that Resident #1 had no recollection of the event. The Report indicated that Resident #2 heard Nurse #1 use profanity as she walked away from the incident.Based on the reasonable person concept, it would be more likely than not, that Resident #1 would have experienced psychosocial harm, recurrent fear, anxiety, anger, or pain as a result of the physical abuse since there is an expectation that he/she would not be hit or have his/her hair pulled by a provider that had been entrusted to care for him/her.Resident #1 was admitted to the Facility in June 2025, diagnoses included vascular dementia, psychotic disorder with delusions, generalized anxiety disorder and repeated falls. Review of Resident #1's admission Minimum Data Set (MDS) Assessment, dated 06/10/25, indicated he/she was moderately cognitively impaired with a score of 9 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact)Resident #2 was admitted to the Facility in November 2024 with diagnoses including Parkinson's Disease. Resident #2's Quarterly MDS Assessment, dated 05/23/25, indicated he/she was moderately cognitively impaired with a score of 11 out of 15 on the BIMS.During an interview on 10/16/25 at 1:27 P.M. Resident #2 said that he/she witnessed a physical altercation between Nurse #1 and Resident #1, at the nurses' station, that occurred a few months ago (exact date and time unknown). Resident #2 said Resident #1 was repeatedly calling out for help and continually attempting to stand from his/her wheelchair just before the incident.Resident #2 said that Resident #1 eventually stood up from his/her wheelchair and that when Nurse #1 approached to assist him/her, Resident #1 grabbed her hand. Resident #2 said that he/she then observed Nurse #1 strike Resident #1 on his/her back with her open hand. During an interview on 10/17/25 at 12:19 P.M. (which also included a review of her written witness statement dated 08/09/25) Nurse #1 said that she worked the evening shift on 08/09/25. Nurse #1 said that Resident #1 had returned from the hospital that morning following a fall, during which he/she sustained fractured ribs. Nurse #1 said she was familiar with Resident #1 noting that he/she had dementia and was at risk of falls. Nurse #1 said that Resident #1 was restless that evening and may have been experiencing discomfort from his/her fractured ribs. Nurse #1 said that at approximately 6:00 P.M. Resident #1 attempted to stand up from his/her wheelchair by the nurses' station, indicating that he/she needed to use the bathroom. Nurse #1 said she encouraged Resident #1 to sit back down because she didn't have the opportunity to assist him/her and was unsure if his/her transfer status had changed since his/her recent fall. Nurse #1 said that Resident #1 then