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	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkshire Rehabilitation & Skilled Care Center	7 Sandisfield Road Box 216 Sandisfield, MA 01255

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who was severely cognitively impaired, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when on 01/24/26, several staff members witnessed Certified Nurse Aide (CNA) #1 interact with Resident #1 in a demeaning and derogatory manner, while redirecting him/her.Findings include: Review of the Facility's Resident Rights Policy, dated as revised July 2021, indicated that residents had the right to be treated with consideration, respect and full recognition of their dignity and individuality. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/27/26, indicated staff alleged that on 01/24/26 at 10:45 A.M., CNA #1 pushed Resident #1 and told him/her, You're nasty!Resident #1 was admitted to the Facility in March 2023, diagnoses included Parkinson's disease, schizophrenia and unsteadiness on feet. Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 01/04/26, indicated Resident #1 was severely cognitively impaired with a score of 3 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). Review of Resident #1's Behavior Care Plan, reviewed and renewed with his/her Quarterly MDS, completed 01/04/26, indicated he/she had a history of wandering intrusively and being aggressive toward staff. The Care Plan interventions indicated Resident #1's wandering behavior should be addressed by attempting to redirect him/her and engaging him/her in a diversional activity. Further review of the Care Plan indicated staff should approach Resident #1 in a calm manner, divert his/her attention, and remove him/her from the situation to another location as needed. During a telephone interview on 05/27/26 at 10:11 A.M., Certified Nurse Aide (CNA) #4 (which also included a review of her Written Witness Statement, dated 01/30/26) said that she witnessed an altercation between Resident #1 and CNA #1 on 01/24/26. CNA #4 said that CNA #1 told Resident #1, You're gross, and used hand gestures indicating that he/she (Resident #1) should move away from her. During an in-person interview on 05/27/26 at 1:05 P.M., Certified Nurse Aide (CNA) #3 said that she witnessed an altercation between CNA #1 and Resident #1 at the nurses' station near the end of the evening shift on 01/24/26. CNA #3 said that Resident #1 wandered out of his/her room, approached the nurses' station and stood within CNA #1's personal space. CNA #3 said that CNA #1 held up her hand to Resident #1 and stated to him/her, Get out of here, you're gross!During a telephone interview on 05/26/26 at 3:25 P.M., Certified Nurse Aide (CNA) #2 said that on 01/24/26 around 10:30 P.M., Resident #1 approached CNA #1, at which time CNA #1 placed her hands on his/her chest in a manner to redirect him/her and stated to him/her go! and get your nastiness away from me!During a telephone interview on 05/27/26 at 9:00 A.M., Nurse #1 said that Resident #1 frequently stood too close to others and had difficulty understanding and maintaining appropriate personal boundaries. Nurse #1 said that on 01/24/26 around 10:30 P.M., Resident #1 was wandering near the nurses' station when CNA #1 stated to him/her to get your nasty away from me while putting her hand on his/her chest. Nurse #1 said Resident #1 did not appear to react to the contact or lose his/her balance; instead, he/she changed direction and walked away from the area. Nurse #1 further said that she advised CNA #1 that Resident #1 should have been redirected in a (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respectful and professional manner.Review of CNA #1's Written Witness Statement, dated 01/27/26, indicated [that on 1/24/26 during the evening shift] she was at the nurses' station when Resident #1 approached her and stood within her personal space. The Statement indicated that she (CNA #1) put her hand up and asked Resident #1 to move away in a polite manner. The Surveyor was unable to interview Certified Nurse Aide (CNA) #1 as she did not respond to the Department of Public Health's telephone or letter requests for an interview. During an interview on 05/27/26 at 4:00 P.M., the Director of Nurses (DON) said that the Facility's investigation determined that Certified Nurse Aide (CNA) #1 failed to treat Resident #1 with dignity and respect during her interaction with him/her on 01/24/26. The DON further said that CNA #1's employment was terminated on 02/04/26 as a result of the incident.

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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 records reviewed and interviews, for two of three sampled residents (Resident #1 and Resident #2), the Facility failed to ensure staff implemented and followed their Abuse Policy related to the need to immediately report an allegation of abuse to Facility administration, when: 1). On 01/24/26, Nurse #1 witnessed an incident involving possible verbal and physical abuse between Certified Nurse Aide (CNA) #1 and Resident #1, did not immediately notify Facility administration. but left a note describing the event under the Nursing Supervisor's office door, where it was not discovered until 01/27/26, three days later. 2). On 4/28/26 around 3:45 P.M., although staff were aware that a physical altercation had occurred between Resident #2 and Resident #3, they did not immediately notify a supervisor, per Facility policy, but waited until 8:30 P.M. (almost five hours later) to report it. Findings include:1). Review of the Facility Policy titled Abuse, Neglect and Exploitation, dated as implemented February 2023, indicated it was the policy of the Facility to provide protection 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 would have written procedures that include reporting of 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 01/27/26, indicated staff alleged that on 01/24/26 at 10:45 A.M., CNA #1 pushed Resident #1 and told him/her, You're nasty! Review of written communication (later identified as the note left under the Nursing Supervisor's door), signed and dated 01/24/26 at 10:45 P.M. by Nurse #1, indicated it reported an allegation that Certified Nurse Aide (CNA) #1 pushed Resident #1 and told him/her I don't want your nasty near me.During a telephone interview on 05/27/26 at 9:00 A.M., Nurse #1 said that on 01/24/26 around 10:30 P.M., Resident #1 was wandering near the nurses' station when CNA #1 made physical contact with Resident #1 and stated to him/her, get your nasty away from me. Nurse #1 said that she wrote a note detailing the incident and slid it under the Nursing Supervisor's office door on 01/24/26. Nurse #1 said that she should have reported the incident to Facility administration immediately by phone. During an interview on 05/27/26 at 4:00 P.M., the Director of Nurses (DON) said that she first became aware of the allegation of abuse involving CNA #1 and Resident #1 on 01/27/26, when the Nursing Supervisor found a note from Nurse #1 reporting the alleged incident. The DON further said the expectation was for all allegations of abuse to be reported to Facility administration immediately.2). Review of the Facility Policy titled Resident to Resident Altercation, dated April 2025, indicated that all staff are to report any suspected resident to resident altercations immediately to their supervisor. Review of the Report submitted by the Facility via HCFRS, dated 04/28/26 at 8:30 P.M., indicated that Resident #3 became angry with Resident #2 and punched him/her in the face, resulting in a nosebleed. Further review of the Report indicated that both Resident #2 and Resident #3 were sent to the Emergency Department (ED). Review of Resident #3's Nurse Progress Note, dated 04/28/26, indicated that around 3:45 P.M. Resident #3 was in the hallway getting assistance from staff when Resident #2 approached him/her, and he/she responded by punching Resident #2 in the face. The Note indicated that Resident #3 was sent to the ED to be evaluated. Review of Resident #2's Nurse Progress Note, dated 04/28/26, indicated that around 3:45 P.M., Resident #2 approached Resident #3 in the hallway and despite staff intervention, he/she was struck in the face by Resident #3, resulting in a nosebleed. The Note indicated that Resident # 2 was sent to the ED for evaluation. The DON said that on 04/28/26, around 8:30 P.M., she contacted the Facility about an unrelated matter. The DON said that during that conversation, the nurse informed her (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of an altercation that had occurred around 3:45 P.M., between Resident #3 and Resident #2. The DON said that Facility policy requires all allegations of abuse, including resident to resident altercations to be reported to Facility administration immediately.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on records reviewed and interviews, for two of three sampled residents (Resident #2 and Resident #3), the Facility failed to ensure that on 04/28/26, after being made aware of an allegation that Resident #3 punched Resident #2 in the nose, they obtained and maintained evidence that a thorough investigation into the allegation had been completed and that a final investigation report was submitted to the Massachusetts Department of Public Health (DPH) within five days, as required.Findings include:Review of the Facility Policy titled Abuse, Neglect and Exploitation, dated as implemented February 2023, indicated the Administrator will follow-up with the government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies. The Policy indicated that once an investigation has been completed, the five-day follow-up should be reported to DPH via the electronic reporting platform. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 04/28/26, indicated that Resident #3 became angry with Resident #2 and punched him/her in the face, at 8:30 P.M., resulting in a nosebleed. The Report indicated the altercation was witnessed by Resident #4 who had reported observing Resident #2 push Resident #3, after which Resident #3 punched Resident #2 in the nose. Further review of the Report indicated that both Resident #2 and Resident #3 were sent to the Emergency Department (ED) for evaluation. The Report further indicated that Resident #4 was the only reported witness. The Report further indicated conclusion (final report) to follow. Review of the Facility's Investigation File, including an incident report and witness statements, identified two staff members as witnesses to the incident. However, review of the Investigation File indicated there was no documentation to support the allegation that Resident #2 pushed Resident #3 was investigated by the Facility. Further review of the File indicated there was no documentation to support that Resident #4 witnessed the altercation, as there was no record of an interview with Resident #4 and no written witness statement was obtained. Additionally, review of the Investigation File indicated the altercation occurred around 3:45 P.M., not at 8:30 P.M., as reported to DPH. These discrepancies regarding the time of the incident, the events that occurred, and the individuals who allegedly witnessed the altercation demonstrate that the investigation was not conducted thoroughly and that the information reported to DPH was not verified for accuracy prior to submission.Review of the Facility Incident Report, dated 04/28/26 at 3:45 P.M., indicated that Resident #3 was receiving staff assistance to adjust his/her clothing, when Resident #2 approached. The Report indicated that despite staff attempts to redirect Resident #2, Resident #3 punched Resident #2 in the nose. Review of Resident #3's Nurse Progress Note, dated 04/28/26, indicated that around 3:45 P.M. Resident #3 was in the hallway getting assistance from staff when Resident #2 approached him/her, and he/she responded by punching Resident #2 in the face. The Note indicated that Resident #3 was sent to the ED to be evaluated. Review of Resident #2's Nurse Progress Note, dated 04/28/26, indicated that around 3:45 P.M., Resident #2 approached Resident #3 in the hallway and despite staff intervention, he/she was struck in the face by Resident #3, resulting in a nosebleed. The Note indicated that Resident # 2 was sent to the ED for evaluation. Review of Certified Nurse Aide (CNA) #6's Written Witness Statement, dated 04/28/26, indicated that on 04/28/26 while she was assisting Resident #3 with his/her clothing, Resident #2 approached them. The Statement indicated that both she (CNA #6) and Nurse #3 attempted to intervene but were unable to prevent Resident #3 from hitting Resident #2 in the nose. Review of Nurse #3's Written Witness Statement, dated 04/28/26, indicated that on 04/28/26 at 3:45 P.M., she was speaking with CNA #6 while she assisted Resident #3 in the hallway when Resident #2 approached. The Statement indicated that despite intervention attempts by CNA #6 and herself (Nurse #3), Resident #3 struck Resident #2 in the face. During an interview on 05/27/26 at 4:00 P.M., the Director of Nurses (DON) said that she was not sure why there were discrepancies between the investigation and what was reported to the DPH in HCFRS. The DON also said they had (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no documentation to support their final investigative findings had been completed and submitted to DPH within five working days (by 05/05/26). The DON further said that she reported the time of the incident as 8:30 P.M., because that was when she was notified by staff that the incident had occurred.