| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 225771 | A. Building<br>B. Wing | 02/04/2026 |

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

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>Based on interviews, and record review, the facility failed to ensure a Registered Nurse (RN) worked eight (8) consecutive hours daily, as required.ˆ ˆSpecifically, the facility failed to ensure that a Registered Nurse worked at least eight consecutive hours daily on four days from 12/28/25 through 1/28/26. Findings include: Review of the PBJ Staffing Data Report CASPER Report 1705D form dated Quarter 4 2025 (July 1 through September 30), prior to survey entrance, indicated the facility triggered for excessively low weekend staffing.ˆ ˆ Review of the facility nursing schedule, dated 12/28/25 through 1/28/26, indicated no documented evidence that a RN worked at least eight consecutive hours on the following dates: -Sunday 1/4/26 -Saturday 1/10/26 -Saturday 1/17/26 -Sunday 1/18/26 ˆ On 1/29/26 at 9:26 A.M. through 9:55 A.M., the surveyor reviewed dates and employee punches/payroll data with the facility Scheduler. During an interview at this time, the Scheduler said the following she was aware of the requirement to have a RN in the facility daily but was not aware that there needed to be specific number of consecutive hours for the RN.ˆ The Scheduler said there was no RN that worked on Saturday 1/10/26, the scheduled RN for Saturday 1/17/26 must have called out, and no RN worked on that day, the scheduled RN for Sunday 1/18/26 worked from 10:40 A.M. until 4:15 P.M. (5.5 hours), the scheduled RN for Sunday 1/4/26 called out and the Director of Nursing (DON) was listed on the schedule to work from 7:00 P.M. to 11:00 P.M. (total 4 hours), and there were no other scheduled RN hours for 1/4/26.ˆThe Scheduler said she did not have access to the payroll information for the DON who was on listed on the schedule for Sunday 1/4/26, but Human Resources (HR) would be able to access the actual hours worked on that day.ˆ ˆ On 1/29/26 at 9:57 A.M., the HR Staff provided the detailed payroll information for Sunday 1/4/26. During an interview at the time, the HR Staff said the DON worked from 7:00 P.M. to 11:00 P.M. (4 hours total) on Sunday 1/4/26. ˆ During an interview on 1/29/26 at 11:18 A.M., the surveyor relayed concerns about the RN coverage to the Administrator and the Administrator said if the information for RN hours was reviewed with the Scheduler and the HR Staff, then the information about the RN hours was correct. The Administrator said the facility was currently in the process of onboarding nursing staff and the location of the facility has been a challenge in doing this.ˆˆ |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and record review, the facility failed to ensure the main facility kitchen used to store, prepare and distribute resident food and beverages was maintained in a clean and sanitary manner in accordance with food service safety standards.Specifically, the facility failed to ensure that:-the fan in the dish room of the main facility kitchen was cleaned and kept free from dust blowing over clean pots and pans.-the dish rack housing clean dish ware and storage rack in the cook's preparation area was kept free of dust and debris to decrease the risk of physical contamination and foodborne illness.ˆ -areas in the main kitchen were appropriately cleaned as required and equipment stored per food safety standards. ˆ Findings include: Review of the facility policy titled Dietary Department Guidelines, undated, indicated the facility must store, prepare and distribute food under sanitary conditions. The policy also included the following: -The Dietary Department will be maintained in a clean and sanitary manner to prevent food borne illness. -All items stored in the refrigerator will be covered, labeled with the contents and the date.ˆ Review of the Food Drug Administration (FDA) Food Code 2017 (www.fda.gov),ˆindicatedˆthe following:ˆ -Food Preparation:ˆ >During preparation, unpackaged food shall be protected from environmental sources of contamination.ˆ -Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils:ˆ >theˆobjectiveˆof cleaning focuses on the need to remove organic matter from food contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted.ˆˆ >Microorganisms may be transmitted fromˆfoodˆto other foods by utensils, cutting boards, thermometers, or other food-contact surfaces.ˆˆ >Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms.ˆˆ >Food-contact surfaces of cooking equipment must be cleaned to prevent encrustations that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use.ˆˆ >The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests.ˆˆ -Cleaning, Frequency and Restrictions:ˆ >Cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should beˆestablishedˆand followed toˆmaintainˆthe facility in a clean and sanitary manner. Primary cleaning should be done at times whenˆfood isˆinˆprotectedˆstorage and when food is not being served or prepared.ˆˆ On 1/28/26 at 7:43 A.M., the surveyor conducted an initial walk through of the main facility kitchen with the Food Service Director (FSD), and the following was observed: -A pan of bagged raw chicken, dated 1/27/26 stored above a sheet pan of undated raw hamburger in the reach in refrigerator. -Three pitchers of unlabeled, undated juice in the reach in refrigerator. During an interview at the time, the FSD said items should be labeled and dated.ˆ -A large clear scoop exposed and placed on the outer top surface of the ice machine. The inner left side and top of the ice machine had white residue. During an interview at the time, the FSD said the ice machine needed to be cleaned. The FSD said there was a cleaning schedule for the ice machine and definitely needed to be done. The FSD said the scoop should not be stored on top of the ice machine because of potential contamination. -Fan which was on, located in the dish room, had copious amounts of dust and was blowing air over clean pots/pans and towards the clean end of the dish machine. During an interview at the time, the FSD said the fan needed to be cleaned.ˆ ˆ On 2/4/26 at 2:05 P.M., the surveyor conducted a follow-up tour of the kitchen with Dietary Aide (DA) #1, (continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | who was the Cook, and the following was observed: -Large clear scoop was exposed and placed on the outer top surface of the ice machine. During an interview at the time, DA #1 said the scoop was used to get ice out of the ice machine. DA #1 said the scoop should not be stored on top of the ice machine because it was open to air and potential infection. DA #1 said storing the scoop on top of the ice machine would increase the risk of contamination, and that it should be stored in its designated holder which was located on the wall.ˆ -Visible dust and dried debris were observed on a dish rack and on the wall behind the rack which housed clean dishware located in the dish room. During an interview at the time, DA #1 said she could not recall the last time the dish rack had been cleaned. DA #1 said there was a cleaning schedule used but after reviewing the schedule with the surveyor, DA #1 said the disk rack was not on the cleaning schedule. DA #1 said the dirty dish rack could be a contamination concern.ˆ -Storage rack located above the cook's preparation area where clean pots/pans were stored, had visible dust. -Storage area where numerous tongs were located had multiple white/tan dried drips. -Window above the preparation area had large dust spanning the left corner and expanding to the top and lower portion of the window.ˆ -Rotary toaster located below the window had greasy black debris and burnt black debris on the rotating rack. During an interview at the time, DA #1 said she could see the black debris on the toaster but was not sure who should clean the toaster.ˆ -A pitcher of unlabeled red liquids. During an interview at the time, DA #1 said the juice should have been labeled with contents and date.ˆ ˆDuring an interview on 2/4/26 at 4:15 P.M., the surveyor relayed the kitchen sanitation concerns to the Administrator who said he understood the concerns.ˆ |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>Based on observations, interviews, and record review, the facility failed to ensure two Residents (#15 and #55) out of a total sample of 15 residents, were afforded dignity and privacy relative to use of their medical devices.ˆ Specifically, for Residents #15 and #55, the facility failed to ensure dignity for both Residents when privacy covers were not utilized for their urinary drainage bags. ˆ Findings include: Review of the facility policy titled Urinary Drainage Bag Policy, reviewed/revised January 2026, included the following: -Urinary drainage bags should be kept in privacy bags to maintain resident's dignity/privacy. ˆ 1. Resident #15 was admitted to the facility in May 2025 with diagnoses including Benign Prostatic Hyperplasia without lower urinary tract symptoms and urinary retention.ˆ ˆ Review of the Minimum Data Set (MDS) Assessment, dated 11/21/25, indicated Resident #15: -has severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of a possible 15 points.ˆ -required substantial/maximum assistance of staff with toileting. -utilized an indwelling urinary catheter. ˆ Review of Resident #15's clinical record included the following: -Suprapubic Catheter Care Plan initiated 5/19/25. -Activities of Daily Living (ADL) Care Plan, initiated 5/16/25, which included the following intervention: >Provide privacy bag and promote dignity ˆ On 1/30/26 at 8:26 A.M., the surveyor observed Resident #15 dressed and ambulating with a walker in the hallway near the nursing station. A urinary drainage bag was observed hanging from the lower portion of the walker and the contents within the urinary drainage bag were visible. There was no privacy cover in place on the Resident's urinary drainage bag.ˆˆ ˆ On 1/30/26 at 9:47 A.M. and at 12:38 P.M., Resident #15 was observed dressed and ambulating with his/her walker around the nursing station. The urinary drainage bag remained on the lower portion of the walker and the contents within the urinary drainage bag were visible as there was no privacy cover in place on the urinary drainage bag. Several residents and staff were observed in the area at these times.ˆ ˆ On 2/4/26 at 3:00 P.M., the surveyor and Nurse #2 observed Resident #15 dressed and seated on the edge of the bed in his/her room. The Resident's walker was positioned in front of him/her and the urinary drainage bag was observed positioned on the lower portion of the walker with the contents of the urinary drainage bag visible, and no privacy cover in place. During an interview at the time, Nurse #2 said Resident #15's urinary drainage bag should be covered with a privacy bag. Nurse #2 said lack of a privacy bag is a concern relative to the Resident's privacy and dignity.ˆ ˆ 2. Resident #55 was admitted to the facility February 2018 with diagnoses including need for assistance with personal care and Neuromuscular Dysfunction of Bladder. ˆ Review of the MDS Assessment, dated 10/31/25, indicated Resident #55: -was cognitively intact as evidenced by a BIMS score of 14 out of 15 total points.ˆ -was dependent on staff for dressing and toileting. -utilized an indwelling urinary catheter. ˆ Review of the clinical record included the following: -Suprapubic Catheter Care plan initiated 7/23/24. -ADL Care plan, initiated 2/28/18, which included the following interventions: >Resident was dependent on staff for lower body dressing and toileting. >Provide privacy and promote dignity.ˆ ˆ On 2/4/26 at 2:15 P.M., the surveyor observed from the hallway Resident #55 was reclining in bed. The urinary drainage bag was observed laying on the floor at the end of the bed and there was no privacy cover on the urinary drainage bag, and the drainage bag contents were visible from the hallway. A Certified Nurses Aide (CNA) was also observed directly outside of the Resident's room and provided snacks/beverages to the Resident's roommate who was standing inside the room.ˆ ˆ On 2/4/26 at 3:00 P.M., the surveyor and Nurse #2 observed Resident #55 from the hallway outside of his/her room. The Resident was lying in bed and the urinary drainage bag remained on the floor at the end of the bed and was visible from the hallway. There was no privacy cover on the urinary drainage bag, and the contents of the bag were visible from the hallway. During an interview at the time, Nurse #2 said the Resident's urinary drainage bag should be off the floor and should be covered with a privacy bag. Nurse #2 said the Resident's visible urinary drainage bag was a dignity concern.ˆ ˆ During an<br>(continued on next page) |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | interview on 2/4/26 at 3:48 P.M., the Regional Nurse said privacy bags should be provided for all residents with urinary catheters to promote dignity and privacy.^^ Please refer to F880. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to ensure advanced directives were executed in accordance with the Resident's wishes for two Residents (#2 and #17), out of a total sample of 15 residents. Specifically, the facility failed to ensure the Resident and Resident Representatives wishes were honored in an emergency situation when:1.For Resident #2, the signed Massachusetts Medical Orders for Life Sustaining Treatment (MOLST - medical order form that relays instructions between health professionals about a patient's care based on an individual's right to accept or refuse medical treatment) Form which indicated to attempt resuscitation (Full Code) did not match the Physician orders which indicated Do Not Resuscitate (DNR)/ Do Not Intubate (DNI). 2.For Resident #17, the MOLST Form which indicated attempt resuscitation did not match the Physician orders which were initiated on 5/9/25 for DNR status. Findings include: Review of the facility policy titled Medical Orders for Life Sustaining Treatment MOLST (Massachusetts and Rhode Island), dated August 2015 indicated the following in part: -is a standardized form that is clearly identifiable -is recognized and honored across treatment settings -The MOLST will be reviewed by the facility interdisciplinary team during the quarterly care plan conference anytime there is a significant change in the resident's condition and at any time that the resident/patient or if the resident/patient lacks decision making capacity the legally recognized healthcare agent requests it. -At any time, a resident/patient with decision making capacity can revoke the MOLST form or change his/her mind about his/her treatment preferences either verbally or in writing or after consultation with the resident/patient's clinician by completing a new MOLST form. The new MOLST form must be signed by the clinician and the resident and the revoked MOLST must be voided. -All discussions about revising or revoking the MOLST should be documented in the medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation and plans for follow-up action if needed. 1.Resident #2 was admitted to the facility in August 2022 with diagnoses including post-traumatic stress disorder, schizoaffective disorder, chronic kidney disease and malignant neoplasm of head, face and neck. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated the Health Care Proxy (HCP) was invoked. Review of Resident #2's Care Plan initiated on 8/3/22, indicated the Resident's HCP was invoked. Review of the MOLST Form signed by the HCP and the Nurse Practitioner on 8/2/22 indicated to attempt resuscitation. Review of the medical record indicated a form titled Comfort Care/Do Not Resuscitate ( DNR) Order Verification, (found in the Resident's physical chart in front of the MOLST form) was signed by the HCP on 1/5/26 and an Advanced Practice Registered Nurse (APRN) on 1/6/26. Review of the January 2026 Physician Order Summary Report indicated the following in part: -Code Status: Do Not Resuscitate (DNR)/Do Not Intubate (DNI), initiated on 1/26/26. During an interview on 2/2/26 at 3:08 P.M., the Nursing Supervisor said Resident #2 had been a full code, however when he/she went out to the hospital in January 2026, the HCP signed a DNR form while at the hospital. When Resident #2 returned to the facility, the Physician order was updated to reflect the HCP's wishes to change Resident #2's code status to a DNR. The Nursing Supervisor reviewed the electronic medical record (EMR) and the MOLST form found in the physical chart and said that the MOLST form indicated for the facility staff to attempt resuscitation and the EMR indicated DNR/DNI. The Nursing Supervisor said she could see how staff might be confused because the Physician order in the EMR did not match the MOLST found in the paper chart and that staff utilize both records to review a resident's code status in the event of an emergency. The Nursing Supervisor additionally pointed to the Comfort Care/Do Not Resuscitate ( DNR) Order Verification form and said this form could cause further confusion as staff will typically go right to the pink MOLST form, if they were going to the physical chart to obtain a resident's code status and skip right over this other form that is on a white piece of paper. During an interview on<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2/4/26 at 11:54 A.M., Nurse #3 said if she were to find or be told that Resident #2 was unresponsive, she would do one of two things, if she was at the nurse's cart she would check the EMR. If she was not at the nurse's cart, she would grab the physical chart. Nurse #3 pulled out Resident #2's physical chart and went directly to the MOLST form. Nurse #3 said she believed the Resident to be a DNR, and she found it odd that the MOLST form indicated to attempt resuscitation. The surveyor turned the page to the Comfort Care/Do Not Resuscitate ( DNR) Order Verification form signed on 1/5/26 and Nurse #3 said that she did not see that form as it was a habit to go directly to the pink MOLST form.^ During an interview on 2/4/26 at 12:03 P.M., the Regional Nurse said because of the discrepancy in Resident #2's medical records, the facility staff might resuscitate a Resident who did not want to be resuscitated, and this would be very upsetting to the family. The Regional Nurse further said when the Resident returned from the hospital with a new Comfort Care/Do Not Resuscitate ( DNR) Order Verification form signed by the HCP on 1/5/26, the MOLST form should have been updated to reflect the new DNR wishes. 2.Resident #17 was admitted to the facility in April 2016 with diagnoses including schizoaffective disorder, traumatic brain injury and dementia. Review of the document titled Guardian's Care Plan/Report dated 3/29/21 indicated no evidence that the Guardian had expanded authority to elect advanced directives for Resident #17. Review of the January 2026 Physician order Summary Report indicated the following in part: -Code Status: DNR, initiated on 5/9/25. Review of the EMR dashboard (home screen when a Resident's EMR is first opened on the computer) indicated the following: -Code Status: DNR Review of the MOLST Form, found in Resident #17's paper chart located at the nurse's station, signed by the Guardian on 12/20/19 and the Nurse Practitioner (NP) on 1/7/20 indicated to attempt resuscitation. Review of a form titled State of [sic] Department of Public Health Transfer of Do Not Resuscitate Order indicated the following: -DNR order, date 5/6/25 -Original DNR order by a name with no designation of Physician or Advanced Practice Registered Nurse (APRN) -Signed by a Registered Nurse on 5/8/25 -Not signed by the Guardian -. When a patient who is to be transferred between healthcare institutions has a DNR order which is to remain in effect during and after the transfer. During an interview on 1/29/26 at 10:07 A.M., Nurse #1 said if she were to find a resident unresponsive, she would go to whatever is closer, the computer or the physical chart to locate the residents' code status. Nurse #1 then demonstrated on the computer where she would locate the code status for Resident #17. Nurse #1 went directly to the dashboard of Resident #17's EMR and said the code status was DNR. Nurse #1 said she would additionally look under miscellaneous in the EMR to try and locate the official MOLST Form. Nurse #1 said if she was unable to locate the MOLST Form in the EMR, she would then go to the paper chart because she preferred to see the MOLST form in writing as she felt that was the most up to date information. Nurse #1 further said that the Resident Representative had recently signed Resident #17 onto hospice services, and she believed him/her to be a DNR.^ During a follow-up interview on 1/29/26 at 10:22 A.M., the surveyor and Nurse #1 reviewed the MOLST Form found in Resident #17's physical chart located at the nurse's station.^Nurse #1 said the MOLST Form indicated attempt resuscitation and did not match the EMR which indicated DNR. Nurse #1 said in this circumstance she would attempt resuscitation. During an interview on 1/29/26 at 11:04 A.M., with the Regional Social Worker and the Director of Social Services, the Regional Social Worker reviewed the form titled State of [sic] Department of Public Health Transfer of Do Not Resuscitate Order and said she was unfamiliar with the form but it appeared to be signed by a Physician and indicated the Resident would be a DNR. The Regional Social Worker said she believed that this occurred while Resident #17 was at the hospital in May 2025. The Regional Social Worker said she believed the hospital spoke with the Guardian, and it was determined that the Resident should be a DNR due to his/her decline in health. The Regional Social Worker said when a Resident returned from the hospital, the facility process was during the next morning meeting (following a resident's return from the hospital), the team would review the discharge information provided by the hospital, including changes in Physician orders and/or advanced directives and ensure the changes were accurate and addressed appropriately. The (continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Regional Social Worker further said she could not verify that Resident #17's advanced directives had been reviewed by the team since the change in his/her code status, but the Physician orders had been changed on 5/9/25 to reflect a DNR code status. The Regional Social Worker^said she reviewed the Guardianship, and it appeared that the Guardianship did not indicate the Guardian had expanded authority to make decisions relative to Resident #17's advanced directives. The Regional Social Worker further said she was unsure why the current January 2026 Physician orders or the^State of [sic] Department of Public Health Transfer of Do Not Resuscitate Order indicated DNR as the Guardian did not have authority to make those decisions (change the advanced directives). During an interview on 1/29/26 at 11:50 A.M., Resident #17's Guardian said he/she recently agreed to sign Resident #17 onto hospice services, because of his/her change in condition. The Guardian said the decline was concerning and scary to him/her because he/she understood that he/she needed to make a difficult decision for Resident #17. The Guardian further said when Resident #17 was well, the Guardian and Resident #17 discussed that Resident #17's wishes were to not be kept alive by machines. The Guardian said when he/she spoke with hospice services last week, the code status was reviewed and the Guardian wanted to ensure the Resident was a DNR/DNI/DNH (Do Not Hospitalize), to honor Resident #17's wishes. The Guardian said he/she could not recall discussing advanced directives, code status or wishes with the facility recently and was unaware of any limitation he/she had as the Guardian of Resident #17. During a follow-up interview on 1/29/26 at 2:14 P.M., the Regional Social Worker said she spoke with the facility's legal team, the legal team reviewed the Guardianship and determined that the Guardian did not have authority to make advanced directive decisions at this time. The Regional Social Worker said at this time the facility would revert to Resident #17 being designated as a full code and initiated the process to obtain expanded authority for the Guardian to make advanced directive decisions. The Regional Social Worker said she is not sure where the system broke down as it is the company's expectation that residents returning from the hospital will be reviewed during the next morning meeting to review any changes.^The Regional Social Worker said had this process occurred the facility could have initiated the process to obtain expanded authority so the Guardian could make advanced directive decisions months ago and there would have been no confusion on Resident #17's code status. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on interviews, and record review, the facility failed to ensure Notices of Transfer or Discharge and Bed Hold were provided to residents or their resident representatives at the time of transfer or shortly thereafter and that the Office of the State Long-term Care Ombudsman was notified at the time of transfer or shortly thereafter for four Residents (#1, #10, #17, and #57), of five applicable Residents reviewed for hospitalizations, out of a total sample of 15 active records and one closed record. ˆSpecifically, the facility failed to ensure Resident's #1, #10, #17, and #57 and/or their Representative were provided a copy of the facility Bed Hold policy, a Notice of Intent to Transfer upon transfers to the hospital or shortly thereafter. The facility also failed to ensure that the Office of the State Long-term Care Ombudsman was notified when the Residents were transferred from the facility to the hospital for evaluation.ˆ ˆ Findings include: 1. Resident #1 was admitted to the facility in January 2014.ˆ ˆ Review of Resident #1's clinical record included the following: -Nurse's Note dated 8/23/25, 911 was called and Resident's Representative was notified of the Resident's transfer to the hospital. -Nurse's Note dated 8/29/25, Resident returned to the facility. ˆ Further review of Resident #1's clinical record indicated: -No documented evidence that the Intent to Transfer and Bed Hold policy were provided to the Resident/Resident Representative upon transfer or shortly thereafter.ˆ -No documented evidence that the Office of the State Long-Term Ombudsman was notified of the Resident's transfer.ˆ ˆ 2. Resident #10 was admitted to the facility in June 2021. ˆ Review of Resident #10's clinical record indicated the following: ˆ-Nurse's Note dated 12/7/25, Resident's skin became clammy, very cool to the touch and color was very white .speech was garbled .sent out to the hospital for evaluation. -Nurse's Note dated 12/16/25, Resident returned to the facility from the hospital . ˆ Further review of Resident #10's clinical record indicated: -No documented evidence that the Intent to Transfer and Bed Hold policy were provided to the Resident/Resident Representative upon transfer or shortly thereafter.ˆ -No documented evidence that the Office of the State Long-Term Ombudsman was notified of the Resident's transfer.ˆ ˆ 3. Resident #17 was admitted to the facility in April 2016.ˆ ˆ Review of Resident #17's clinical record indicated the following: -Nurse's Note dated 1/22/26, Resident had an unwitnessed fall with pain, redness and swelling to his/her right hip. The Provider was updated and the Resident was sent to the hospital for further evaluation. -Nurse's Note dated 1/23/26, Resident returned from the hospital . ˆ Further review of Resident #17's clinical record indicated: -No documented evidence that the Intent to Transfer and Bed Hold policy were provided to the Resident/Resident Representative upon transfer or shortly thereafter.ˆ -No documented evidence that the Office of the State Long-Term Ombudsman was notified of the Resident's transfer.ˆ ˆ ˆ 4. Resident #57 was admitted to the facility in June 2021. ˆ Review of Resident #57's clinical record indicated the following: -Nurse's Note dated 12/18/25, Resident had a physical altercation with another resident. Provider was updated and gave an order to transfer the Resident to the hospital for evaluation . -Nurse's Note dated 12/21/25, Resident returned from the hospital . -Nurse's Note dated 1/8/26, Resident noted to have shortness of breath and was wheezing. Resident's family was notified and agreed to send the Resident out to the hospital for evaluation . ˆ Further review of the Resident #57's clinical record indicated: -The Resident did not return to the facility after the transfer to the hospital on 1/8/26.ˆ -No documented evidence that the Intent to Transfer and Bed Hold policy were provided to the Resident/Resident Representative upon transfer or shortly thereafter.ˆ -No documented evidence that the Office of the State Long-Term Ombudsman was notified of the Resident's transfer.ˆ ˆ During an interview on 1/30/26 at 2:33 P.M., the Regional Nurse said when a resident is transferred out of the facility, a copy of the facility Bed Hold policy and an Intent to Transfer notice would be completed and provided to the resident/resident representative and copies provided to the Office of the State Long-Term Ombudsman. The Regional Nurse said the nursing staff would document in the resident's clinical<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | record that this task was completed and copies of these forms would be located in the resident's clinical record.ˆ The Regional Nurse was unable to find evidence that the Intent to Transfer and facility Bed Hold policy had been provided to the Residents/Resident Representatives when Resident's # 1, #10, #17 and #57 were transferred to the hospital. The Regional Nurse was also unable to find evidence that the Office of the State Long-Term Ombudsman had been notified of Resident's #1, #10, #17, and #57 transfers and had been provided with the transfer/bed hold notices as required. |

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| F 0646<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to notify the State Mental Health Authority for a resident review (person-centered assessment taking into account all relevant information) after a significant change in mental condition occurred for one Resident (#1) out of a total sample of 15 residents. Specifically, the facility failed to complete and request a Preadmission Screening and Resident Review Level II screen (PASRR- an evaluation done to determine if a resident has an intellectual or developmental disability and/or serious mental illness and if a Resident is in need of additional specialized support services at the facility) after Resident #1 received emergency mental health support due to mental illness on two occasions.Findings include:Review of the facility protocol titled PASRR Quick Reference, updated 7/30/25 indicated the following in part:-Why do you submit a PASRR Level I in the portal?---Something has changed with the resident (i.e. went out to the hospital for a psych eval or overdose.)-PASRR should be reviewed at morning meeting the following business day after the resident is admitted ensuring a PASRR is completed. Resident #1 was admitted to the facility in January 2014 with diagnoses including schizophrenia, anxiety disorder, bipolar disorder, and major depressive disorder. Review of a Nursing Progress Note dated 9/11/25 indicated Resident #1:-stated that he/she wanted to kill him/herself to a few staff members.-was sent out to the emergency room for a psych evaluation.-told the Police officer that if he/she was serious he/she had things in his/her room to do it. Review of the Hospital Discharge summary dated [DATE] indicated Resident #1 was seen for suicidal ideation. Review of Resident #1's Behavioral Progress Note dated 10/1/25 indicated:-Resident reported feeling down, depressed, and hopeless.-Resident stated he/she would cause harm to him/herself.-When asked directly about suicide he/she expressed, he/she thought of suicide.-When asked directly if he/she had a plan, he/she expressed he/she had a plan but would not elaborate. Review of Resident #1's Nursing Progress Note dated 10/1/25 indicated:-Nurse was notified that the Resident was suicidal and had a plan.-On-call Provider was notified and instructed the Nurse to obtain a Section 12 (a Massachusetts law that allows the admission of an individual to a general or psychiatric hospital for psychiatric evaluation and, potentially, treatment. Section 12(a) allows for an individual to be brought against his or her will to such a hospital for evaluation). Review of the Hospital Discharge summary dated [DATE], indicated Resident #1 was seen for thoughts of suicide and screened by the crisis team.Further review of the medical record failed to indicate documented evidence that the facility notified the State Mental Health Authority for a resident review after Resident #1 received emergency mental health support due to mental illness on 9/11/25 and 10/1/25. During a telephone interview on 2/2/26 at 11:38 A.M., the Regional Social Worker said any time someone is sent out for any change in mental health the facility would do a PASRR resident review upon return. During a follow-up interview on 2/2/26 at 2:00 P.M., the Regional Social Worker said she reached out to the PASRR office to see if a PASRR resident review had been submitted for either of the significant mental health changes for Resident #1 on 9/11/25 and 10/1/25 and noted that nothing had been sent to the PASRR office. The Regional Social Worker further said she would have expected a resident review to have been submitted so that the PASRR office would have an opportunity to determine if Resident #1 was positive for Level II screening which could promote specialized service. The Regional Social Worker said that the Director of Social Services had been working on obtaining access to the PASSR portal but currently did not have access. Please refer to F657 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the person-centered plan of care was revised for two Resident's (#1 and #6), out of a total sample of 15 residents. Specifically, the facility failed to ensure:For Resident #1, care plans were updated when he/she voiced suicidal ideations resulting in the Resident being sent out for a psychiatric evaluation to be conducted at the hospital on two occasions. For Resident #6, nutrition interventions recommended by the Dietitian were reviewed with the Resident's Provider timely and interventions implemented to assist with healing of the Resident's wounds, placing him/her at risk for potential delay in wound healing. Findings include:Review of the facility policy titled Comprehensive Care Plans, revised 11/2017 indicated the following:<br><br>-Care plans are a combination of:<br><br>---Data concerning the resident that is obtained from the physician<br><br>---Clinical records such as the hospital discharge summary<br><br>---Evaluations done by professional and other disciplines<br><br>---The resident and/or family goals for treatment<br><br>---Acute chronic events behaviors and or illness<br><br>-Based on the above, the interdisciplinary team develops a comprehensive care plan for each resident that includes measurable outcomes and timelines to accommodate preferences, special medical nursing, and psychosocial needs identified in the assessment<br><br>-The care plan is evaluated and revised as needed but at least quarterly<br><br>1.Resident #1 was admitted to the facility in January 2014 with diagnoses including schizophrenia, anxiety disorder, bipolar disorder, and major depressive disorder.<br><br>Review of a Nursing Progress Note dated 9/11/25, indicated Resident #1 was stating to a few staff members that he/she wanted to kill him/herself. Resident #1 was sent out to the emergency room for evaluation, and the Resident told the Police Officer that if he/she was serious he/she had things in his/her room to do it.<br><br>Review of hospital Discharge summary dated [DATE], indicated Resident #1 was seen for Suicidal Ideation.<br><br>Review of a Behavioral Progress Note dated 10/1/25, indicated Resident #1 reported feeling down, depressed, and hopeless and that he/she would cause harm to him/herself. When Resident #1 was asked directly about suicide, he/she expressed that he/she thought of suicide. When the Resident was asked directly if he/she had a plan, he/she expressed he/she had a plan but would not elaborate.<br><br>Review of a Nursing Progress Note dated 10/1/25, indicated the Nurse was notified that Resident #1 (continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was suicidal and had a plan. The on-going Provider was notified and instructed the Nurse to obtain a Section 12 from the Physician and transfer the Resident to the emergency room.<br><br>Review of hospital Discharge summary dated [DATE], indicated Resident #1 was seen for thoughts of suicide and screened by the crisis team.<br><br>Review of Resident #1's Psychosocial Well-Being Care Plans initiated 1/16/14 and revised 3/31/25, indicated:<br><br>-Anxiety, suicide ideation.<br><br>-Interventions in place, initiated on 1/16/14.<br><br>Further review of the medical record failed to indicate any documented evidence that the facility updated the Resident's Care Plan after Resident #1 received emergency mental health support on 9/11/25 and 10/1/25.<br><br>During an interview on 2/2/26 at 10:27 A.M., the Director of Social Services said when a resident returns from a hospitalization relative to suicidal ideations, the care plan should be updated and include individualized interventions as well as any recommendation made by the hospital. The Director of Social Services further said it appeared the care plans had not been updated for Resident #1 and was unable to provide additional information.<br><br>During an interview on 2/2/26 at 10:49 A.M., the Regional Nurse said the facility staff would follow the facility policy when residents had suicidal thoughts, that would include updating the care plans. The Regional Nurse reviewed Resident #1's care plans and said that she would have expected the care plans to be updated with information specific to Resident #1 and relative to suicidal ideations, however they had not been since 2014.<br><br>2. Resident #6 was admitted to the facility in January 2025 with diagnoses including atherosclerosis of arteries of the left leg with ulceration and Type 2 Diabetes Mellitus with diabetic peripheral angiopathy without gangrene and Adult Failure to Thrive.<br><br>Review of the facility policy titled Consultant Services, dated April 2015, indicated the facility will identify and facilitate consultant to meet the resident's needs to ensure optimum care for each resident/patient through consultant services. The policy also included the following:<br><br>-A note should be recorded on the consultation form by any health care consultant who sees the resident .<br><br>-The consultant should document findings and recommendations .<br><br>-The charge nurse will notify the attending physician of findings, and he/she can then order outlined by the consultant<br><br>-A consultant's report or some form of documentation pertaining to the results will be retained in the clinical record.<br><br>Review of the Minimum Data Set (MDS) Assessment, dated 1/9/26, indicated Resident #6:<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points.<br><br>-had two arterial ulcers present.<br><br>Review of Resident #6's Alteration in Skin Integrity Care Plan, initiated 2/2/25, indicated Resident #6 had non-pressure/vascular areas to his/her left outer ankle and lateral lower leg, included the following interventions:<br><br>-Administer antibiotic therapy as ordered by the Physician<br><br>-Follow Physician's order for skin care and treatments. Utilize best practice guidelines<br><br>Review of the Dietitian Progress Note, dated 1/24/26, indicated:<br><br>-was updated on the Resident's vascular wound that has not healed.<br><br>-Recommended:<br><br>>L-arginine powder 5 grams (gm) twice daily with Zinc 8-11 milligrams (mg) for ten days and off 10 days until wound is healed.<br><br>>Vitamin C 250 mg twice daily.<br><br>Review of the February 2026 Physician's orders included the following:<br><br>-Treatment order: cleanse left lateral ankle wound .initiated 2/3/26<br><br>-Treatment order: apply skin prep to left anterior lower extremity .initiated 12/9/25<br><br>-Treatment order: cleanse right abraded area initiated 1/28/26<br><br>-Levaquin (antibiotic) 500 mg daily for possible cellulitis to right lower extremity for seven days, initiated 1/28/26<br><br>Review of the Resident's clinical record failed to indicate documented evidence of the response to the Dietitian's recommendations made on 1/24/26.<br><br>During an interview on 2/2/26 at 4:19 P.M., the Dietitian said she relays her recommendations in the interdisciplinary progress notes and links these recommendations so that they can be reviewed by nursing and Physician. The Dietitian said in addition, she thinks that she verbally relayed these recommendations to the Nurse who had asked her to look into the concern with the Resident's vascular wounds that were not healing. The Dietitian said L-Arginine is a source of protein and would assist with wound healing and the Vitamin C would assist with preventing infection.<br><br>During an interview on 2/4/26 at 1:21 P.M., the Assistant Director of Nurses (ADON) said the Dietitian has access to the electronic medical records for residents. The ADON said the Dietitian's recommendations for pharmacy type orders like L-arginine, Vitamin C, and Zinc would be in a progress note that would be flagged or linking in the progress notes and then would show up in the<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 24-hour report that nursing and administration reviewed daily. The ADON said she reviewed the 24-hour reports, and these recommendations were not linked/flagged relative to Resident #6's recommendations from 1/24/26.<br><br>During an interview on 2/4/26 at 1:30 P.M. and 3:40 P.M., the Regional Nurse said the Resident's Provider was updated today (2/4/26) relative to the Dietitian's recommendations from 1/24/26 and approved the recommendations. The Regional Nurse said the expectation would be that once the Dietitian had made recommendations, the nursing staff would notify the Provider within 24 hours to approve or decline the recommendations. The Regional Nurse said that she would also expect a Nurses' note to be written with what occurred relative to the Dietitian recommendation. The Regional Nurse said there was a system breakdown which resulted in a delay in treatment for Resident #6. The Regional Nurse said the Dietitian's recommendations were for wound healing and malnutrition and that these recommendations were not addressed until today (11 days later). |

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| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide routine and 24-hour emergency dental care for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist one Resident (#42), out of a total sample of 15 residents, in obtaining routine dental services.Specifically, the facility failed to schedule dental appointments to ensure that Resident #42 received routine dental services as ordered. Findings include: Review of the facility policy titled Dental Services/Dentures dated April 2015 indicated the following:-Dental services will be provided to each resident, as needed, by a qualified dentist, as part of the facility's oral health program.-Staff will assist residents in obtaining routine and emergency dental care.-Services will be provided by the resident's dentist of choice or by the facility's consulting dentist.-The appropriate health care professional will document the provision of dental services and oral hygiene procedures in the resident's clinical record. Resident #42 was admitted to the facility in November 2024 with diagnoses including Dementia, Dysphagia and Adult Failure to Thrive. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #42 was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of a total possible score of 15. On 1/28/26 at 11:11 A.M., the surveyor observed Resident #42 had jagged, and missing teeth. The surveyor also observed the Resident was chewing on his/her tongue. During an interview at the time, Resident #42 said he/she had teeth hanging down in his/her mouth and the facility would not let him/her see a Dentist. Review of the active Physician orders for Resident #42 indicated the following:-Consults: Dental care as needed, last revised 11/14/24 Review of Resident #42's Care Plan, last revised 10/13/25 indicated:-has poor dentition-will have no difficulty chewing-Dental consult as needed-monitor for difficulty chewing or swallowing-provide assistance with oral care every shift, after meals Review of the facility Oral Health evaluations dated 6/24/25, 10/22/25, and 1/23/26 indicated that based on the evaluation and observation at the time of the oral health exam, Resident #42 required routine mouth care. Review of the clinical record failed to provide any evidence that Resident #42 had been offered or received routine dental services while residing in the facility. During an interview on 1/30/26 at 10:37 A.M., the Regional Nurse said that Resident #42 should have been seen by the Dentist at some time since admission to the facility and that all residents should be seen by the Dentist annually. The Regional Nurse also said that she would review the Resident's last oral evaluation completed 1/23/26 and perform her own oral evaluation for Resident #42. During an interview on 1/30/26 at 10:59 A.M., the Director of Nursing (DON) said that all Residents should be seen by the Dentist routinely every six months to one year. The DON said she was not sure when the Dentist last visited the facility and that she would find out when Resident #42 had last been seen by the Dentist. During a follow-up interview on 1/30/26 at 11:05 A.M., the Regional Nurse said that she had completed an oral health exam for Resident #42 and that the Resident had missing teeth and was biting his/her tongue. The Regional Nurse also said that the Resident definitely needed to see a Dentist and the Resident should have had routine dental services in place. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observations, interviews, and record review, the facility failed to ensure infection control standards were implemented for two Residents (#6 and #55), out of a total sample of 15 residents. Specifically, For Resident #6, the facility failed to minimize the potential spread for infection during a wound dressing change when the Nurse did not change gloves and perform hand hygiene as required increasing the potential for contamination and wound infection. For Resident #55, the facility failed to ensure the urinary drainage bag was maintained off the floor, and that facility staff donned the required personal protective equipment (PPE) when handling the urinary drainage bag. Findings include:1. Resident #6 was admitted to the facility in January 2025 with diagnoses including atherosclerosis of arteries of the left leg with ulceration and Type 2 Diabetes Mellitus with diabetic peripheral angiopathy without gangrene. Review of the facility policy titled Clean Dressing Technique, undated, indicated non-sterile dressings protect wounds from contamination and absorb drainage. The policy also included the following:-Licensed staff members will use clean dressing technique for all dressing changes unless otherwise specified by the Medical Doctor (MD).-Gather supplies and place on clean field, including several clean gloves.-Sanitize hands and apply clean gloves.-Remove old dressing and discard in plastic bag.-Remove gloves, sanitize hands and apply clean gloves.-Cleanse wound with solution ordered. Cleanse from the center of the wound to the periphery.-Remove gloves, sanitize hands and apply clean gloves. -Apply any medication ordered and dress wound.-Remove gloves and sanitize hands. Review of the Minimum Data Set (MDS) Assessment, dated 1/9/26, indicated Resident #6:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points-has two arterial ulcers present. Review of Resident #6's Alteration in Skin Integrity Care Plan, initiated 2/2/25, indicated Resident #6 had non-pressure/vascular areas to his/her left outer ankle and lateral lower leg, and included the following interventions:-Administer antibiotic therapy as ordered by the Physician-Follow Physician's order for skin care and treatments. Utilize best practice guidelines. Review of the February 2026 Physician's orders indicated:-Treatment Order: apply skin prep daily to left anterior lower leg every day shift for wound care, initiated 12/9/25. -Treatment Order: cleanse left lateral ankle wound with normal saline (NS), apply 0.25 Dakin's solution to packing strip then apply to wound bed, cover with Vaseline gauze then cover with ABD (absorbent dressing) pad and wrap with Kerlix each day and PRN (as needed) if soiled or displaced. Apply house antifungal cream to peri-wound Q (every) day, every day shift and every 4 hours, may change dressing PRN if soiled and displaced. Apply house anti-fungal cream to peri-wound each day, initiated 2/3/26.-Cleanse right lower extremity abraded/area with NS (Normal Saline), apply triple antibiotic ointment and cover each day with DCD (dry clean dressing) and PRN if soiled or displaced, initiated 1/28/26.-Minerin Cream (generic Eucerin) to bilateral lower extremities twice daily and as needed, initiated 1/23/26.-Levaquin 500 milligrams (mg) daily for possible cellulitis to right lower extremity for seven days, initiated 1/28/26. On 2/4/26 at 2:30 P.M. through 2:50 P.M., the surveyor observed Nurse #2 perform the dressing changes for Resident #6's wounds and observed the following:-An over-bed table with clean towel and wound supplies was positioned next to the Resident's bed. Two pairs of gloves were observed on the clean towel. -Resident #6 was dressed and seated in a wheelchair next to the bed.-Nurse #2 had on a gown, surgical mask and was observed to put on (don) one pair of gloves from the clean towel.-Nurse #2 removed the Resident's dressing on the left ankle and discarded the soiled dressing in the trash.-Nurse #2 removed the dressing from the back of the Resident's left leg and discarded the soiled dressings and packing strips into the trash.-Nurse #2 cleansed the wound areas with presoaked gauze containing NS, using the same gloves that removed the soiled dressings.-Nurse #2 used the same soiled gloved hands to wave air over the wounds to dry the Resident's skin.-Nurse #2 then applied Minerin ointment to the Resident's left leg using the same gloved hands.-Nurse #2 used her finger of the same soiled gloves to reach into a medication cup containing skin prep and apply the skin prep<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225771 | A. Building<br>B. Wing | 02/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Berkshire Rehabilitation & Skilled Care Center | 7 Sandisfield Road Box 216<br>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.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | around the left leg wounds.-Nurse #2 used her gloved fingers, reached into a medication cup containing presoaked gauze strips in 0.25 Dakins solution, removed the strip and applied the strip to one of the Resident's left leg wound and then repeated the same to the second leg wound. -Nurse #2, using the same soiled gloves, applied folded xeroform dressings to the wounds, and then wrapped the Resident's left lower leg with kerlix wrap.-Nurse #2 removed her gloves, performed hand hygiene and donned a new pair of gloves which were on the towel with the wound supplies. -Nurse # 2 was observed to use gloved hands to wash the Resident's right shin with gauze presoaked with NS and discarded the soiled gauze into the trash.-Nurse #2 then used the same gloved hands to pick up a piece of dry gauze and gently dried the Resident's right front shin and discarded the used gauze into the trash.-Nurse #2 put a gloved finger into a medication cup containing triple antibiotic ointment and applied the ointment to the Resident's right shin areas using her gloved finger.-Nurse#2 wrapped the Resident's right lower leg with kerlix wrap, removed her PPE (gown and gloves), discarded them into the trash, performed hand hygiene, and removed the towel containing the wound products from the Resident's room. During an interview immediately following the wound care observation, Nurse #2 said gloves should be removed after removing old wound dressings and hand hygiene performed before applying new gloves and prior to applying the new clean wound dressings. Nurse #2 said she did not discard her gloves until she completed the entire wound treatments for the Resident's left leg. Nurse #2 said by not removing her gloves and performing hand hygiene when required could increase the risk for contamination and potential infection in the Resident's wounds. During an interview on 2/4/26 at 3:48 P.M., the surveyor discussed the wound dressing care observations with the Regional Nurse. The Regional Nurse said glove changes and hand hygiene should occur throughout the wound dressing changes and by not changing gloves and performing hand hygiene after removing old dressings, cleaning the wound, and applying new dressings, the risk of contamination and infection would increase. 2. Resident #55 was admitted to the facility in February 2018 with diagnoses including need for assistance with personal care and neuromuscular dysfunction of the bladder. Review of the facility policy titled Enhanced Barrier Precautions (EBP), undated, indicated it was the policy of the facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms (MDROs). The policy also included the following:-EBP require the use of gown and gloves for certain residents during specific high-contact resident care activities in which there is an increased risk for transmission of multidrug-resistant organisms. -High-contact resident care activities include .providing hygiene, transferring, toileting, device care .-EBP will be implemented for residents with indwelling medical devices ( .catheters .) Review of the MDS Assessment, dated 10/31/25, indicated Resident #55: -was cognitively intact as evidenced by a BIMS score of 14 out of 15 total points.ˆ -was dependent on staff for dressing and toileting. -utilized an indwelling urinary catheter. On 2/4/26 at 2:15 P.M., the surveyor observed Resident #55 lying in bed and the Resident's uncovered urinary drainage bag was laying on the floor and yellow contents was observed within the bag. EBP signage was observed posted outside of the Resident's room. On 2/4/26 at 3:00 P.M., the surveyor and Nurse #2 observed from the hallway, Resident #55 lying in bed and his/her urinary drainage bag remained on the floor with the contents of the urinary drainage bag visible. During an interview at the time, Nurse #2 said the Resident's urinary drainage bag should not be on the floor, was an infection control concern and an increased risk of contamination. Nurse #2 entered the Resident's room, did not perform hand hygiene or put on a gown and gloves, and was observed to pick up the Resident's urinary drainage bag from the floor and attempted to secure it to the side of the Resident's bed frame. During an interview on 2/4/26 at 3:48 P.M., the Regional Nurse said Resident #55's urinary drainage bag and tubing should be off the floor and that if the urinary drainage bag was laying on the floor, this would be an infection control concern. The Regional Nurse said the hooks on the urinary drainage bags should be secured to the end of the Resident's bed. The Regional Nurse further said that when Nurse #2 went to adjust the Resident's urinary drainage bag, she should have performed hand hygiene and put on a gown and gloves. |