STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415119	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkshire Place	455 Douglas Avenue Providence, RI 02908

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure Resident ID #1's right to be free from abuse by failing to assess, monitor, and implement effective interventions to address Resident ID #2's known and escalating history of physically aggressive behaviors including failure to update the care plan following documented resident-to-resident incidents and failure to fully implement psychiatric recommendations resulting in a resident-to-resident altercation on 4/27/2026 in which Resident ID #2 struck Resident ID #1 on the left eyebrow with a cane, causing a laceration requiring wound closure with steri-strips and ongoing wound treatment. Resident ID #1, who carries diagnoses of paranoid schizophrenia and adjustment disorder with mixed anxiety and depressed mood, was cognitively intact and was aware of and distressed by the assault, as evidenced by his/her request for police involvement and the decision to press criminal charges. These actions are consistent with a reasonable person experiencing fear, violation of personal safety, and psychological distress in what is his/her place of residence. This failure placed Resident ID #1 and other residents in the facility at risk of serious physical and psychosocial harm from a resident with a documented, unmitigated pattern of escalating aggression.Findings are as follows:Review of a facility policy titled, Abuse Prohibition last revised on 10/31/2022 states in part, It is the policy of this facility to ensure that all residents are treated with respect and dignity and that all residents are free from abuse, mistreatment, neglect .Abuse: willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish .Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/27/2026 revealed that on 4/27/2026 Resident ID #1 was struck by Resident ID #2 with his/her cane which resulted in Resident ID #1 sustaining a laceration to his/her left eyebrow. 1. Record review revealed that Resident ID #1 was admitted to the facility in October of 2025 with diagnoses including, but not limited to, paranoia schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves), adjustment disorder (a disorder when an individual experiences difficult coping with a life change) with mixed anxiety and depressed mood.Review of Resident ID #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact condition.Record review of a progress note dated 4/27/2026 at 10:30 AM authored by the Registered Nurse Practitioner (RNP), Staff A, revealed Resident ID #1 was on the receiving end of a physical altercation with another resident. S/he was noted to have a deep bleeding abrasion to his/her left eyebrow. Further, a police report has been requested (by the victim), Resident ID #1.Further review of the progress notes dated 4/27/2026 at 11:44 AM authored by Licensed Practical Nurse, Staff B, revealed that Resident ID #1 was observed with a new laceration to his/her left eyebrow measuring 0.5 centimeters (cm) in length by 2.0 cm in width by 0.1 cm in depth related to a resident-to-resident incident. Wound closure strips were applied to the laceration. Further review revealed Resident ID #1 was educated on the need for sutures however, the resident refused to go to the hospital.Record review revealed a physician's order dated 4/27/2026 to monitor the wound closure strips to the laceration on Resident ID #1's left eyebrow with additional instructions to (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	cleanse the wound with normal saline, pat dry and apply bacitracin and cover with a bandage every shift.Record review revealed Resident ID #2, was admitted to the facility in December of 2024 with diagnoses including, but not limited to, an impulse disorder (a psychiatric condition characterized by the inability to resist urges or impulses that may harm oneself or others), adjustment disorder with mixed emotions and conduct, irritability and anger, restlessness and agitation, persistent mood disorder, and generalized anxiety.Review of Resident ID #2's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 out of 15, indicating intact condition. Additional review of the MDS revealed, S/he exhibited both physical and verbal behaviors for 1 to 3 days during the assessment look back period. Record review revealed the following progress notes for Resident ID #2:-9/13/2025 at 7:02 PM during a smoking session, the resident threatened to slit the throat of another resident if s/he touches his/her stuff again. Additionally, the note indicates upon interview by staff the resident stated in part, just because I said I'm going to Rip [his/her] heart out if [s/he] touches anything of mine again, so what? And next time it'll be you.-11/7/2025 at 1:43 PM Resident was involved in a verbal dispute with another resident. The resident engaged in raising his/her voice, name-calling, and verbal threats.-12/28/2025 1:04 PM progress note authored by the on-call provider revealed, Resident ID #2 was involved in an incident tonight in which another resident took off his/her helmet and struck Resident ID #2 on the leg there was no evidence of injury. Additionally, the progress note revealed that the nursing staff reports after the incident Resident ID #2 was overheard stating to the other resident the next time you put your hands on me I will kill you.-2/21/2026 at 1:40 PM authored by the on-call provider the resident is evaluated for new aggressive behavior attacked his/her roommate with a cane due to the T.V. volume. The resident will require emergency room transfer for psychiatry evaluation.-3/9/2026 at 3:46 PM authored by the charge nurse revealed that when Resident ID #2 did not win the Bingo s/he threw the poker chips on the floor. S/he was asked to leave the dining room twice. The second time s/he stood at the door swearing and yelling at the activity aide and other residents.-3/17/2026 at 5:52 AM authored by the charge nurse revealed Resident ID #2's roommate has been avoiding using the shared bathroom due to Resident ID #2 making inappropriate comments and displays frustration when the light is turned on during the night.-4/10/2026 at 1:03 PM authored by the charge nurse revealed Resident ID #2 threw his/her lunch plate across the nurses station at a Nursing Assistant because s/he was unhappy with the portion size.-4/14/2026 at 11:33 AM revealed the Interdisciplinary team met with the resident to discuss his/her recent behaviors and throwing of a plate. This writer explained that any violent behavior like throwing objects would not be tolerated as it puts residents and staff at risk. Resident expressed understanding but adamantly denied throwing anything despite multiple witnesses. This writer explained that any further unsafe acts would result in potentially receiving a 30-day notice of involuntary discharge due to safety concerns.-4/27/2026 at 12:32 PM authored by the Director of Nursing Services revealed, Resident ID #2 was noted to be ambulating down the hall heading towards his/her room. Another resident (Resident ID #1) was ambulating down the hall walking in the opposite direction. The residents began engaging in a verbal dispute. Before staff could intervene Resident ID #2 used his/her cane to make contact with Resident ID #1. The police were contacted and arrived to the facility, Resident ID #2 was subsequently discharged from the facility into police custody.Record review revealed a care plan dated 1/16/2025 indicating Resident ID #2 has a behavior problem of being verbally aggressive towards staff with resident-to-resident altercations occurring on 12/28/2025, 2/21/2026 and 4/27/2026.Additional record review failed to reveal interventions to mitigate the risk of his/her physical aggressive behaviors to other residents in the facility or interventions for staff to implement/utilize to ensure the safety of the other residents residing in the facility after his/her resident-to-resident incident on 2/21/2026 and documented throwing of objects on 3/9/2026 and 4/10/2026. 2. Record review of a psychiatric evaluation and consultation note dated 4/23/2026 revealed a recommendation to start Trazadone 25 milligrams (mg) twice daily as needed for agitation, anxiety and insomnia and to monitor his/her response and tolerability.Record review of a (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Physician's order dated 4/24/2026 for trazadone 25 mg twice daily as needed for insomnia.Record review failed to reveal evidence that the trazadone order was implemented to include agitation and anxiety, as indications for use.During a surveyor interview on 4/30/2026 with the RNP, Staff A, at 1:48 PM she revealed it would be her expectation that the order for trazadone would have included agitation and anxiety as indications for use. During a surveyor interview on 4/30/2026 at approximately 3:50 PM with the Director of Nursing Services, she revealed it would be her expectation that the order for Trazadone would have included the indication to be used for agitation or anxiety. Additionally, she was unable to provide evidence that the resident's care plan was updated to include interventions for staff to implement in order to mitigate the risk of his/her physically aggressive behaviors as documented on 2/21/2026, 3/9/2026, and 4/10/2026. Further, she acknowledged that Resident ID #2 was observed striking Resident ID #1 with his/her cane on 4/27/2026 causing a laceration to his/her left eyebrow which required steri strips and treatment. During a surveyor interview on 4/30/2026 at 4:08 PM with the Administrator, she acknowledged that Resident ID #2 was discharged into police custody on 4/27/2026 secondary to admitted ly striking Resident ID #1 with his/her cane that resulted in injury.Record review of a [police department] Incident Report dated 4/27/2026 revealed Resident ID #1 wanted to press charges after stating s/he was struck with a walking cane. Resident ID #2 admitted to striking Resident ID #1 with his/her cane. The report further revealed Resident ID #2 was subsequently arrested on one count of felony assault with a dangerous weapon.The facility's failure to assess, monitor, and implement effective interventions to address Resident ID #2's known history of escalating aggressive behaviors, including failure to update the care plan and fully implement psychiatric recommendations, resulted in a resident-to-resident altercation causing injury to Resident ID #1, and demonstrates the facility did not ensure a safe environment free from abuse.Cross reference F740

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F 0740 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that Resident ID #2 received adequate behavioral health services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, for 1 of 2 residents reviewed. Specifically, the facility failed to implement the full psychiatric recommendation for trazodone - including agitation and anxiety as indications for use - and failed to update the care plan with effective interventions to address Resident ID #2's known and escalating pattern of physically aggressive behaviors, contributing to a resident-to-resident altercation on 4/27/2026 in which Resident ID #2 struck Resident ID #1 with a cane, causing a laceration to the left eyebrow requiring wound closure with steri-strips and ongoing wound treatment.Findings are as follows:Review of the facility policy titled Abuse Prohibition, last revised on 10/31/2022, states in part: It is the policy of this facility to ensure that all residents are treated with respect and dignity and that all residents are free from abuse, mistreatment, neglect .Abuse: willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish .Record review revealed that Resident ID #2 was admitted to the facility in December of 2024 with diagnoses including, but not limited to, an impulse disorder (a psychiatric condition characterized by the inability to resist urges or impulses that may harm oneself or others), adjustment disorder with mixed emotions and conduct, irritability and anger, restlessness and agitation, persistent mood disorder, and generalized anxiety.Review of Resident ID #2's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. Additional review of the MDS revealed that s/he exhibited both physical and verbal behaviors for 1 to 3 days during the assessment look-back period.Record review revealed the following documented behavioral incidents for Resident ID #2:9/13/2025 at 7:02 PM -During a smoking session, Resident ID #2 threatened to slit the throat of another resident. Upon interview by staff, the resident stated in part, just because I said I'm going to rip [his/her] heart out if [s/he] touches anything of mine again, so what? And next time it'll be you.11/7/2025 at 1:43 PM - Resident ID #2 was involved in a verbal dispute with another resident, engaging in raising his/her voice, name-calling, and verbal threats.12/28/2025 at 1:04 PM -A progress note authored by the on-call provider revealed Resident ID #2 was involved in an incident in which another resident struck Resident ID #2 on the leg with a helmet. Following the incident, Resident ID #2 was overheard stating to the other resident, the next time you put your hands on me I will kill you.2/21/2026 at 1:40 PM - A progress note authored by the on-call provider revealed Resident ID #2 attacked his/her roommate with a cane due to the television volume and required emergency room transfer for a psychiatric evaluation.3/9/2026 at 3:46 PM - A progress note authored by the charge nurse revealed that when Resident ID #2 did not win at Bingo, s/he threw poker chips on the floor, was asked to leave the dining room twice, and stood at the door swearing and yelling at the activity aide and other residents.3/17/2026 at 5:52 AM - A progress note authored by the charge nurse revealed Resident ID #2's roommate had been avoiding the shared bathroom due to Resident ID #2 making inappropriate comments and displaying frustration when the light was turned on during the night.4/10/2026 at 1:03 PM - A progress note authored by the charge nurse revealed Resident ID #2 threw his/her lunch plate across the nurses' station at a nursing assistant because s/he was unhappy with the portion size.4/14/2026 at 11:33 AM - A progress note revealed the Interdisciplinary Team (IDT) met with Resident ID #2 to discuss his/her recent behaviors, including the throwing of a plate. The resident was informed that any violent behavior would not be tolerated and that further unsafe acts could result in a 30-day notice of involuntary discharge. The resident expressed understanding but denied throwing anything despite multiple witnesses.Record review revealed a psychiatric evaluation and consultation note dated 4/23/2026 with a recommendation to start (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	trazodone 25 milligrams (mg) twice daily as needed for agitation, anxiety, and insomnia, and to monitor his/her response and tolerability.Record review of a physician's order dated 4/24/2026 revealed trazodone 25 mg twice daily as needed was ordered for insomnia only.Record review failed to reveal evidence that the trazodone order was implemented to include agitation and anxiety as indications for use, as recommended by the consulting psychiatrist.Record review revealed a care plan initiated on 1/16/2025 indicating Resident ID #2 has a behavior problem of being verbally aggressive towards staff, with documented resident-to-resident altercations on 12/28/2025, 2/21/2026, and 4/27/2026.Additional record review failed to reveal interventions to mitigate the risk of Resident ID #2's physically aggressive behaviors toward other residents, or interventions for staff to implement to ensure the safety of other residents residing in the facility, following the resident-to-resident incident on 2/21/2026 and the documented throwing of objects on 3/9/2026 and 4/10/2026.During a surveyor interview on 4/30/2026 with the Registered Nurse Practitioner (RNP), Staff A, at 1:48 PM, she stated it would be her expectation that the order for trazodone would have included agitation and anxiety as indications for use.During a surveyor interview on 4/30/2026 at approximately 3:50 PM with the Director of Nursing Services (DNS), she stated it would be her expectation that the trazodone order would have included agitation and anxiety as indications for use. Additionally, she was unable to provide evidence that Resident ID #2's care plan was updated to include interventions to mitigate the risk of his/her physically aggressive behaviors, as documented on 2/21/2026, 3/9/2026, and 4/10/2026.The facility's failure to fully implement the psychiatric recommendation for trazodone and to update the care plan with effective behavioral interventions following Resident ID #2's known and escalating pattern of aggressive behaviors resulted in a resident-to-resident altercation on 4/27/2026 that caused physical injury to Resident ID #1 and demonstrated the facility's failure to provide adequate behavioral health services to support Resident ID #2's highest practicable mental and psychosocial well-being, while simultaneously placing other residents at risk of harm.