STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225250	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Commons Nursing & Rehabilitation Center	Christian Hill Road Great Barrington, MA 01230

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an environment that was free of accident hazards and risks for three Residents (#7, #63, and #67), out of a total sample of 26 residents. Specifically, For Resident #7, the facility failed to conduct a thorough investigation and provide effective interventions and adequate supervision to prevent falls when the Resident was identified as high falls risk due to cognitive impairment, had multiple previous falls including one fall with sustained fractures, and was left unattended in the Activity Room with other residents and sustained a hip fracture requiring hospitalization and surgical intervention.For Resident #63, the facility failed to implement assistive devices and appropriate interventions/notifications during dining to reduce the risks of aspiration (inhalation of foreign materials into the lungs) for the Resident. For Resident #67, who had a history of falls, the facility failed to analyze the reason for the Resident's most recent fall on 6/22/25 and ensure modified interventions to prevent further falls were implemented. Review of the facility policy titled Accidents and Incidents - Investigating and Reporting, revised 12/29/11, indicated the following: -all accidents or incidents involving residents . occurring on the premises must be investigated and reported to the Administrator. -the purpose of the policy was to ensure accurate reporting, timely investigation, and subsequent follow up is completed with each accident/incident in order to identify PI (Process Improvement) opportunities. -regardless of how minor an accident or incident may be . report the accident/incident to the department supervisor as soon as possible. -complete an Incident Report for all reported accidents or incidents. -the nurse supervisor/charge nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident. -an Incident and Accident form must be completed prior to the end of the shift and submitted to the Director of Nurses (DON) promptly. -if Incident/Accident Report is completed for a fall, corresponding post fall investigation shall also be completed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled Falls Management: Post Fall, revised and approved on 11/2/23, indicated all residents experiencing a fall will receive appropriate care and investigation of the cause. The policy also included the following: -review of investigation and intervention will be conducted by the centers identified Interdisciplinary Falls Team. -the purpose was to address any injury, provide care for recovery from fall, and reduce the risk for future falls. -review the resident's medical record and assessments to identify any causes that may have contributed to the fall. -complete an Incident Report/Post fall investigation/ 5 Whys Analysis after the fall. -remove any causes of fall and implement preventative measures to prevent reoccurrence. -update care plan/Kardex to reflect new interventions. -conduct Interdisciplinary Falls Team meeting at the subsequent clinical A.M. meeting. >review the 5 Whys analysis. >determine need for additional actions/interventions based on team evaluation of root cause. >communicate information to staff. -review the resident weekly for four weeks at Interdisciplinary meeting to determine effectiveness of interventions. Revise the care plan accordingly. 1.Resident #7 fell in the Activity Room on 6/11/25 and sustained a hip fracture that required surgical intervention. Medical record documentation indicated that staff were not present in the Activity Room at the time of the fall to provide supervision and touch assistance to the Resident if needed. Resident #7 previously sustained a fall on 5/22/25 in the Activity Room and the facility failed to complete a thorough investigation of that fall and implement effective interventions to prevent recurrences of the Resident sustaining any further falls. -Nursing Progress Notes on 5/22/25: Resident #7 was in the Activity Room, was standing in front of his/her rolling walker, attempted to sit in a stationary chair, missed and fell. The Resident's fall was witnessed by other residents who were in the Activity room. An incomplete Falls investigation failed to indicate staff presence at the time of the fall. Nurse #4 said the Resident was educated after the fall, to feel for the arms of the chair prior to sitting. -Nursing Progress Notes on 6/11/25: Resident #7 was observed lying on his/her left side on the floor in the Activity Room. The Resident was found unable to bear weight on his/her left leg, unable to do internal/external rotation (of the left leg), complained of increased pain, transferred out of the facility for evaluation on 6/11/25 and re-admitted to the facility on [DATE] after left hip surgery for partial hip replacement (hemiarthroplasty: surgical repair of the hip after a fracture). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #7 was admitted to the facility in April 2023 with diagnoses including Dementia, generalized muscle weakness, unsteadiness on feet and repeated falls. Review of the Minimum Data Set (MDS) Assessments for Resident #7 indicated: -severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of four out of a possible 15 points, dated 3/19/25. -moderate cognitive impairment as evidenced by a BIMS score of 12 out of a possible 15 points, dated 6/4/25. -Chair to bed and bed to chair transfers: required partial to moderate assist -ambulation: required supervision to touch assist Review of the clinical record indicated: -Falls Care Plan, initiated 5/19/23, indicated Resident #7 was at risk for falls due to confusion and forgetfulness. -Nursing Progress Notes and Accident/ Incident Reports on 3/8/25, 3/12/25 and 3/13/25: Resident #7 was found seated on his/her bathroom floor with bruising and swelling observed on the Resident's left [sic] foot. An ordered X-ray determined the Resident had fractures of his/her 3rd and 4th toes. Interventions added to the plan of care subsequent to the fall included: non-skid socks when in bed, staff to make frequent checks every two hours and as needed especially on the evening shift, assistance of staff with activities of daily living (ADLs) and ambulation. -Nursing Progress Notes and Accident/ Incident Reports on 4/14/25: a Certified Nurse Aide (CNA) found Resident #7 lying on the floor in the hallway on his/her right side. The Resident was observed with a hematoma on the back of his/her head. Interventions added to the plan of care subsequent to the fall included: offer for Resident to go to bed after dinner meal, remind Resident to ask for assistance with ADLs, and provide assistance of one staff. -Physical Therapy Discharge summary, dated [DATE], indicated Resident #7 required assistance of staff prior to and following activity for transfers (chair to bed, chair to chair) and contact guard assistance of staff (light touching, tactile cueing), supervision/touching assist with use of rollator device for ambulation. -Nursing Progress Notes and Accident/ Incident Reports on 5/6/25, Resident #7 was self-propelling his/her wheelchair back to the room, stood up, folded up his/her wheelchair to put it aside, stepped back and fell onto the floor. The fall was witnessed by two other residents and a CNA. Intervention added to the plan of care subsequent to the fall included: Resident will have reminder signs in the room to ask for help with tasks. During an interview on 7/31/25 at 9:33 A.M., Rehabilitation Staff #2 said he was very familiar with Resident #7 and had worked on/off with the Resident for over a year. Rehabilitation Staff #2 said Resident #7 had fallen numerous times, and due to his/her cognitive impairment and forgetfulness, required verbal cues to contact guard/assist of one staff with transfers and ambulation using a walker. Rehabilitation Staff #2 said Resident #7 had not been independent with mobility for the past (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	year due to his/her cognition and decreased safety awareness Review of the Accident/Incident Reports indicated: -5/22/25: the fall in the Activity Room was not witnessed by facility staff. The immediate intervention added after the fall indicated for staff to assist in activities. -6/10/25 [sic], indicated Resident #7's fall in the Activity Room (on 6/11/25) was unwitnessed by facility staff. Rehabilitation Staff #3 observed Resident #7 ambulating in the hallway, unassisted by staff towards the Activity Room for the 2:00 P.M. activity. Rehabilitation Staff #3 indicated that she walked with Resident #7 and waited until the Resident sat down in one of the chairs before leaving the Activity Room. Review of CNA #8's statement indicated she was assisting another resident to the activity when she heard screaming, rushed to the door of the Activity Room and observed Resident #7 lying on the floor on his/her left side and after one of the Activity Staff entered the room, CNA #8 went to get assistance. During an interview on 7/31/25 at 9:09 A.M., the Activity Director (AD) said: -Resident #7 attended activities often. -if a resident required assistance of staff for mobility/ambulation due to his/her physical ability, then the CNAs or Nurses would have to assist the resident to activities. -the AD said the Activities Staff usually tried to observe the residents in the Activity Room to determine if it was safe to leave the room unattended when gathering other residents for the scheduled activity. -relative to Resident #7, he/she was previously able to walk independently, but currently he/she utilized a wheelchair and required supervision. -Resident #7 had a fall in the Activity Room in June 2025 which was unwitnessed by staff. At the time of the fall, Activities Staff were gathering residents for the scheduled activity and the Activities Staff had not assisted Resident #7 to the Activity Room. -prior to 6/11/25, Resident #7 was not identified as someone who needed to be supervised for safety while in activities. The AD said after the 6/11/25 fall, Resident #7 was not to be left alone (without facility staff) in the Activity Room. -she was unaware Resident #7 had a fall on 5/22/25 which also occurred in the Activity Room. During an interview on 7/31/25 at 9:26 A.M., Activity Staff #1 said: -when the fall occurred on 5/22/25, Resident #7 was independent with ambulation and could be assisted by Activities Staff to the activities. -Activity Staff #1 said at that time, the Resident would often be brought to the Activity Room and left unattended. -when the Resident fell on 6/11/25, there were no staff in the Activity Room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/31/25 at 10:03 A.M., the Director of Rehabilitation (DOR) said: -Resident #7 was noncompliant with the use of the assistive device (walker) and has had numerous falls. -since March 2025, the Resident required assistance of one staff with transfers and ambulation using a walker and should be assisted by certified staff (Nurses/CNAs). -non-trained staff (i.e. Activities Staff) should not be providing assistance with the Resident's ambulation/transfers. -when activities occur, there were staff in/out of the room but there were not always staff in the room when residents were present, and residents were left unattended. -she could not recall what interventions were added after Resident #7's fall in the Activity Room on 5/22/25 to prevent recurrence. During an interview on 7/31/25 at 10:38 A.M., Unit Manager (UM) #1 said: -Resident #7 had some falls, was previously ambulatory with a walker, now required assistance from staff and utilized a wheelchair. -the Resident was forgetful and could be non-compliant due to his/her memory impairment. -when a resident falls, a fall investigation would be completed, and an intervention would be put into place and added to the resident's plan of care. -once the initial fall investigation was completed, the fall investigation would be reviewed by the Charge Nurse and/or the UM for completeness and then it was given to the DON for review. -relative to the Resident's fall on 5/22/25, the Accident/Incident Report was incomplete and missing required information. On 7/31/25, the surveyor and the DON reviewed Resident #7's clinical record. During interviews on 7/31/25 at 12:21 P.M. and 12:33 P.M., the DON said: -according to the fall investigation dated 5/22/25, the new intervention indicated for staff to assist in activities, and that the meaning of this intervention was unclear. -the Nurse's Progress Note dated 5/22/25, indicating the immediate intervention was to remind the Resident to feel for the arms for the chair prior to sitting was not an appropriate intervention because the Resident was cognitively impaired. -there was no intervention put into place after the Resident's 5/22/25 fall to prevent additional falls based on the circumstances in the Activity Room. -a more thorough review of the fall investigation should have been completed for completeness and appropriateness of the interventions, and had the facility reviewed the Resident's fall from 5/22/25 more thoroughly, they would have put a plan into place to include supervision when the Resident was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	in activities. 2. Resident #63 was observed drinking coffee from a non-specialty cup during the breakfast meal when the Resident was recommended to use an assistive device Provale Cup to encourage pacing with drinking. The facility staff allowed the Resident to drink from a regular coffee mug during a breakfast meal observation on two separate occasions: 7/24/25 from 8:31 A.M. to 8:47 A.M. and 7/25/25 from 8:36 A.M to 8:44 A.M., and resulted with Resident #63 coughing and choking, when he/she was supposed to be utilizing a Provale cup. During the 7/24/25 observation, the Resident asked CNA #2 who was present to help him/her with breathing as he/she was coughing and choking. 1 Resident #63 was admitted to the facility in March 2024 with diagnoses including Protein - Calorie Malnutrition, Dementia, Parkinsonism, Gastro-Esophageal Reflux (GERD), Dysphagia, Pneumonia, and Acute Respiratory Failure. Review of Resident #63's MDS assessment dated [DATE], indicated the following: -Moderately impaired cognition as evidenced by a BIMS score of 12 out of 15 -Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time -Usually understands - misses some part/intent of message but comprehends most conversation. Review of Resident #63's Speech Therapy Evaluation dated 4/25/25, indicated: -Assessment Summary in part: >Resident presents with baseline mild oropharyngeal dysphasia (disorder or impairment in initiating a swallow) as he/she demonstrated tolerance of current least restrictive device (LRD) of mechanical soft solids/ground with added moisture (cut into bite size pieces) and thin liquids in Provale cup (cup designed for people with dysphagia to deliver small sips of thin liquids). >Resident benefits from continued supervision and cueing for use of slow rate, small/single sips/bites, upright for at least 30 minutes status post meals. >Skilled Speech Therapy interventions not indicated as Resident was tolerating baseline diet with minimal to no overt signs and symptoms of aspiration and Resident enjoys current diet textures. Review of the Dietician Progress Note dated 7/9/25, indicated Resident #63: -remained a nutritional risk -mechanical soft diet with thin liquids >Intervention (in part): -Provale cup to encourage pacing. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #63's meal ticket dated 7/28/25, indicated the following: -Beverage thickened to: Thin -Food in bowls, Provale Cup, small spoons. On 7/24/25 from 8:31 A.M. to 8:47 A.M., in the Unit One Dining Room, the surveyor observed the following: -8:31 A.M.: Resident #63 sat in the Dining Room, eating breakfast independently. Two staff were in the DR, passing breakfast trays and assisting other residents with breakfast set up. Resident #63 was observed to cough consistently from 8:31 A.M. to 8:46 A.M. -8:36 A.M.: Resident #63 coughed hard while drinking and mucus came out his/her nose. -8:44 A.M.: Resident #63 told CNA #2 he/she was all done with breakfast and wanted to leave the DR. CNA #2 cleaned the thick, clear, mucus from his/her upper lip and the Resident remained at the table. -8:47 A.M.: Resident #63 drank from a regular coffee mug (no lid or specialized mug was available on the table for the Resident to utilize), making a loud sucking noise and proceeded to cough repeatedly. Resident #63 told CNA #2 that he/she needed help because he/she was old and needed help breathing. CNA #2 removed Resident #63 from the DR. On 7/25/25 from 8:36 A.M. to 8:44 A.M. the surveyor observed the following in the Unit One Dining Room: -8:36 A.M.: Resident #63 was seated at the DR table, and served his/her meal tray that included a cup of coffee that was thin consistency. Resident #63 picked up his/her cup of coffee, took a sip and began to cough and continued to cough. -8:44 A.M.: Resident #63 placed his/her coffee cup down on the table and exited the DR. A staff member entered the DR and placed a specialized cup on the table when the Resident was exiting the room. During an interview on 7/25/25 at 8:50 A.M., CNA #7 said the Resident required a specialized cup for fluids, but the Resident had already exited the room and did not use the cup when he/she drank the coffee. During an interview on 7/29/25 at 9:59 A.M., the Registered Dietician (RD) said: -Resident #63 currently had a Provale cup in place. -Occupation Therapy (OT) made the recommendation to use the Provable cup on 1/15/25 to help maintain independence while eating, however was unable to locate the documentation. -When a resident was noted to continuously cough during meals staff should stop the resident from drinking right away and let nursing know that he/she needed to be assessed. -RD had not been made aware that Resident #63 had experienced coughing episodes recently until (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the late entry Nursing Progress Note dated 6/23/25 and time stamped 12:03 A.M., indicated Resident #67 was found in his/her room on the floor. Further review of the Nursing Progress Note failed to indicate the date and time the incident occurred. Review of the Accident/Incident Report dated 6/22/25, indicated Resident #67 fell on 6/22/25 at 2:05 P.M. -Included in the Accident/Incident Report Packet was the Accident/Incident Report Form completed by nursing, one witness statement from a Certified Nurses Aide (CNA), and a pain assessment. -the Accident/Incident Report Form completed by nursing indicated areas for the Director of Nursing, Administrator, and Medical Director to sign that they had reviewed the report, all areas were blank without the required signatures. Further review of the additional documentation contained in the fall report failed to indicate a 5 Whys Flow chart, documentation that the CNA Kardex had been updated post fall, or documentation that Fall Care Plan interventions were reviewed and modified according to the findings of the 5 Whys Flow chart. During an interview on 7/30/25 at 12:39 P.M., the DON said a full fall investigation was not completed for Resident #67's fall on 6/22/25. The DON said witness statements should have been gathered from all staff on the unit but only one CNA and one Nurse completed documentation. The DON said the 5 Whys flow chart should have been completed and then the Kardex and Fall Care Plan should have been updated with new interventions that were put into place and this was not done. The DON further said nursing should have documented every shift that the Resident was monitored for any changes, for 72-hours post fall and this was not done. The DON said the facility should have been doing regular risk meetings to review falls weekly for four weeks post fall and the facility had not implemented risk meetings. During a follow-up interview on 7/30/25 at 1:34 P.M., the DON said not completing a full fall investigation including analyzing the fall and implementing new appropriate fall interventions puts Resident #67 at risk for further falls and a chance for a fall with injury to occur.^

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, and interviews, the facility failed to ensure that beverages served during meals were palatable and at appropriate temperatures on three (Unit One, Unit Two and Unit Three) out of three units observed. Specifically, the facility failed to ensure the temperature of coffee served during meals were palatable when numerous residents had expressed concerns to the Food Service Director (FSD). Findings include: On 7/28/25 from 2:00 P.M. to 3:00 P.M., the surveyor met with residents during a Resident Council Meeting, and the following was discussed: -the coffee/hot beverages were lukewarm during resident meals. On 7/29/25 at 11:22 A.M., the surveyor requested test trays for the lunch meal for Unit One, Unit Two and Unit Three from the FSD. During an interview on 7/29/25 at 11:44 A.M., the FSD said there have been complaints from residents about the temperatures of the coffee/hot water served not being hot enough. The FSD said she has explained to residents that because of safety, and by the instruction of management, they have been unable to serve the hot beverages over 140 degrees. The FSD said there had been an issue with residents sustaining burns and had received directive from management that this was what needed to occur. The FSD said other food items may be over 140 degrees but the coffee/hot water was unable to be. On 7/29/25 at 11:48 A.M., a test tray was conducted on Unit Three with the Corporate Infection Control Nurse, and the following temperature was obtained:-coffee was 119 degrees Fahrenheit (F), was lukewarm to taste, was not hot or at an appetizing temperature. On 7/29/25 at 12:38 P.M., a test tray was conducted on Unit One with the FSD, and the following temperature was obtained: -coffee was 111.0 degrees F, was lukewarm to taste, was not hot or at an appetizing temperature. On 7/29/25 at 12:48 P.M., test tray temperatures were obtained on Unit Two with Nurse #4, and the following temperatures were obtained: -coffee was 101.9 degrees F, was lukewarm to taste, was not hot or at an appetizing temperature.During an interview at the time, Nurse #4 said the coffee was lukewarm, not hot, and would request to have it heated up if served at this temperature. During an interview on 7/29/25 at 2:45 P.M., the FSD said the resident concerns about the coffee has been an ongoing issue since March 2024, when she was instructed by the previous management to lower the temperature of the coffee/hot water to 140 degrees F prior to sending to the units. The FSD said she knew there was resident concerns about the coffee/hot beverage temperatures since last year, had brought these concerns to the previous administration and was told to inform the residents that the hot beverage temperatures had been lowered for safety reasons. The FSD said she had not relayed these concerns to the new Administrator, who has been at the facility for about one year. The FSD said there was no longer a Quality Assurance Process Improvement (QAPI) plan in place relative to food/beverage temperatures that was active but that she completed test trays to monitor food temperatures. The FSD said the temperature goal for the hot beverages when received by the residents should be close to 140 degrees F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225250	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, and interviews, the facility failed to adhere to infection control standards of practice while serving meals to residents on one Unit (Unit One), out of three Units observed, and maintain a hygienically clean environment to prevent contamination and the spread of infection in the facility laundry room.Specifically, the facility failed to:1. Ensure that staff passing breakfast meal trays in resident rooms on Unit One removed personal protective equipment (PPE: items such as gowns and gloves worn to prevent the spread of infection) after providing care for one Resident on Enhanced Barrier Precautions (EBP), prior to exiting the resident's room, and did not place a previously delivered resident breakfast meal tray in the unit food truck with undelivered resident meals trays to prevent contamination and the potential spread of infections.2. Ensure that the facility laundry room was maintained in a hygienically clean environment when stagnant water, dust laden fans, and windowsills laden with dead bugs and paint chips were observed in the proximity of clean laundry, to prevent the spread of infection to the extent possible. Findings include: 1.Review of a printout provided by the facility titled, Sequence for Putting on Personal Protective Equipment (PPE). How to safely remove personal protective equipment example1 and 2, undated, retrieved from https://www.cdc.gov/infection-control/media/pdfs/Toolkits-PPE-Sequence-P.pdf indicated: -Remove all PPE before exiting the patient room. On 7/25/25 at 7:50 A.M., the surveyor observed the following during the breakfast meal pass on Unit One: -The meal truck was brought to the unit by the kitchen staff. -three staff members served meal trays to residents in their rooms including Certified Nurse Aide (CNA) #1. On 7/25/25 at 7:53 A.M., the surveyor observed CNA #1: -exit a resident room with a PPE precaution sign at his/her door. CNA #1 was observed wearing a PPE gown and holding a resident breakfast tray in her hands. -CNA #1 walked out into the hallway and approached the breakfast truck that was parked in the hallway and contained undelivered meals for other residents while still wearing the PPE gown from the Precautions resident room. - CNA #1 then turned around, walked to the resident door and placed the breakfast tray that was in her hands on top of the container that contained PPE supplies, while still wearing the PPE gown. - CNA #1 re-entered the same resident's room that had the PPE sign at the door leaving the breakfast tray on the PPE supplies container. - CNA #1 was observed to exit the resident room without the PPE gown. - CNA #1 was observed to pick up the breakfast tray that she previously placed on top of the PPE supplies container and then replaced the contaminated breakfast tray back into the breakfast truck (continued on next page)

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	225250	A. Building B. Wing	07/31/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that contained undelivered resident meals. During an interview on 7/25/25 at 7:56 A.M., CNA #1 said that it was the first time she had to wear a gown. CNA #1 said she was informed by other CNAs in the hallway after she came out of the room that she was not supposed to come out of the resident's room wearing a gown. CNA #1 said that the resident had a bag on his/her body, but she was not sure what the bag was. CNA #1 said she knew she had to wear a gown when she entered the Resident's room but was unsure when to remove the gown. CNA #1 said the resident refused his/her breakfast tray, and she was unsure what to do with the breakfast tray. During an interview on 7/25/25 at 8:05 A.M., Unit Manager (UM) #2 said that the Resident was on EBP related to the resident having a colostomy (surgical procedure that creates an opening in the colon to allow stool to be collected in a bag outside the body). UM #2 said CNA #1 should not have worn a gown to deliver a meal to residents if staff was not providing care to the residents. UM #2 said that CNA #1 should not have placed the breakfast tray on the PPE container outside of the resident's room. UM #2 further said that placing the (contaminated) breakfast tray in the meal truck with other undelivered meals was an infection control issue and the breakfast tray should have been returned to the kitchen, not in the meal truck with other residents' breakfast trays, to prevent the spread of infection. During an interview on 7/25/25 at 3:14 P.M., the Infection Control Preventionist Nurse (ICP) said that staff should not return the breakfast tray to the truck with other resident meals. The ICP further said CNA #1 should have removed the PPE gown prior to exiting the Resident's room but she had not. 2. On 7/29/25 from 2:30 P.M. to 2:44 P.M., the following was observed in the facility laundry room: -The trough behind the washing machines had a layer of stagnant water with debris scattered throughout the trough. -The windowsill near the washing machines where slippers were drying had chips that had cracked off the wall and fallen onto the windowsill, and a layer of dead bugs. -Three fans in the dryer/clean linen area that had thick layers of dust on them, were in use, and blowing towards multiple carts of clean laundry. During an interview following the observations in the laundry room, Housekeeper #1 said there was no current cleaning schedule or cleaning check list for the laundry staff to ensure the laundry room remained clean. Housekeeper #1 said it was the responsibility of all the housekeeping staff to tidy up. Housekeeper #1 said the fans should not have a thick layer of dust on them and they should be wiped down regularly especially since they blow towards clean linen and clothing. Housekeeper #1 said the standing water at the back of the washing machines had been there since he started in May 2025 and he was unsure whose job it was to make sure the trough was cleaned regularly. Housekeeper #1 further said the windowsills near the washing machines were dirty and should have been cleaned. During an interview on 7/29/25 at 3:35 P.M., the Director of Maintenance said it was his departments responsibility to make sure the drains were working behind the washing machines, so no standing water built up. The Director of Maintenance said no one had made him aware that there was standing water behind the washing machines.^ (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225250	A. Building B. Wing	07/31/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/29/25 at 3:30 P.M., the Housekeeping Director said surface cleaning in the laundry room was done once weekly. The Housekeeping Director further said there was no log use to show when the laundry room was last cleaned so she was unable to tell when the fans and windowsills were last wiped down.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225250	A. Building B. Wing	07/31/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record reviews, the facility failed to provide a dignified dining experience for one Resident (#140) out of a total sample of 26 residents.Specifically, for Resident #140, the facility failed to provide a dignified dining experience during breakfast and lunch meal service when the Resident was dependent on staff for assistance with meals and:-was not served his/her meal at the same time as other residents seated at the same table.-had clothing protectors applied instead of napkins before his/her meal was served. Findings include: Review of the facility's policy titled Nutrition and Meal; Meal Tray Delivery Outside of Dining Room, dated 5/2/05, indicated:-Nursing personnel will monitor residents throughout meals to ensure resident assistance is provided promptly, per individual need. Review of the facility's policy titled Residents' Rights, revised dated 10/4/23, indicated:-A facility must treat each resident with respect and dignity and care in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life and recognizing each resident's individuality. The facility must protect and promote the rights of the resident.-The resident has the right to a safe, clean, comfortable and home environment, including but not limited to receiving treatment and support for daily living safely. Resident #140 was admitted to the facility in December 2021 with diagnoses including Pneumonitis due to inhalation of food and vomit, Dysphagia Oropharyngeal Phase, Protein Calorie Malnutrition, and Acute on Chronic Respiratory Failure with Hypoxia. Review of the Minimum Data Set (MDS) assessment, dated 6/18/25, indicated Resident #140:-was moderately cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15.-required supervision during meals. Review of Person-Centered Care Plan, initiated 12/6/23 and revised 1/9/25, indicated Resident #140:-has impaired swallowing: Dysphagia (difficulty swallowing food or liquids).-has mechanical soft diet with nectar thickened fluids consistency on 1/2/25, liquids changed to honey thickened.>goal - the Resident will not have episodes of choking x 90 days.>intervention - supervision with meals. Review of the Dietician's Nutritional History/Assessment (quarterly) completed on 6/11/25 indicated Resident #140:>Eating Ability - independent, continual supervision 1:8 and set-up with limited assist. On 7/28/25 at 8:54 A.M., the surveyor observed eleven residents and one CNA in the dining room on Unit 1. The surveyor observed that ten residents had breakfast meals and Resident #140 was without a breakfast meal. Resident #140 was observed asking CNA #8 for his/her breakfast meal and CNA #8 said she would look into it. During an interview at the time, CNA #8 said that Resident #140 needed 1:1 supervision so he/she had to wait.On 7/28/25 at 8:58 A.M., the surveyor observed that Resident #140 continued to ask for his/her breakfast meal and CNA #8 said that the Residents' breakfast was on its way. At this time, the surveyor observed CNA #4 remove Resident #140's breakfast meal tray from the food truck and bring it to him/her. On 7/29/25 at 12:28 P.M., the surveyor observed Resident #140, four residents and two staff members in the dining room. The surveyor observed a staff member approach Resident #140 and place a clothing protector on him/her. The surveyor observed a second staff member approach Resident #140's tablemate and served him/her their lunch meal. Resident #140 was observed to look at his/her tablemate and then looked over to the entry way where staff were standing.On 7/29/25 at 12:36 P.M., the surveyor observed Resident #140 waiting to be served his/her lunch meal. At this time, a staff member was observed to set up the Resident's meal, pulled up a chair and sat next to Resident #140. During an interview on 7/29/25 at 12:54 P.M., CNA #2 said that Resident #140 needed staff supervision during meals, and someone should have sat with the Resident when staff were serving meals. CNA #2 further said that she did not know why Resident #140 had to wait and watch other residents receive their meals as he/she waited to be served last. During an interview on 7/29/25 at 1:38 P.M., the Registered Dietician (RD) said that residents were served their meals based on table numbers and how the meals were arranged on the meal truck. The RD gave the surveyor a handwritten resident seated arrangement in the dining room and Resident #140 was listed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225250	A. Building B. Wing	07/31/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last on the list. The RD also said that Resident #140 needed supervision during meals and could have received his/her meal at the same time with other residents while he/she remained supervised. During an interview on 7/29/25 at 1:45 P.M., the Clinical Nurse Consultant (CNC) #2 said that staff typically served Resident #140 his/her meal last as Resident #140 grabbed food from his/her tablemate's plate. During an interview on 7/29/25 at 1:48 P.M., the Director of Nursing (DON), said that Resident #140 should have received his/her breakfast and lunch meal at the same time with other residents. The DON further said Resident #140 should have received his/her meals at the same time to provide dignified experience, but they had not.

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	225250	A. Building B. Wing	07/31/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement abuse policies and procedures when two Certified Nurse Aides (CNA #8 and CNA #2) documented a potential allegation of abuse pertaining to one Resident (#7), out of a total sample of 26 residents. Specifically, the facility failed to ensure the allegations of abuse were identified, reported within the required timeframe, and protection was provided to residents pending the outcome of the investigation, when CNA #8 and CNA #2 documented in witness statements that Nurse #4 responded inappropriately to Resident #7 after the Resident sustained a fall.Findings include: Review of the facility policy titled Accidents and Incidents - Investigating and Reporting, revised 12/29/11, indicated all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on the premises must be investigated and reported to the Administrator.The policy also included the following:-to ensure accurate reporting, timely investigation, and subsequent follow up is completed with each accident/incident in order to identify process improvement (PI) opportunities. -regardless of how minor an accident or incident may be . report the accident/incident to the department supervisor as soon as possible.-complete an Incident Report for all reported accidents/incidents.-an employee witnessing an accident or incident involving a resident . must report such occurrence to his/her immediate supervisor as soon as practical.-procedures governing the reporting and investigation of abuse, neglect and/or misappropriation of resident property are located in the facility's Abuse policy.-the nurse supervisor/charge nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident.-an incident and accident form must be completed prior to the end of the shift and submitted to the Director of Nurses promptly. Review of the facility policy titled Resident Abuse Prevention, Investigation and Reporting Policy, revised 10/17/22, indicated it was the responsibility of all covered individuals (anyone who is the owner, operator, employee, manager, agent or contractor of the facility) to ensure an environment free of abuse, mistreatment, misappropriation of resident property, and exploitation.The policy indicated:a. purpose of the policy included:-to define abuse, neglect, mistreatment, misappropriation of property, and exploitation.-to outline the process to be followed for internal identification and reporting of suspected abuse.-to describe the investigative process to be used in instances of reported abuse.-to assure the protection of residents during and following an allegation/investigation of abuse.-to outline the procedure for reporting allegations of abuse and investigative findings to the Department of Public Health (DPH) .b. Identification:-all covered individuals are responsible for identifying and reporting immediately to their supervisor to ensure immediate investigation any witnessed or allegation of abuse they are told about by residents, families, visitors, or other staff.c. Protection and Notification:-upon receiving an allegation of abuse, covered individuals will take steps necessary to protect all residents and then immediately notify the Administrator. d. Preliminary Investigation:-because all suspected cases of abuse must be promptly and accurately reported to the DPH within mandated timelines, immediate action is necessary in order to determine whether a reported incident likely constitutes a suspected case of abuse requiring a report.-when a covered individual believes that he or she has reasonable cause to believe that a resident has been abused, neglected or mistreated, exploited or has had property misappropriated, the covered individual has the responsibility to report to his/her supervisor as well as the right to report to DPH. -the Administrator/designee will report to DPH within the required time frames.-determination of whether a suspected case of abuse exists, shall be given the highest priority at the facility. -the Administrator or specific designees shall, as promptly as possible after report of the incident: >remove the accused in order to prevent further potential harm to the resident(s)>examine and speak with the resident, if possible>identify and preliminary interview key witnesses, and>identify and preliminary review key documents and any involved instrumentality in order to determine with reasonable certainty what (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225250	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Commons Nursing & Rehabilitation Center	Christian Hill Road Great Barrington, MA 01230

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred and whether the incident constitutes a suspected case of abuse. e. Reporting to DPH:-in cases where there is reasonable cause to believe that abuse, neglect, exploitation or mistreatment has occurred, federal regulation requires reporting to the Department by covered individuals, and ultimately the Administrator/designee .>within two (2) hours .allegation of abuse Resident #7 was admitted to the facility in April 2023 with diagnoses including Dementia, muscle weakness, unsteadiness on feet, and repeated falls. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the following relative to Resident #7:-was moderately cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 12 out of 15-had no behaviors or rejections of care-required partial/moderate assistance of staff with transfers-required supervision or touching assistance of staff with ambulation Review of a Nursing Progress Note dated 6/11/25 at 2:41 P.M., and written by Nurse #4 indicated the following:-he/she was summoned to the Activity Room-Resident #7 was found lying on his/her left side (on the floor) Review of the facility's internal investigation for the fall (on 6/11/25), dated 6/10/25 [sic], indicated the following staff statements:-CNA #8 indicated in a written statement that she heard screaming and observed Resident #7 lying on the floor in the activity room and ran to get someone. Nurse #4 responded, walked slowly to the Resident, did not ask if he/she was okay and instructed staff to get Resident #7 off the floor without completing an assessment. CNA #8 said Nurse #4 looked at the Resident, told him/her to look at her face and the look on Nurse #4's face to the Resident was not nice and Nurse #4 told the Resident this is becoming a every week thing. CNA #8 indicated that she (CNA #8) went back to the unit. -CNA #2 indicated in a written statement that she was called to the activity room for assistance and observed Resident #7 lying on the floor on his/her left side. When the Nurse (#4) arrived, she told CNA #2 to pick the Resident up without performing any assessment. CNA #2 indicated once the Resident was seated in the chair, Nurse #4 said look at my face, this is becoming a every week thing. CNA #2 indicated that once she knew the Resident was safe in the chair, she returned to her unit. Further review of the facility's internal investigation surrounding the fall incident on 6/11/25 indicated the person who prepared the report was Nurse #4. On 7/30/25 at 4:50 P.M., the surveyor and the Director of Nursing (DON) reviewed the facility fall investigation dated 6/11/25. During an interview at the time, the DON said the Unit Managers (UMs) were responsible for reviewing the incident reports, but the ultimate responsibility was on the DON to review them. The surveyor requested the DON review the written witness statements from the 6/11/25 and the DON said she was aware of the witness statement made by CNA #8, who was an agency staff and no longer worked at the facility. The DON said she did follow up with CNA #8 about her statement relative to Nurse #4, and that prior to the 6/11/25 incident, CNA #8 had expressed she had issues with Nurse #4. The DON further said she instructed CNA #8 to not put personal feelings into a statement about a resident incident, and that the purpose of the witness statement was to report what occurred during the incident. The DON said she did not document the conversation with CNA #8. When the surveyor asked the DON to review the written statement dated 6/11/25 from CNA #2, the DON said she did not recall reading the written statement from CNA #2. After reviewing the written witness statements from CNA #8 and CNA #2, the DON said that according to the statements, there would be a potential verbal abuse allegation concern. The DON said Nurse #4 should have been suspended, and the incident should have been reported within two hours to DPH, and these steps did not occur. The DON said it was important to investigate potential abuse allegations in order to protect the resident and other residents from potential further abuse, and to conduct an internal investigation in order to determine if the allegation was substantiated or unsubstantiated, and that this process was not followed. On 7/31/25 at 8:48 A.M., the surveyor observed Nurse #4 was working in the facility on the unit where Resident #7 resided. On 7/31/25 at 11:27 A.M., the surveyor and Unit Manager (UM) #1 reviewed the fall incident from 6/11/25. UM #1 said after the surveyor and the DON spoke about the 6/11/25 incident, she obtained an interview from Resident #7 about the circumstances of the fall on 6/11/25 and also spoke with the Resident's Representative about the incident. UM #1 said she had not seen (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225250	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the initial investigation from 6/11/25 and had she reviewed it, she would have immediately brought the concern to the attention of the DON due to the fact that the CNA witness statements were alarming. UM #1 said there was a dynamic with staff involving Nurse #4 around the date of this incident, but regardless of the dynamics, had she been aware of the staff statements about what occurred with Nurse #4, she would have immediately notified the DON. On 7/31/25 at 11:47 A.M., the DON said after speaking with the surveyors on 7/30/25, she spoke with the Administrator and the Corporate Consultant, and they reviewed the information from the witness statements on 6/11/25. The DON said upon reviewing the witness statements from CNA #8 and CNA #2, it was determined that the incident should be reported to DPH as an allegation of verbal abuse. The DON said at that point Nurse #4 who was working, was brought to and remained in the administration office and interviewed about the incident. The DON said typically, for any allegation of abuse/neglect, the facility would suspend the employee until the internal investigation has been completed. The DON said upon talking with the Corporate Consultant, it was decided that Nurse #4 did not need to be suspended. The DON said the staff involved in the 6/11/25 incident were not interviewed and that typically this would have been done. During an interview on 7/31/25 at 1:01 P.M., the Corporate Consultant said she reviewed the information relative to the 6/11/25 incident offsite as she had left the facility at the time the incident was reported to her. The Corporate Consultant said Nurse #4 was interviewed on 7/30/25 and a written statement was obtained by Nurse #4 on this day (7/31/25), and the investigation would be concluded today. The Corporate Consultant said the protocol for investigating an allegation of abuse indicated for the staff to be suspended pending the outcome of the investigation. The Corporate Consultant said currently, the investigation into the allegation of verbal abuse was not concluded and that it was ongoing. The Corporate Consultant said Nurse #4 returned to the facility on this date (7/31/25) to work. The Corporate Consultant said the abuse policy and procedures were not followed and should have been. Please Refer to F689

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225250	A. Building B. Wing	07/31/2025

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure an effective discharge plan was implemented for post-discharge care for one Resident (#130) out of a total sample of three residents reviewed for closed records. Specifically, for Resident #130, the facility failed to ensure services such as visiting nurse and therapy, were in place when he/she was discharged from the facility when Resident #130 expressed interest in having the services in place for a safe facility discharge and reduce the risk of re-hospitalization. Findings include: Review of the facility policy titled Discharge Planning, revised 1/24/25, indicated the following: -The purpose of this policy is to establish an effective Discharge planning process that focuses on the resident's discharge goals, the preparation of resident to be active participants and effectively transition to post-discharge care, and the reduction of factors leading to preventable readmissions. >The social services staff, in concert with the interdisciplinary team, will discuss the resident's discharge needs based on the setting he or she is returning to. -Post discharge >The Social Worker or designee will call the resident/responsible party to follow-up after discharge. The purpose of this call is to ask the resident/responsible party if the discharge went according to plan. >Documentation of the calls will be written as an addendum to the closed record in the social service progress notes. Resident #130 was admitted to the facility in May 2025 with a diagnoses including Sepsis and Urinary Tract Infection (UTI). Review of the Social Service Evaluation and assessment dated [DATE], indicated Resident #130 planned to return to the community with support from Visiting Nurses Services (VNA - community provider that has nursing, physical therapy, occupational therapy, and home health aide service that come directly to a persons' home) and Resident Representative (RR) #1. Review of Resident #130's Community - Return to Community Care Plan, effective 5/16/25, indicated Resident #130's goal was to return to his/her home in the community. Review of the Nursing Progress Note dated 5/20/25, indicated the following: -.Patient states.I'm going home after this appointment.Nurse Practitioner (NP) saw patient and gave orders for patient to discharge home with medications and services. Review of the Social Services progress note dated 5/20/25 indicated the following: -Resident states he/she would be going home today.Order for discharge obtained by nursing.Resident booked his/her own primary care (PCP) appointment. RR #1 came and picked up Resident. Review of Resident #130's May 2025 Physician's orders indicated the following: -Discharge home with home health, Physical Therapy, Occupational Therapy, and Nursing evaluation.order date 5/20/25. Review of the Post-Acute Discharge Transition Summary dated 5/20/25, indicated no information under Section B: Discharge Information which contained a line to identify the Home Health Agency and phone number of the Home Health Agency that would provide in-home services. During an interview on 7/28/25 at 1:55 P.M., the Social Work Assistant (SWA) said Resident #130 requested VNA services when he/she returned to the community. The SWA said this information is documented on the Post-Acute Discharge Transition Summary in Section B. The SWA said she could find no documentation VNA services were put into place for Resident #130 at the time of his/her discharge. The SWA further said she was unable to find any documentation a post discharge call was made to check in on Resident #130. During a phone interview on 7/28/25 at 1:55 P.M., Resident #130 said at the time he/she discharged from the facility no one set up VNA services for him/her. Resident #130 said he/she could have really benefited from in-home nursing and therapy services as he/she was deconditioned. Resident #130 said that RR #1 had to set up all the in-home services him/herself once Resident #130 was at home as the facility did not assist in implementing services or provide information about services at the time of discharge. During a phone interview on 7/28/25 at 4:10 P.M., RR #1 said Resident #130 really needed to have nursing, physical therapy, and occupational therapy when he/she discharged to the community but no referrals had been made by the facility. RR #1 said no staff at the facility provided him/her with any (continued on next page)

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	225250	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Commons Nursing & Rehabilitation Center	Christian Hill Road Great Barrington, MA 01230

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information on community services at the time of discharge. RR #1 said he/she had to work in coordination with Resident #130's community Physician to get the services in place and Resident #130 went without services for about two weeks which really set Resident #130's progress back as Resident #130 was deconditioned. During a follow-up interview on 7/30/25 at 9:11 A.M., the SWA said she could not be sure why no staff in the Social Services Department had made a referral for VNA services for Resident #130. The SWA said since the Physician's orders indicated VNA services were to be put into place a referral should have been made for VNA services and this was not done.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that Minimum Data Set (MDS) Assessments were accurate for three Residents (#4, #7 and #67), out of a total sample of 26 Residents. Specifically, For Resident #4, the facility failed to ensure the MDS assessment dated [DATE] accurately indicated the daily use of hypoglycemic (medication to lower blood sugar) and antipsychotic (medication to treat mood and behaviors) medications and did not include the use of anticoagulant (medication to thin the blood and prevent blood clotting) medication. For Resident #7, the facility failed to ensure the MDS assessment dated [DATE] accurately indicated three falls that occurred since the last MDS Assessment. For Resident #67, the facility failed to ensure the MDS assessment dated [DATE] accurately indicated falls that occurred since the last MDS Assessment.Findings include: 1. Resident #4 was admitted to the facility in April 2021 with diagnoses including Diabetes Mellitus Type 1, Cerebral Infarction (stroke) and psychotic disorder with delusions. Review of the January 2025 Physician's orders included the following medications: -Aripiprazole (Abilify - antipsychotic medication), 15 milligrams (mg), daily, initiated 5/13/24. -Novolog Insulin 100 Unit (U)/1 milliliter (ml) solution, 6 units subcutaneous before meals, initiated 7/12/23 -Lantus Solostar Pen 100 U/1 ml solution, 32 units subcutaneous at 8:00 P.M., initiated 12/18/24 -there was no order for the Resident to receive anticoagulant medication. Review of the MDS Assessment, dated 1/29/25, indicated the following under Section N: -received Insulin injections for 7 days of the reference period -was on an antipsychotic medication during the reference period -was on an anticoagulant medication during the reference period -did not receive hypoglycemic agents (including Insulin) during the reference period -Antipsychotic medications were not received Review of the January 2025 Medication Administration Record (MAR), indicated the following were administered during the reference of period of the MDS assessment dated [DATE]: -Aripiprazole 15 mg daily -Novolog Insulin 100 U/1 ml solution 6 units before meals -Lantus Solostar Pen 100 U/1ml solution, 32 units daily at 8:00 P.M.-no anticoagulant medication was administered (continued on next page)

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	225250	A. Building B. Wing	07/31/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/25 at 10:00 A.M., MDS Nurse #1 said the 1/29/25 MDS Assessment for Resident #4 was inaccurate and needed to be modified. MDS Nurse #1 said the Resident should have been coded under Section N as receiving hypoglycemic medications and that antipsychotic medication was administered on a routine basis and should not have indicated the Resident received an anticoagulant medication. 2. Resident #7 was admitted to the facility in April 2023 with diagnoses including Hypertension, Diabetes, Dementia, Muscle Weakness, unsteadiness on feet and repeated falls. Review of the Resident's clinical record indicated he/she experienced falls on the following dates: -4/14/25 -5/6/25 -5/22/25 Review of the MDS assessment dated [DATE], indicated the following under Section J: -no falls occurred since the last MDS assessment (dated 3/19/25). During an interview on 7/31/25 at 2:25 P.M., MDS Nurse #3 said the 6/4/25 MDS Assessment for Resident #7 was inaccurate and would need to be modified under Section J. MDS Nurse #3 said Section J should have indicated the Resident had two falls with no injury and had one fall with minor injury since the previous MDS Assessment on 3/19/25. 3. Resident #67 was admitted to the facility in July 2024 with diagnoses including Unspecified Dementia and Major Depressive Disorder. Review of the most recent MDS assessment dated [DATE], indicated Resident #67 had no falls between the last MDS Assessment on 2/26/25 and the current MDS Assessment on 5/21/25. Review of Resident #67's Nursing Progress Note dated 3/22/25, indicated Resident #67 sustained a fall on 3/22/25. Review of Resident #67's Nursing Progress Note, dated 4/5/25, indicated Resident #67 sustained a fall on 4/5/25. During an interview on 7/30/25 at 10:05 A.M., MDS Nurse #1 said Resident #67 had falls on 3/22/25 and 4/5/25 and those falls should have been coded as YES on the most recent MDS assessment dated [DATE] because they happened between the current MDS Assessment and the 2/26/25 MDS Assessment. MDS Nurse #1 further said a modification would need to be done. Please Refer to F689

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that necessary treatment and services, consistent with professional standards of practice, were provided to promote the healing of pressure ulcers for one Resident (#49) out of a total sample of 26 residents.Specifically, for Resident #49, the facility failed to:-adhere to the Physician ordered wound treatment during wound treatment provided on 7/25/25, putting the Resident at risk for potential worsening of the pressure ulcer.-review the Wound Consultant treatment recommendations made on 7/24/25 to discontinue a medicated cream, with the Resident's Primary Medical Practitioner and update wound treatment orders timely, resulting in a delay in updated wound treatment per the Wound Consultant's recommendations. Findings include: Review of the facility policy titled Skin Integrity Management effective 3/1/2011 and revised 11/15/23, indicated but was not limited to:-Policy: .It is also the policy of this facility, consistent with CMS regulations that any resident with pressure ulcer or injury receives necessary treatment and services, consistent with professional standard of practice, to promote healing, prevent infection and prevent new ulcers from developing.-Purpose:<To maintain the integrity of our resident's skin.<To minimize the risks and prevent the occurrence of skin breakdown.<To develop and implement a comprehensive, person-centered plan of care aimed at maintaining skin integrity, prompt identification, intervention and management of any skin breakdown.-Parameters of a comprehensive skin assessment:.Moisture- skin can be dry or damaged from too much wetness (maceration).-Procedures:<Obtain referral to Wound Consultant who will partner with facility nurse in conducting weekly wound assessment and treatment review.Every treatment recommendation will be reviewed, timely with the resident's primary Medical Practitioner and an order will be entered in the resident's electronic medical record. Review of the facility policy titled Aseptic Dressing Change and Wound Measurement effective June 2010, indicated but was not limited to the following:-Policy: .to provide a safe, hygienic environment for residents who are in need of dressing application by adhering to the guidelines set forth by the Nursing Standard of Practice, CDC and Infection Control Standards.-Procedure:<Apply ointments, etc. as ordered. On 7/25/25 at 11:48 A.M., during a treatment and wound dressing change observation of Resident #49's right ischium pressure ulcer area, the surveyor observed that Nurse #1 failed to apply Skin Prep as ordered by the Physician to the right ischium pressure ulcer periwound. During an interview on 7/25/25 at 3:04 P.M., Nurse #1 said she did not apply Skin Prep to Resident #49's right ischium pressure ulcer periwound during the treatment and wound dressing change performed in the morning on 7/25/25 and that she should have. Resident #49 re-admitted to the facility in August 2024, with diagnoses including pressure ulcer of left buttock, pressure ulcer of right buttock, Diabetes Mellitus with diabetic neuropathy, paraplegia, and peripheral vascular disease. Review of Resident #49's July 2025 Physician's orders indicated:-Right ischium pressure ulcer treatment, initiated 7/3/25<Remove tape slowly to avoid tearing the skin.<Cleanse wound with normal saline or one-quarter strength Dakins (wound cleansing solution). Pat dry.<Skin Prep (a liquid or wipe that forms a protective barrier on the skin) periwound (tissue surrounding the wound).<Apply Calcium Alginate (wound dressing that forms a moist gel) to wound bed.<Tuck one-four by four folded in half to keep periwound from touching.<Secure with gauze and superabsorbent pad.<Wound treatment to be performed twice daily and as needed (PRN). Review of Resident #49's current Plan of Care relative to pressure ulcers, initiated 11/16/24 and revised 5/18/25, indicated:-was at high risk for pressure ulcer development and high risk for delayed or even inability to heal existing wounds.-admitted with multiple pressure ulcers.-will not develop additional areas of breakdown, and existing wounds will progress towards healing.-Resident with Stage four pressure areas located on right and left ischia.-Interventions: Treatment to area per Physician's orders, and follow skin and wound care protocols. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #49:-was cognitively intact as evidenced by a score of 15 out of a (continued on next page)

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	225250	A. Building B. Wing	07/31/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible 15 on a Brief Interview for Mental Status (BIMS) exam.-had two Stage four pressure ulcers, which were present upon admission. Review of Resident #49's Wound Consultant Progress Note with date of service 7/24/25 indicated:-Stage four pressure ulcer of right ischium.-Periwound moist and macerated (softened/impaired skin integrity resulting from prolonged exposure to moisture).-Treatment recommendations are the same as Physician's orders initiated on 7/3/25-Stage four pressure ulcer of left ischium:-Periwound denuded (upper layer of skin [epidermis] and parts of the dermis are stripped away) with non-blanchable ecchymosis (discoloration/type of bruising).-Treatment recommendations:1. Cleanse wound.2. Apply one-quarter strength Dakin's moist gauze to base of the wound.3. Secure with abdominal (ABD) pad, Superabsorbent pad.4. Change twice a day, PRN.-no recommendation pertaining to Lotrisone cream. Review of Resident #49's July 2025 Treatment Administration Record (TAR) indicated:-Clotrimazole-Betamethasone Dipropionate 1% - 0.05% (Lotrisone) cream had been applied to Resident's left ischium pressure ulcer periwound three times daily from 7/25/25 through the 6:00 A.M. administration on 7/29/25. -The wound treatment for Resident's left ischium pressure ulcer, which included application of Lotrisone cream to the periwound, was completed twice daily from 7/25/25 through the 10:00 A.M. treatment on 7/29/25. During an interview on 7/30/25 at 12:49 P.M., the Director of Nursing (DON) said the expectation was that the Physician's orders were followed when wound care treatment was provided. During an interview on 7/31/25 at 1:50 P.M., Physician #1 said the expectation was that Physician's orders were followed when wound care treatment was provided. Physician #1 said that when Skin Prep was not applied to a periwound as ordered, it could result in a potential for pressure injury. During an interview on 7/29/25 at 11:15 A.M., Unit Manager (UM) #1 said Resident #49's wound treatment recommendations made by the Wound Consultant on 7/24/25 had not yet been reviewed by Resident's Provider. UM #1 said that the Wound Consultant recommended [sic] on 7/24/25 that Lotrisone cream no longer be applied to the Resident's left ischial pressure ulcer periwound, and that the recommendation needed to be reviewed with the Provider and the Physician's order needed to be updated. UM #1 said that this was a delay in treatment. During an interview on 7/30/25 at 12:19 P.M., the Wound Consultant said the expectation was that wound treatment recommendations were reviewed by the Residents' Provider and Physician's orders were updated when recommendations were made by the Wound Consultant. During an interview on 7/30/25 at 12:49 P.M., the Director of Nursing (DON) said the expectation was that any recommendations made by the Wound Consultant during weekly wound rounds on Thursdays would be reviewed with the Residents' Provider and the Physician's orders would be updated the same day. During an interview on 7/31/25 at 11:50 A.M., Nurse #2 said the Wound Consultant recommended [sic] discontinuing the Lotrisone cream for Resident #49's left ischium pressure ulcer periwound, noting the rash to the periwound had resolved. Nurse #2 said she did not review the recommendations made by the Wound Consultant on 7/24/25 with the Resident's Provider on 7/24/25, nor did she review the recommendations with the Resident's Provider on 7/25/25. During an interview on 7/31/25 at 1:50 P.M., the Physician said the expectation was that recommendations made by the Wound Consultant would be reviewed with the Provider within 24 hours of the recommendations being made.

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	225250	A. Building B. Wing	07/31/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards of practice of fluid management for one Resident (#15), out of one applicable resident receiving dialysis (process that filters waste, salt, and fluid from the blood when the kidneys are unable to work adequately) services, out of a total sample of 26 residents.ˆ Specifically, for Resident #15, the facility failed to:ˆ -Accurately monitor daily fluid intake as ordered by the Physician, when the Resident was dependent on renal dialysis, placing the Resident at risk for medical complications related to fluid overload. Findings Include: Review of the facility policy titled Dialysis Residents, Coordination of Care Of, dated May 2005, and last revised November 2018, indicated:ˆ -The nursing facility is responsible for the overall quality of care and services the resident receives and provides the services, consistent with professional standards of practices, to residents receiving dialysis as outlined by their comprehensive person-centered plan of care. -Care plan will include: monitoring of vital signs, weights, nutritional approaches, fluid needs/restriction, labs. -The nursing facility will be responsible for the overall quality of care the resident receives including the customary standards of care provided by the facility and the following: -Monitoring fluid balance through recording and assessment of intake and output, as indicated. Review of the facility policy titled Intake and Output (I&O), Monitoring Of, dated May 2005 and last revised October 2018, indicated:ˆ -Intake and output measurement is instituted based on clinician judgement or physician order. -To monitor for fluid deficit/imbalance. -Resident receiving dialysis. -Resident on physician ordered fluid restriction. Total shift and daily intake and output records. -Notify physician if clinical assessment of resident indicates. Resident #15 was admitted to the facility in December 2023 with diagnoses including End Stage Renal Disease (ESRD), Chronic Kidney Disease (CKD), Hypertension and Urinary Tract Infection (UTI).ˆ Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #15:ˆˆ -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total of 15.ˆ -was receiving dialysis.ˆˆ -was on a Therapeutic diet. Review of the Comprehensive Person-Centered Care Plan, initiated 1/15/24, indicated Resident #15:-was at risk for potential for fluid overload related to End Stage Renal Disease with need for Hemodialysis (HD).ˆ -Care Plan interventions included: >monitor signs and symptoms of fluid overload and report to notify Medical Doctor/Nurse Practitioner (MD/NP) of significant changes as needed (PRN).>Educate and reinforce information on fluid needs and restrictions and diet recommendations. Review of Resident #15's July 2025 Physician orders indicated:ˆˆ -Dialysis weekly on Monday, Wednesday, and Friday, initiated 4/3/25.ˆˆ -Eve (evening) Fluid Restriction 1500 ML (Milliliters [ml]), initiated 4/9/25 >Dietary: Dinner = 240 ml>Nursing: Eve = 300 ml -Add meal intake to total shift intake -Noc (night) Fluid Restriction 1500 ml, initiated 4/9/25: >Nursing: NOC = 180 ml-Day Fluid Restriction 1500 ml, initiated 4/9/25: >Dietary: Bkfast (breakfast) = 240 ml>Lunch = 240 ml >Nursing: Day = 300 ml-Add meal intake to total shift intake >May not omit diet restrictions on special occasions ., initiated 4/4/25 Review of Resident #15's May 2025, June 2025, and July 2025 Medication Administration Records (MARs) Documentation of Fluids Intake indicated that Resident #15 exceeded the daily fluid intake restriction amount.MAR documentation indicated the following fluid intake amounts on the following dates: May 2025: 5/2/25: 1660 ml, 5/3/25: 1710 ml, 5/4/25: 1895 ml, 5/5/25: 1690 ml, 5/15/25: 1675 ml, 5/16/25: 3700 ml, 5/20/25: 2290 ml, 5/21/25: 1700 ml, 5/22/25: 2425 ml, 5/23/25: 2960 ml, 5/24/25: 1720 ml, 5/25/25: 2870 ml, 5/29/25: 1515 ml and 5/31/25: 1600ml June 2025: 6/1/25: 1955 ml, 6/4/25: 1840 ml, 6/6/25: 1960 ml, 6/8/25: 1790 ml, 6/10/25: 1940 ml, 6/11/25: 1790 ml, 6/15/25: 1850 ml, 6/16/25: 1880 ml, 6/19/25: 2160 ml, 6/20/25: 1660 ml, 6/23/25: 1960 ml, 6/27/25: 2300 ml, 6/28/25: 1900 ml, 6/29/25: 2100 ml and 6/30/25: 1730 ml. July 2025: 7/6/25: 3070 ml, 7/7/25: 1725 ml, 7/10/25: 2260 ml, 7/11/25: 1520 ml, 7/12/25: 2040 ml, 7/13/25: 2140 ml, 7/14/25: 2325 ml, 7/15/25: 2460 ml, 7/16/25: 2200 ml, 7/17/25: 2300 ml, (continued on next page)

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	225250	A. Building B. Wing	07/31/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/19/25: 2150 ml, 7/20/25: 2320 ml, 7/21/25: 1890 ml, 7/22/25: 1710 ml, 7/24/25: 1820 ml, 7/27/25: 2560 ml, 7/28/25: 1600 ml, 7/29/25: 2220 ml and 7/30/25: 1790 ml. Review of Resident #15's Physician Progress Notes indicated: -3/29/25: stop 1200 ml fluids/24 hours fluid restriction.-5/27/25: Physician exam indicate concerning edema only on lower extremities. Review of Resident #15's Interdisciplinary Progress Notes indicated: -3/20/25: 1200 ml fluid restriction (600 ml dietary/600 ml nursing) -4/10/25: Dialysis recommendation increase fluid restriction to 1500 ml q (every) day. Resident and Dietary aware. -7/31/25: w/o (without) consistency modification and a 1500ml fluid restriction (720 ml dietary/780 nursing). On 7/31/25 at 8:32 A.M., the surveyor observed Resident #15 sitting on his/her bed with a bedside table positioned in front of the Resident and a breakfast tray on the table with an empty coffee cup. During an interview at the time, Resident #15 said that he/she typically gets a full cup of coffee and a small cup of cranberry juice with his/her meals. The surveyor further observed a water bottle on the bedside table that was half filled with water. Resident #15 said that he/she does not like the water from the facility and have his/her family provide 24 packs of bottled water that he/she keeps in his/her room for use. The surveyor observed 16 full plastic water bottles on a second bedside table next to the Resident's bed.^ During an interview on 7/31/25 at 8:48 A.M., Nurse #5 said that Resident #15 was not compliant with the Physician ordered fluid restrictions. Nurse #5 also said that Resident #15 was allotted 1500 ml of fluids per day and the Resident does not drink water from staff and had his/her own water bottles in his/her room, that was provided by family. Nurse #5 said that the Physician was not aware that Resident #15 was not compliant with the 1500 ml of fluid allowed as Nurse #5 had not brought it to the Physician's attention. During an interview on 7/31/25 at 8:50 A.M., the Charge Nurse/Nurse #4 said that Resident #15 was not compliant with the 1500 ml of fluid restriction. Nurse #4 also said that she had not updated the Physician that the Resident had not been compliant with the 1500 ml fluid restriction as the Resident was his/her own person. During an interview on 7/31/25 at 10:45 A.M., Nurse Practitioner (NP) #1 said that Resident #15 was on 1500 ml fluid restriction and she had not reviewed the Resident's medical records. NP #1 said that she does not know the reason why the Resident was on fluid restriction when the Resident was going to dialysis, and dialysis treatments would be pulling the fluids out. NP #1 also said that monitoring Resident #15's fluid restrictions were nursing responsibilities. NP #1 said the risk for Resident #15 going over his/her allotted fluid restriction order depends on the Resident's medical diagnosis such as Congestive Heart Failure (CHF) and other medical issues that would affect the Resident, including difficulty breathing and fluid overload. NP #1 said that when the dialysis center reinstated the 1500 ml fluid restriction, she initiated the order for the Resident. NP #1 further said that when a recommendation was made, she discussed it with nursing staff and would refer to the dialysis center orders for fluid restrictions.^ During an interview on 7/31/25 at 11:05 A.M., the Director of Nursing (DON) said that Resident #15's 1500 ml fluid restriction should have been monitored by nursing staff as ordered. The DON also said that nursing staff should have notified the Physician and the dialysis center that Resident #15 was going over the allotted fluid restriction order and follow the dialysis center recommendations.^ During an interview on 7/31/25 at 12:13 P.M., Additional Staff Member (Dialysis Nurse - DN) #3 said that the dialysis center noticed that Resident #15 was coming in on his/her dialysis days heavier than his/her usual weight and was fluid overloaded when they assessed the Resident's weight prior to starting dialysis treatment. DN #3 said that the facility had not notified the dialysis center that the Resident was consuming more fluids than ordered. DN #3 also said that the dialysis center was removing 2.5 - 2.9 Liters of fluid from Resident #15 when he/she comes in for dialysis treatment. DN #3 said that the dialysis center reinstated the fluid restriction order back to 1500 ml per day. DN #3 also said that the risk of Resident #15 going over the fluid restriction order included fluid overload with the risk of shortness of breath, and edema. DN #3 said at times the Resident might say that he/she do not feel good but was unable to describe the problem. DN #3 said that they monitor the Resident weight trends and typically they remove 1 - 1.5 liters of fluids when the Resident comes for dialysis. DN #3 further (continued on next page)

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	225250	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Commons Nursing & Rehabilitation Center	Christian Hill Road Great Barrington, MA 01230

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the dialysis center will notify the facility when the dialysis center was removing more than the typical amount of fluids for Resident #15. DN #3 said that the facility staff had not communicated with the dialysis center that the Resident was going over the allotted fluid restriction.^^ During a follow-up interview on 7/31/25 at 1:55 P.M., the DON said Resident #15's fluid restriction order had to be monitored, and nursing staff should notify the Physician and the dialysis center if the Resident was going over the allotted fluid restriction orders. The DON also said that although the Resident is allowed 1500 ml per day fluid restriction by the Physician, nursing staff should notify the Physician and dialysis center if the Resident was consuming more fluid and/or less fluid. The DON said that the risk for less fluid consumption has the potential for altered mental status and dehydration and the risk for more fluid consumption is fluid overload which is not safe for a Resident receiving dialysis care and having a diagnosis of ESRD.^ During an interview on 7/31/25 at 2:10 P.M., the Registered Dietician (RD) said she reached out to the dialysis center, and she was told that typically they remove 2.5 - 2.9 liters of fluid from Resident #15 when he/she had dialysis treatments. The RD said that nursing has not informed her about the Resident going over his fluid restriction and the expectation was that nursing will notify the RD, and she will in turn reach out to dialysis which she did today. The RD also said that she does not know the reason behind the discontinuation of the fluid restriction in March (3/29/25) by the NP. The RD said that she followed up with dialysis and the Resident was sent to see the Nephrologist and confirmed that the fluid restriction should be reinstated as the Resident was fluid overloaded on the days that Resident #15 had dialysis treatment. The RD said that she would have updated the resident care plan, provided an education to nursing staff, the Resident, and the Resident's family if she was made aware of the Resident being fluid non-complaint. The RD also said that she saw the Resident today and observed several water bottles in the Resident's room and educated the Resident on his/her fluid restriction. The RD said the risk of fluid overload depends on the Resident.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview, and record review, the facility failed to issue the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN: notice issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services, the resident has not used all his/her Medicare benefit days, and plans to remain in the facility after coverage has ended) for two Residents (#19 and #141) out of a total sample of 26 residents. Specifically, for Residents #19 and #141, the facility failed to issue a SNF ABN to the Resident and/or Resident Representative for notification that their skilled services may not be paid for by Medicare and what financial responsibility would need to be assumed when the effective date of Medicare Part A coverage for skilled services ended and both Residents remained in the facility. Findings include: 1. Resident #19 was admitted to the facility in May 2025 with diagnoses including Metabolic Encephalopathy, Pneumonia, and Emphysema. Review of Resident #19's Medicare Notice of Non-Coverage (NOMNC) letter indicated Resident #19's Medicare Part A benefit ended at the facility on 7/7/25. Review of Resident #19's Nursing Progress Notes indicated Resident #19 remained in the facility after his/her Medicare Part A benefit ended. Review of the medical record failed to indicate that a SNF ABN letter was provided by the facility for Resident #19. 2. Resident #141 was admitted to the facility in April 2025 with diagnoses including Sepsis, Alzheimer's Disease, and Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #141's Medicare Notice of Non-Coverage (NOMNC) letter indicated Resident #141's Medicare Part A benefit ended at the facility on 5/22/25. Review of Resident #141's Nursing Progress Notes indicated Resident #141 remained in the facility after his/her Medicare Part A benefit ended. Review of the medical record failed to indicate that a SNF ABN letter was provided by the facility for Resident #141. During an interview on 7/28/25 at 1:09 P.M., Minimum Data Set (MDS) Nurse #1 said Resident #19 remained in the facility after his/her Medicare Part A benefit ended and he/she should have received a SNF ABN letter and did not. During a follow-up interview on 7/28/25 at 1:49 P.M., MDS Nurse #1 said Resident #141 remained in the facility after his/her Medicare Part A benefit ended and he/she should have received a SNF ABN letter and did not.

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure that a Level II (comprehensive evaluation that identifies the specialized services required) Preadmission Screening and Resident Review (PASARR- evaluation done if it was determined by the Level I (initial pre-screening] screen that a resident had an intellectual or developmental disability and/or serious mental illness [SMI] and if a resident was in need of additional support services at the facility) screen was submitted for one Resident (#60), out of a total sample of 26 residents.Specifically, for Resident #60, the facility failed to request a Level II PASARR evaluation when the Resident screened positive for ID (intellectual Disability)/DD (Developmental Disability) during a Level I PASRR Evaluation. Findings include: Review of facility policy titled Preadmission Screening and Resident Review (PASRR), last revised dated 9/22/23, indicated the following:-Make referrals to the Department of Developmental Services (DDS) and/or the Department of Mental Health (DMH)/Designee in a timely manner, when required.-DDS: individuals who have or may have ID or DD/RC (related condition). Resident #60 was admitted to the facility in November 2024 with diagnoses including Major Depressive Disorder, Disorder of Psychosocial Development and Intellectual Disabilities. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #60:-was severely cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of three out of a possible score of 15. -was prescribed antipsychotic and antidepressant medications. Review of Resident #60's Level I PASRR evaluation completed on 11/19/24, indicated:-was positive for Intellectual and/or Developmental Disability (ID/DD) Further review of Resident #60's clinical record failed to indicate any evidence that a Level II PASRR evaluation had been initiated and/or completed. During an interview on 7/30/25 at 11:00 A.M., the Clinical Reimbursement Coordinator (CRC)/MDS Nurse #2 said that Resident #60's Level I PASRR was submitted to the portal dated 11/22/24 which indicated Resident #60 had a positive screen for ID/DD. The CRC/MDS Nurse #2 said that a Level II PASRR should have been completed for Resident #60, and it was not done. CRC/MDS Nurse #2 said that a Level I assessment should have been faxed and/or called into the DDS office, and it was not faxed or called into the DDS office. CRC/MDS Nurse #2 also said a request for a Level II PASRR should have been submitted to DDS office, but this was not done.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure that medical records were complete and accurate for one Resident (#76), out of a total sample of 26 residents.Specifically, for Resident #76, the facility failed to:1. ensure the Physician's Orders accurately reflected the Resident's Representative from [DATE] through [DATE], resulting in the potential risk for the Resident's confidential information to be provided to an unauthorized party and the risk for an unauthorized party to make medical decisions for the Resident.2. obtain and document in the Resident's medical record evidence of the Resident's court-appointed Guardian from [DATE] through [DATE]. Findings include: Review of the facility policy titled Medical Records Policy effective [DATE], indicated but was not limited to the following:-Guidelines: Each resident will have an active medical record. This record shall be kept current, complete and available at all times to authorized personnel. Resident #76 was admitted to the facility in February 2025, with diagnoses including encounter for palliative care and history of transient ischemic attack and cerebral infarction. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #76:-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of six out of a possible 15. Review of Resident #76's Order Appointing Temporary Guardian for an Incapacitated Person signed by the Justice of the Probate and Family Court on [DATE], indicated:-Resident was appointed a Temporary Guardian on [DATE].-The powers of the Temporary Guardian included authorization to revoke the Resident's Health Care Proxy.-A review hearing would be held on [DATE].-Appointment of the Temporary Guardian would expire 90 days from [DATE]. Review of Resident #76's Letters of Guardianship for an Incapacitated Person signed by the Register of Probate on [DATE] indicated the following:-Resident was appointed a Temporary Guardian on [DATE].-The Temporary Guardian appointment would expire on [DATE]. 1. Review of Resident #76's [DATE] Physician's orders indicated:-Health Care Proxy (HCP) invoked on [DATE]. Start date [DATE].-No documentation regarding Guardianship. Review of Resident #75's clinical record indicated the Resident's Health Care Proxy to be someone other than the emergency contact provided in the Resident's medical record. During an interview on [DATE] at 9:30 A.M., with Social Worker (SW) #1 and #2, SW #2 said Resident #76's active Physician's orders indicated the Resident's HCP was invoked. SW's #1 and #2 said the current Physician's order was not accurate. SW #2 said an HCP was not the same as the Guardian. SW #1 said the Physician's order should indicate the Resident's HCP was invoked with a legal Guardian. SW #2 said the Physician's order should be updated to accurately indicate Resident #76's Representative so that the facility contacted the Resident's authorized Representative as appropriate. 2. Review of Resident #76's Progress Notes from February 2025 through [DATE] indicated:-Social Services Progress Note, dated [DATE], which indicated the Resident had a Temporary Guardian who attended a Guardianship review hearing on [DATE], and no updated documentation regarding the Resident's authorized Representative had been received by the facility.-No documentation that the facility made attempts to determine the status of the Resident's Guardianship following the Guardianship review hearing on [DATE]. During an interview on [DATE] at 1:40 P.M., SW #2 said Resident #76's Temporary Guardianship appointment expired on [DATE], and the facility did not have evidence of the Resident's current authorized Representative. SW #2 said the facility did not have evidence that the Resident's previously appointed Temporary Guardian had been appointed the Resident's Permanent Guardian. During an interview on [DATE] at 9:30 A.M., SW #2 said the facility should have attempted to obtain documentation regarding the status of Resident #76's Guardianship within two weeks following a Guardianship review hearing. SW #2 said there had not been any attempts made by the facility to determine Resident #76's current Representative until the surveyor inquired about the Resident's Guardianship status on [DATE] (four months after Resident #76's Temporary Guardianship appointment had expired).