STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225341	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamstown Commons Nursing & Rehab	25 Adams Road Williamstown, MA 01267

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment and was dependent on staff to meet his/her healthcare needs, the Facility failed to ensure he/she was treated in a respectful and dignified manner, when although Resident #1 said the words no and stop to Certified Nurse Aide (CNA) #1 during the provision of care, CNA #1 did not honor Resident #1's wishes, and continued with care. Findings include: Review of the Facility's policy, titled, Resident Rights, dated as revised 10/04/23, indicated the Facility must treat each resident with respect and dignity 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.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS) dated, 02/28/26, indicated that after receiving care, Resident #1 kept saying, she hurt me (referring to Certified Nurse Aide (CNA) #1).Review of the Facility Investigation Summary, dated 02/28/26, indicated the following:-On 02/28/26 at approximately 7:40 A.M., the nurse reported Resident #1 stated, I hurt, I hurt, she is bad, she is bad.-The nurse said Resident #1 was unable to elaborate on what he/she was saying.-Upon interview with the Director of Nursing (DON) and the Weekend Supervisor, CNA #1 said she provided care to Resident #1 the morning of 02/28/26, that Resident #1 was not acting him/herself, that he/she said no and stop and said she continued to provide care to him/her.Resident #1 was admitted to the Facility in August 2022, diagnoses included unspecified dementia with psychotic disturbance, generalized anxiety disorder, and major depressive disorder.Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 02/17/26, indicated Resident #1 was severely cognitively impaired with a score of 3 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). The Assessment also indicated Resident #1 was dependent on staff for activities of daily living such as dressing, bathing, and hygiene.Resident #1 was unable to be interviewed due to his/her severe cognitive impairment.During a telephone interview on 03/31/26 at 1:30 P.M, which included a review of her written witness statement dated 02/28/26, Nurse #1 said she was working the day shift on 02/28/26 and knew Resident #1 very well.Nurse #1 said CNA #1 was floated to Unit 3 (where Resident #1 resided) from another Unit after the shift began and she said she saw CNA #1 enter Resident #1's room. Nurse #1 said she went down to Resident #1's room (exact time unknown) to check in with CNA #1 and to go over what her assignment would be for the shift and plans for the day.Nurse #1 said when she entered the room, she observed CNA #1 trying to put a shirt on Resident #1 in an abrupt manner and said she noticed Resident #1 had an anxious look on his/her face.Nurse #1 said she told CNA #1 that she would finish dressing Resident #1, then she (Nurse #1) proceeded to put Resident #1's shirt on him/her without issue. Nurse #1 said she told CNA #1 that she would be right back and said she went and told Nurse #2 she did not like the interaction between CNA #1 and Resident #1. Nurse #1 then said she called the Weekend Supervisor to ask CNA #1 be sent back to Unit 2 and asked her if there was a different CNA with more patience that could come to Unit 3 instead.Nurse #1 said she immediately went back to Resident #1's room, said that Resident #1 was seated at the edge of his/her bed, said he/she appeared anxious and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repeated the words, stop, don't hurt me. Nurse #1 said she and CNA #1 assisted Resident #1 into his/her wheelchair and CNA #1 wheeled Resident #1 out to the nurses' station next to Nurse #2. Nurse #1 said she and Nurse #2 contacted the Weekend Supervisor immediately, explained the situation, and per the Supervisor's request, instructed CNA #1 to report to the Supervisor's office.Nurse #1 said if staff are providing care to a resident and they refuse care or ask you to stop, you are supposed to stop what you are doing and try to re-approach them later if possible.During a telephone interview on 03/31/26 at 1:45 P.M., which included a review of her written witness statement, dated 02/28/26, Nurse #2 said she was working on Unit 3 during the day shift on 02/28/26, that she usually works on Unit 3 and knew Resident #1 very well.Nurse #2 said on 02/28/26 at approximately 7:40 A.M., she was at her medication cart next to the nurses' station and CNA #1 wheeled Resident #1 and parked him/her in his/her wheelchair next to her. Nurse #2 said Resident #1 repeated the words, I hurt, I hurt and that he/she was hugging him/herself. Nurse #2 said Resident #1 often has a difficult time expressing him/herself and often speaks in word salad (confused mixture of seemingly random words and phrases) and was unable to verbalize what he/she was upset about.Nurse #2 said if staff are providing care for a resident and they tell you to stop you should not continue, whether they have dementia or not.During a telephone interview on 02/28/26 at 4:15 P.M., the Weekend Supervisor said she was on duty during the day shift on 02/28/26 and was aware of the situation regarding Resident #1 and CNA #1.The Weekend Supervisor said she was aware there was a problem on Unit 3 when Nurse #1 and Nurse #2 called (exact time unknown) to tell her they wanted to send CNA #1 back to Unit #2. The Weekend Supervisor said she instructed Nurse #1 and Nurse #2 to ask CNA #1 to leave Unit 3 and report to the Unit 2 break room.The Weekend Supervisor said Nurse #1 told her that she went to Resident #1's room twice to assist CNA #1 and that Nurse #1 had also said that CNA #1 was not gentle in her approach with regard to caring for Resident #1.The Weekend Supervisor said she attempted to speak with Resident #1, that Resident #1 said something like, she hurt me, said that his/her arms were crossed in front of him/her and said he/she appeared anxious.The Weekend Supervisor said she called the Director of Nursing (DON) told her about the incident, and that the DON interviewed CNA #1 in her presence via speakerphone.The Weekend Supervisor said the DON asked CNA #1 to explain how she provided care to Resident #1 that morning, that CNA #1 said Resident #1 was not acting like him/herself, and said he/she said no and stop while she was providing care.The Weekend Supervisor said the DON asked CNA #1 if she stopped care after Resident #1 said no and stop and that CNA #1 told them she had not stopped. The Weekend Supervisor said CNA #1 refused to write a statement about the incident and that she told them quit.The Weekend Supervisor said it was the expectation of staff, that when they are providing care and a resident is resisting care or verbally says to stop, that the caregiver stops what they are doing.During an interview on 02/28/26 at 4:45 P.M., the DON said on 02/28/26 the Weekend Supervisor called her to tell her nursing reported a concern regarding care provided by CNA #1 to Resident #1. The DON said she provided education to CNA #1 immediately and told her it was expected if a resident ever says no, or stop, that you stop whatever it is you are doing.