

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER Penacook Place, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Water Street Haverhill, MA 01830	
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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was severely cognitively impaired and dependent on staff to meet his/her care needs, the facility failed to ensure staff consistently implemented and followed their abuse policy related to protection and reporting abuse allegations, when on 12/13/25 Certified Nurse Aide (CNA) #2 witnessed, but did not immediately report, that Resident #1 was allegedly verbally abused by a staff member, and waited until 12/16/25 (three days later) to report the incident, therefore placing Resident #1 and other residents on the unit at risk for potential abuse. Findings include: Review of the Facility Policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 03/01/25, indicated it is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment immediately to the Administrator of the facility. The Policy indicated the facility will develop and operationalize policies and procedures for the protection of residents and for the reporting of abuse. The Policy indicated its purpose was to assure the facility is doing all that is within its control to prevent occurrences. The Policy indicated it would protect residents from harm during an investigation. Review of Resident #1's clinical record indicated his/her diagnoses included Dementia with Behavioral Disturbance and Anxiety. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 11/04/25, indicated he/she had severely impaired cognition, disorganized thinking and rejected care daily. Review of Resident #1's Care Plan, reviewed and renewed with his/her November 2025 MDS, indicated he/she was at risk for altercation in mood, such as agitation, tearfulness changes in mood, due to dementia with behavioral disturbance and disorientation. The Care Plan indicated that interventions included to administer medications, behavioral health consults as needed and to monitor for acute episode feelings or sadness. During a telephone interview on 01/28/26 at 1:20 P.M., CNA #2 said on 12/13/25 at 6:30 P.M., while supervising residents with severe cognitive impairment in the activity room, CNA #1 entered and Resident #1 told CNA #1 loudly to get out of my uncle's restaurant! CNA #2 said CNA #1 responded back loudly mind your own business, I am not talking to you. CNA #2 said Resident #1 then stated to CNA #1 loudly listen you ugly bitch, and that CNA #1 replied back to Resident #1 saying you're an ugly bitch, and left with another resident who had also been sitting in the activity room, to provide his/her care. CNA #2 said she did not confront CNA #1 at the time of the incident because she felt CNA #1 would not acknowledge that she was wrong to speak to Resident #1 in that manner. CNA #2 said she did not report the incident to anyone until around 8:00 A.M. on 12/16/25 (three days later). CNA #2 said she forgot about the incident until she overheard Unit Manager #1 and Nurse #1 discussing Resident #1. CNA #2 said she reported the incident to them and assumed they would report it to the Director of Nurses. CNA #2 said around 9:00 A.M. on 12/16/25 while speaking with the Scheduling Coordinator, she told her about the incident. CNA #2 said she did not mention to her that Unit Manager #1 and Nurse #1 were already made aware of it. CNA #2 said the Scheduling Coordinator immediately reported the incident to the Human Resource Director. CNA #2 said she thought</p> <p>(continued on next page)</p>		

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>allegations of abuse needed to be reported to the Director of Nurses (DON) or the Administrator within two hours of the incident. CNA #2 said she did not report it until 12/16/25 (three days later) because the incident occurred in the evening over the weekend and neither of them (DON or Administrator) were at the Facility. CNA #2 said she had not received instruction on what to do if neither the DON and/or the Administrator were in the Facility. As a result of CNA #2 waiting three days to report the incident, CNA #1 continued to work on Facility unit(s) placing the residents at risk for potential abuse. Review of CNA #1's Time Detail indicated she worked the following:- 12/13/25; (incident occurred around 6:30 P.M.) CNA #1 worked until 10:42 P.M. -12/14/25; from 3:35 P.M. to 10:57 P.M.-12/16/25; from 3:55 P.M. to 5:02 P.M. (when suspended) During an interview on 01/20/26 at 1:35 P.M., Nurse #1 said she did not recall receiving any information on 12/16/25 from CNA #2 related to Resident #1 being called a bitch by a CNA or any other verbally abusive statement. During a telephone interview on 01/30/26 at 11:25 A.M., Unit Manager #1 said she did not recall receiving any information on 12/16/25 from CNA #2 related to Resident #1 being called a bitch by a CNA or any other verbally abusive statement. During an interview on 01/20/26 at 2:10 P.M., the Scheduling Coordinator said mid-morning on 12/16/25, CNA #2 came to her office and stated that over the weekend she witnessed CNA #1 tell Resident #1 to mind his/her own business. The Scheduling Coordinator said CNA #2 told her that Resident #1 replied listen you ugly bitch to CNA #1, and CNA #1 repeated it back at Resident #1 stating no, you listen you ugly bitch. The Scheduling Coordinator said she immediately reported the allegation of verbal abuse to the Human Resource Director. During an interview on 01/20/26 at 2:35 P.M., the Human Resource Director said on 12/16/25 at around 2:45 P.M., the Scheduling Coordinator along with CNA #2 reported to her that she (CNA #2) witnessed CNA #1 tell Resident #1 to mind his/her own business and repeated back to Resident #1 the statement to get out, you ugly bitch. The Human Resource Director said she proceeded to a meeting that was going to be held with the DON and another staff member for an unrelated issue. The Human Resource Director said she did not immediately report the alleged incident of abuse to the DON but waited to report it after the meeting ended around 4:00 P.M., an hour later. During an interview on 01/20/26 at 9:30 A.M., the DON said it was difficult to recall, but said she thought the Scheduling Coordinator reported to her at 3:00 P.M. on 12/16/25 that on 12/13/25 CNA #2 witnessed CNA #1 allegedly verbally abused Resident #1. The DON said she discovered that CNA #1 was working on the Unit on 12/16/25, immediately removed her from it and began to investigate. The DON said it was expected that staff members immediately report any alleged incidents of abuse per Facility Policy.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was severely cognitively impaired, the Facility failed to ensure staff consistently implemented and followed policies and procedures to immediately report an altercation of abuse to Administrative staff as required, so the Facility could report the incident to the State Survey Agency, within the required time frames. On 12/13/25 although a staff member witnessed Certified Nurse Aide (CNA) #1 engage in a suspected verbally abusive altercation with Resident #1, it was not reported to Administration until 12/16/25, and therefore not reported to their State Survey Agency, until three days later. Findings include: Review of the Facility Policy titled Abuse, Exploitation or Misappropriation-Reporting and Investigating, dated September 2022, indicated all reports of resident abuse are reported to local, state and federal agencies (as required by current regulations). The Policy indicated that if abuse is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The Policy indicated the administrator or individual making the allegation immediately reports his or her suspicion to the following agencies which included the state licensing/certification agency responsible for surveying/licensing the facility. The Policy indicated that immediately is defined as within two hours of an allegation involving abuse. Review of Resident #1's clinical record indicated his/her diagnoses included Dementia with Behavioral Disturbance and Anxiety. During a telephone interview on 01/28/26 at 1:20 P.M., CNA #2 said on 12/13/25 at 6:30 P.M., while supervising residents with severe cognitive impairment in the activity room, Resident #1 told CNA #1 get out of my uncle's restaurant! and CNA #1 responded back loudly mind your own business, I am not talking to you. CNA #2 said Resident #1 then stated to CNA #1 loudly listen you ugly bitch, and said CNA #1 replied back to Resident #1 you're an ugly bitch, and left the room with another resident that had also been in the activity room, to provide his/her care. CNA #2 said she did not report the incident to anyone until around 8:00 A.M. on 12/16/25. CNA #2 said she forgot about the incident until she overheard Unit Manager #1 and Nurse #1 discussing Resident #1. CNA #2 said she reported the incident to them. CNA #2 said around 9:00 A.M. on 12/16/25 while speaking with the Scheduling Coordinator, she also told her about the incident. CNA #2 said the Scheduling Coordinator immediately reported the incident to the Human Resource Director. CNA #2 said she did not report it until 12/16/25 (three days later) because the incident occurred in the evening over the weekend and neither of them (DON and Administrator) were at the Facility. During an interview on 01/20/26 at 1:35 P.M., Nurse #1 said she did not recall receiving any information on 12/16/25 from CNA #2 related to Resident #1 being called a bitch by a CNA or any other verbally abusive statement. During a telephone interview on 01/30/26 at 11:25 A.M., Unit Manager #1 said she did not recall receiving any information on 12/16/25 from CNA #2 related to Resident #1 being called a bitch by a CNA or any other verbally abusive statement. During an interview on 01/20/26 at 2:10 P.M., the Scheduling Coordinator said mid-morning on 12/16/25, CNA #2 told her that over the weekend she witnessed CNA #1 tell Resident #1 to mind his/her own business, that Resident #1 replied listen you ugly bitch to CNA #1, and CNA #1 repeated it back to Resident #1 stating no, you listen you ugly bitch. The Scheduling Coordinator said she immediately reported the allegation of verbal abuse to the Human Resource Director. During an interview on 01/20/26 at 2:35 P.M., the Human Resource Director said on 12/16/25 at around 2:45 P.M., the Scheduling Coordinator along with CNA #2 reported to her that she (CNA #2) witnessed CNA #1 tell Resident #1 to mind his/her own business and repeated back at Resident #1 the statement to get out, you ugly bitch. The Human Resource Director said she had a meeting with the DON, and at the end of the meeting she reported what CNA #2 told her. During an interview on 01/20/26 at 9:30</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A.M., the DON said it was difficult to recall but thought the Scheduling Coordinator reported to her at 3:00 P.M. on 12/16/25 that on 12/13/25 CNA #2 witnessed CNA #1 allegedly verbally abuse Resident #1. The DON said she discovered that CNA #1 was working on the Unit on 12/16/25, immediately removed her from it and began to investigate. The DON said it was expected that staff members immediately report any alleged incidents of abuse, per Facility Policy, to enable the Facility to report the incident to the State Agency within two hours of it being known to have occurred. Review of the Health Care Facility Reporting System indicated the Facility's report was created on 12/16/25 at 5:37 P.M. reporting that Resident #1 was allegedly verbally abused by CNA #1, which was three days after the alleged verbally abusive incident took place.</p>		