STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225449	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hathorne Hill Rehabilitation and Healthcare Center	15 Kirkbride Drive Danvers, MA 01923

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 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 interviews, observations, and policy review, the facility failed to ensure staff treated one Resident (#140) in a dignified manner during the dining experience out of a total sample of 26 residents. Specifically, for Resident #140 who was dependent on staff for assistance with meals, the facility failed to provide assistance when his/her meal was delivered.Findings include:Review of the facility policy titled Dignity, dated 2/21, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. When assisting with care, residents are supported in exercising their rights for example, residents are: provided with a dignified dining experience. Resident #104 was admitted to the facility in February 2021 with diagnoses that included dysphagia, cerebral infarction, and macular degeneration. Review of Resident #104's most recent Minimum Data Set (MDS) assessment, dated 10/23/25, indicated he/she scored a 11 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairments. Further review of the MDS indicated he/she requires partial/moderate assistance from staff for eating. On 12/2/25 at 8:25 A.M., the surveyor observed Resident #140 in bed awake with his/her meal left on their bedside table not set up to consume. No staff were present in the room to assist the Resident. On 12/3/25 from 8:24 A.M. to 8:35 A.M., the surveyor observed Resident #140 in bed awake with his/her meal left on their bedside table not set up to consume. No staff were present in the room to assist the Resident. On 12/4/25 from 8:25 A.M. to 8:30 A.M., the surveyor observed Resident #140 in bed awake with his/her meal set up to consume on their over the bed table. No staff were present in the room to assist the Resident. The Resident was observed to not initiate self-feeding. Review of Resident #104's activity of daily living care plan, dated 8/14/25, indicated he/she requires assist with eating. Review of Resident #104's active CNA (Certified Nurse Aide) Kardex (form indicating the need of the Resident), indicated he/she required assist for eating, if coughing occurs, no food/liquids until coughing resolves. Review of Resident #104's dietary assessment, dated 10/20/25, indicated the Resident required Feeding skills: Set-up help/Extensive Assist/Dependent Assist. During an interview on 12/4/25 at 8:30 A.M., CNA #1 said Resident #140 needs assistance from staff to eat and is not sure who delivered his/her tray but they should have assisted the Resident once it was delivered. During an interview on 12/4/25 at 8:31 A.M., Unit Manager #1 said Resident #140 needs assistance from staff to eat because they are unable to see. Unit Manager #1 said staff should not deliver the tray until they are ready to assist the resident. Unit Manager #1 said she expects staff to follow each resident's plan of care.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs), for one Resident (#46) out of a total sample of 26 residents. Specifically, for Resident #46 the facility failed to provide assistance and/or supervision with meals as per the plan of care.Findings include:Review of the facility policy titled Activities of Daily Living (ADLs), dated 4/25, indicated Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. A resident's ability to perform ADLs is measured using clinical tools, including the MDS. Functional decline and improvement are evaluated using the following MDS definitions: Supervision or touching assistance - if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. Partial/moderate assistance - if the helper does less than half the effort. Substantial/maximal assistance - if the helper does more than half the effort. Resident #46 was admitted to the facility in October 2024 with diagnoses that included dysphagia following cerebral infarction, aphasia, and major depressive disorder. Review of Resident #46's most recent Minimum Data Set (MDS) assessment, dated 11/25/25, indicated he/she scored a 1 out of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. Further review of the MDS indicating he/she required supervision/touching assistance from staff for eating. On 12/2/25 at 8:24 A.M., the surveyor observed Resident #46 in bed with his/her food tray set up for consumption. Staff were not present in the room or in the hallway. The Resident was not able to be seen from the hallway. The Resident was observed to not initiate self-feeding. On 12/3/25 from 8:21 A.M. to 8:35 A.M., the surveyor observed Resident #46 in bed with his/her food tray set up for consumption. Staff were not present in the room or in the hallway. The Resident was not able to be seen from the hallway. The Resident was observed to not initiate self-feeding and was sleeping at times. On 12/3/25 from 1:12 P.M. to 1:20 P.M., the surveyor observed Resident #46 in his/her wheelchair with their meal tray set-up to consume. The Resident was observed to not initiate self-feeding. On 12/4/25 from 8:27 A.M. to 8:32 A.M., the surveyor observed Resident #46 in bed with his/her food tray set up for consumption. Staff were not present in the room. The Resident was observed to not initiate self-feeding and was not able to be seen from the hallway. Review of Resident #46's activity of daily living care plan, dated 11/2/25, indicated Provide the individualized diet to the resident and assist as per his/her need. Ensure that the proper assistive devices are used for eating and drinking as indicated. Review of Resident #46's nutrition care plan, dated 11/2/25, indicated monitor for signs and symptoms of aspiration. Review of Resident #46's active Certified Nurse Aide (CNA) Kardex (form that indicates the needs of the Resident), indicated he/she requires tube feeding and water flushes. See MD orders for current feeding orders. Review of Resident #46's Nurse Practitioner (NP) progress note, dated 10/27/25, indicated dysphagia: Strict aspiration precautions. Review of Resident #46's dietary assessment, dated 11/24/25, indicated the Resident required Feeding skills: Supervision/Limited Assist/Extensive Assist/Dependent Assist. Review of Resident #46's nursing progress note, dated 12/1/25, indicated the Resident was assisted with meals. Review of Resident #46's Physiatry progress note, dated 12/1/25, indicated diet is dysphagia advanced texture, regular fluids. Requiring assist. Review of Resident #46's active physician orders, indicated Regular diet, Dysphagia Advanced texture, Regular Fluid consistency. During an interview on 12/4/25 at 8:31 A.M., Unit Manager #1 said she expects staff to follow each resident's plan of care. During an interview on 12/4/25 at 8:33 A.M., Nurse #1 said Resident #46 had a recent stroke and needs assistance with meals. Nurse #1 said if the meal is in the Residents room, then a staff member should be with him/her as they are at risk for chocking. During an interview on 12/4/25 at 8:34 A.M., Certified Nurse Aide #2 said Resident #46 should have a staff member with them during meals because they have a hard time feeding themselves. CNA #2 said if a resident is supposed to be supervised or assisted then staff should be with that resident for the duration of their meal at all times.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview the facility failed to ensure that for two out of five staff records reviewed (Nurse #2 and Additional Staff #2), who did not receive the covid vaccination, signed a statement certifying that they are exempt from vaccination and they received information about the risks and benefits of COVID-19 vaccine.Findings include:Review of Nurse #2's personnel health records indicated a facility document titled Covid-19 Vaccine Consent form had a check mark indicating the declination of the covid vaccine, but the document was not signed by the staff member.Review of Additional Staff #2's personnel health records indicated a facility document titled Covid-19 Vaccine Consent form had a check mark indicating the declination of the covid vaccine, but the document was not signed by the staff member.During an interview on 12/3/25 at 1:30 P.M. the Staff Development Coordinator/Infection Preventionist (SDC/IP) said that the Human Resource (HR) Director is responsible for the hiring process, including maintaining the staff employment records and ensuring documents are signed. During an interview on 12/3/25 at 1:35 P.M., the Human Resource (HR) Director said that the SDC/IP should be ensuring the staff sign the covid consent forms as she is the nurse. The HR director said that the SDC/IP is in charge of the vaccine consents during the hiring process. The HR Director then said that there is no facility policy for what to include in the personnel records or how to maintain them. She then said she has a new hire check off list that she follows but was not able to produce this list for either staff member.