STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225697	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hadley Pointe Nursing Rehab & Care	20 North Maple Street Hadley, MA 01035

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. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for two of four sampled residents (Resident #1 and Resident #2) who were both alert and oriented and dependent on staff for care, the Facility failed to ensure they were both treated in a dignified and respectful manner, when both residents reported that during the overnight shift on 08/17/25, that Certified Nurse Aide (CNA) #1 was abrupt, rude, did not respect their wishes and treated them in an undignified and disrespectful manner. Findings include:Review of the Facility Policy titled Resident Rights, dated as revised 11/28/16, indicated the 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/her quality of life, recognizing each resident's individuality. The Policy indicated the resident has the right to be treated with respect and dignity.1) Resident #2 was admitted to the Facility in August 2025, diagnoses included acute bronchitis, moderate dementia with mood disturbance, and osteoarthritis, multiple sites.Review of Resident #2's Medical Record indicated he/she was responsible for making his/her own medical decisions.Review of Resident #2's Activities of Daily Living (ADL) Baseline Care Plan, dated 08/15/25, indicated he/she was dependent on staff for bathing, bed mobility and transfers due to weakness. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/18/25, indicated that on 08/17/25 at 5:45 A.M., Resident #2 alleged that Certified Nurse Aide (CNA) #1 was directing profanity at him/her during care and that his/her roommate witnessed the incident. Review of the Facility's Investigation Summary, dated 08/23/25, indicated that CNA #1 entered Resident #2's room, whipped off the sheets and started providing care without explaining what she was doing. The Summary indicated that Resident #2 alleged that CNA #1 was rude and rough during care. The Summary further indicated Resident #4, the roommate of Resident #2, said that he/she heard CNA #1 use profanity when providing care to Resident #2. Resident #4 was admitted to the Facility in July 2025. Resident #4's most recent Minimum Data Set (MDS) Assessment, dated 08/11/25, indicated Resident #4 was cognitively intact with a score of 15 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). During a telephone interview on 09/16/25 at 11:12 AM, Resident #2 said that during his/her short term stay at the Facility in August of 2025, CNA #1 provided him/her care on two occasions and was rude and abrupt both times. Resident #2 said that early one morning (unable to recall exact date/time), when it was still dark outside, CNA #1 entered his/her room and without explaining what she was going to do, she abruptly pulled back the bed sheet and started washing the front of his/her body. Resident #2 said that when he/she did not move fast enough, CNA #1 got frustrated and directed profanity at him/her, saying What the fuck, I don't have time for this. and Move your fucking ass, I don't have all day. Resident #2 said that CNA #1 acted extremely unprofessional and that her attitude and demeaning language made him/her feel upset and very agitated. Resident #2 further said that his/her roommate overheard the entire exchange and that they both reported the incident to Nurse #1 the morning of the incident. During an interview on 09/16/25 at 11:00 A.M., Resident #4 said that he/she heard CNA #1 speaking disrespectfully and directing profanity towards Resident #2. Resident #4 said that he/she was in bed, and that CNA #1 and Resident #2 were on the other side of the privacy curtain. Although Resident #4 could not recall the exact date, he/she said the incident occurred very early one morning in August 2025, and that he/she reported the incident to Nurse #1 that same morning. Resident #4 further said that CNA #1 entered the room with a chip on her shoulder and while assisting Resident #2 with his/her care she used harsh language, telling Resident #2 move your fucking ass, I haven't got all day.During a telephone interview on 09/18/25 at 4:23 P.M., Certified Nurse Aide (CNA) #1 said that on 08/16/25 while she was working the evening shift, her boss at the staffing agency pressured her to stay for the overnight shift, into 08/17/25. CNA #1 said that she agreed to stay but said she told her boss that she was very tired and could only work until 5:00 A.M., that day.CNA #1 said that she made a second set of rounds on her residents at 4:00 A.M. so she could leave work by 5:00 A.M. CNA #1 said that Resident #2 was awake when she entered his/her room, and she helped him/her get washed. CNA #1 said she did not use profanity but acknowledged that she got agitated with Resident #2, and told him/her that he/she was aggravating her and that she had wanted to leave by 5:00 A.M. CNA #2 further said, I know I should not have said those things to Resident #2 and that I should have left and got the Nurse instead. During an interview on 09/16/25 at 08:20 A.M., Nurse #1 (which also included a review of her written witness statement dated 08/17/25) said that at 5:45 A.M. on 08/17/25, Resident #2 told her that CNA #1 had come into his/her room that morning to wash him/her up in bed and

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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 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. Based on records reviewed and interviews, for one of four residents (Resident #3) who reported a complaint about being neglected to staff member and requested that the staff member write and submit a written complaint on his/her behalf, the Facility failed to ensure that staff implemented and followed their abuse policy, 1) related to the need to immediately report an allegation of abuse to the Administrator and/or Director of Nurses, and 2) for one of four sampled employee files (Activity Assistant #1), the Facility failed to ensure that a Massachusetts Nurse Aide Registry (NAR) background check was conducted upon hire. Findings include:Review of the Facility Policy titled Abuse Prohibition, dated as revised 10/24/22, indicated that anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of what shift worked.Further review of the Policy indicated that potential employees would be screened for a history of abuse, neglect or misappropriation, including checking with the appropriate licensing boards and registries.1) Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/18/25, indicated that Resident #3 accused Certified Nurse Aide (CNA)#2 of neglect. The Report indicated that Resident #1 alleged that after he/she asked CNA #2 for incontinence care, he/she waited three hours for assistance.Review of a Handwritten Statement, (written by an unidentified staff member at Resident #3's request) signed and dated by Resident #3 on 08/15/25, indicated that he/she sat in an incontinence brief that was soiled with feces for three hours, despite asking CNA #2 for assistance.Resident #3 was admitted to the Facility in June 2025, diagnoses included depression and unsteadiness on feet. Review of Resident #3's admission Minimum Data Set (MDS) Assessment, dated 07/04/25, indicated Resident #3 was cognitively intact with a score of 15 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). Further review of the Assessment indicated Resident #3 required substantial assistance from staff with Activities of Daily Living (ADLs) and mobility. During an interview on 09/16/25 at 11:23 A.M., Resident #3 said he/she did not remember all the details of the incident involving CNA #2 but said he/she asked a CNA (exact name unknown) to write a complaint describing the incident and to give it to the Administrator. Resident #3 said he/she had the CNA write the statement because his/her own handwriting was atrocious. During an interview on 09/16/25 at 4:30 P.M., the Administrator said that he was not aware of Resident #3's allegation of neglect involving CNA #2, until he found a Handwritten Statement (that was signed and dated 8/15/25) under his door on 08/18/25 (three days later). The Administrator said the incident was reported to DPH on 08/18/25 when he discovered Resident #3's Statement. The Administrator said he was unable to identify who completed the statement for Resident #3 and left it for him. The Administrator said the expectation was for staff to report any allegations of abuse immediately to their supervisor and/or administration. 2) Review of Activity Assistant #1's personnel file indicated that he was hired on 08/04/25. Further review of the File indicated that there was no documentation to support that a Massachusetts NAR background check was conducted upon hire.During an interview on 09/16/25 at 4:00 P.M., the Human Resource (HR) Representative said that he was new to his HR role, having started in May 2025. The HR Representative said he had only performed NAR checks on nurses and CNAs upon hire and did not realize they were required for all potential employees. During an interview on 09/16/25 at 4:30 P.M., the Administrator said there was no documentation to support that an NAR check was conducted on Activity Assistant #1.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on records reviewed and interviews, for two of three sampled residents (Resident #1 and Resident #2), the Facility failed to ensure that after the Director of Nurses (DON) #1 was made aware on 08/17/25 at 5:50 A.M., of allegations of abuse made by both of these residents, against Certified Nurse Aide #1, that the allegations were reported to the Department of Public Health (DPH) within two hours as required.Findings include:Review of the Facility Policy titled Abuse Prohibition, dated as revised 10/24/22, indicated that immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will Report allegations [to the appropriate state and local authorities] involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 08/17/25 at 10:08 A.M., indicated that Resident #1 alleged that Certified Nurse Aide, (CNA) #1 was rough while providing incontinence care. The Report indicated that CNA #1 took hold of Resident #1's left leg and rolled him/her onto his/her side, which caused pain in his/her left hip. The Report further indicated that when Resident #1 asked CNA #1 to stop, CNA #1 began yelling at him/her. Review of HCFRS indicated a second abuse allegation, involving CNA #1 and Resident #2, was included in the Report submitted on 8/17/25 at 10:08 A.M., and the Department of Public Health (DPH) directed the Facility to resubmit the second incident separately as required. Review of the Report submitted by the Facility via HCFRS, dated as submitted on 08/18/25 at 6:54 P.M., indicated that on 08/17/25 at 5:45 A.M., Resident #2 alleged that Certified Nurse Aide (CNA) #1 directed profanity at him/her during care and that his/her roommate witnessed the incident. Review of a Facility Investigation Summary, dated 08/22/25, indicated the Former DON #1 (hereby referred to as DON #1) received a call at 5:50 A.M., about the incident involving CNA #1 and Resident #1.Review of a Facility Investigation Summary, dated 08/23/25, indicated DON #1 received a call at 7:30 A.M., about the incident involving CNA #1 and Resident #2.During a telephone interview on 09/17/25 at 12:20 P.M., the Director of Nurses (DON) #1 said that he did not recall the exact time he was notified of both abuse allegations.During an interview on 09/16/25 at 4:30 P.M., the Administrator said that staff are expected report any allegations of abuse to Administration immediately, and that administration, in turn, must report those allegations to DPH within two hours as required.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on records reviewed and interviews, after being made aware on 8/17/25, of two separate allegations of resident abuse (the first by Resident #2 and the second a little later that same morning by Resident #1) by the same accused staff member (Certified Nurse Aide #1), the Facility failed to ensure that after being made aware of the second allegation, that they obtained and maintained evidence that a thorough investigation was completed, including but not limited to obtaining the accused staff member witness statement and/or an interview about the second allegation. Findings include:Review of the Facility Policy titled Abuse Prohibition, dated as revised 10/24/22, indicated that anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of what shift worked. The Policy indicated that an initial investigation would be initiated within 24 hours and would be thoroughly documented within the risk management portal and would ensure that documentation of witness interviews is included.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/18/25, indicated that on 08/17/25 at 5:45 A.M., Resident #2 alleged that Certified Nurse Aide (CNA) #1 was directing profanity at him/her during care and that his/her roommate witnessed the incident. Review of the Facility Investigation file indicated there was no documentation to show that the accused CNA (#1) was interviewed about the incident involving Resident #2 on 08/17/25, and/or that a written witness statement was obtained and maintained by the Facility. During a telephone interview on 09/08/25 at 4:23 P.M., Certified Nurse Aide (CNA) #1 said she worked a double shift at the Facility through a Staffing Agency, beginning on 08/16/25 at 3:00 P.M. and ending on 08/17/25 at 5:30 A.M. CNA #1 said that said that around 5:30 A.M. on 08/17/25, Nurse #1 asked her to complete a written statement regarding an allegation of abuse that had been made by a resident she had on her assignment, and she was directed to leave the Facility. CNA #1 said that later that morning the Agency informed her of a second abuse allegation involving another resident on her assignment. CNA #1 said that although a Police Sergeant contacted her about the second allegation, no one from the Facility reached out for a statement regarding the second allegation.During an interview on 09/16/25 at 08:20 A.M., Nurse #1 said an allegation of abuse involving Resident #1 and CNA #1 was reported to her around 5:30 A.M. on 08/17/25. Nurse #1 said she instructed CNA #1 to complete a witness statement and to leave the Facility, pending investigation. Nurse #1 said that a second allegation of abuse involving CNA #1 was reported at 5:45 A.M., after she (CNA #1) had left the Facility therefore, she was unable to obtain a written statement from CNA #1, about the second allegation. During a telephone interview on 09/17/25 at 12:20 P.M., the Former Director of Nurses (hereby referred to as DON #1) said that he notified the Staffing Agency of the second allegation of abuse involving CNA #1 and asked that she no longer be assigned to the Facility. DON #1 said he did not reach out to CNA #1 for a statement as part of his investigation. During an interview on 09/16/25 at 3:50 P.M., the Current Director of Nurses (DON #2) said there was no documented evidence that a statement was obtained from the accused CNA (CNA #1) regarding the verbal abuse allegation, or that she was interviewed, as required.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of four sampled residents (Resident #1), who had limited movement in his/her left leg and required assistance from two staff members when turning and repositioning in bed, the Facility failed to ensure staff consistently implemented and followed his/her care plan interventions related to bed mobility, when on 08/17/25, during the overnight shift, Certified Nurse Aide (CNA) #1 turned and repositioned Resident #1 without another staff member present to assist her, which caused him/her to experience pain. Findings include:Review of the Facility Policy titled: Person-Centered Care Plan, dated as revised 10/24/22, indicated the Facility must develop and implement a person-centered care plan for each patient that includes measurable objectives and timetables to meet a patient's medical, nursing, nutrition, mental and psychosocial needs that are identified in the comprehensive assessments. Further review of the Policy indicated the Care Plan must be customized to each patient's needs and describe services to be furnished. The Policy indicated that the Care Plan will be communicated to appropriate staff, patient, patient representative and family.Resident #1 was admitted to the Facility in August 2019, diagnoses included osteoarthritis, multiple sites, chronic pain syndrome, diabetes mellitus and major depressive disorder, recurrent.Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/19/25, indicated Resident #1 was cognitively intact with a score of 15 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)Further review of the Assessment indicated Resident #1's range of motion in the lower extremities was limited on both sides, and that he/she was totally dependent on staff for Activities of Daily Living (ADLs) and mobility.Review of Resident #1's Activities of Daily Living (ADL) Care Plan, dated as reviewed 07/10/25, indicated he/she had limited range of motion in the left leg. The Care Plan identified that Resident #1 required assistance from two staff members for bed mobility and positioning in bed. The Care Plan further indicated that Resident #1 required a mechanical lift for transfer with assistance from two staff members Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/17/25, indicated at 5:30 A.M., Resident #1 alleged that Certified Nurse Aide, (CNA) #1 was rough while providing incontinence care. The Report indicated that CNA #1 took hold of Resident #1's left leg and rolled him/her onto his/her side, which caused pain in his/her left hip. The Report further indicated that when Resident #1 asked CNA #1 to stop, CNA #1 continued with the movement. During an interview on 09/16/25 at 11:12 AM, Resident #1 said that the first time CNA #1 provided his/her care was during the incident on 08/17/25 just before 5:00 A.M. Resident #1 said that staff usually crossed his/her legs at the ankles when they rolled him/her and that he/she did not have a chance to explain that before CNA #1 suddenly grabbed his/her left leg without any warning, bent it upward, and pulled on it to roll him/her over. Resident #1 said he/she told CNA #1, You're hurting me, let go of my leg, but CNA #1 continued moving him/her until he/she was on his/her side, ignoring his/her complaint of pain. Resident #1 said that since he/she was already positioned on his/her side, he/she allowed CNA #1 to provide incontinence care and that CNA #1 was not gentle during the process. Resident #1 further said that the Facility staff did not consistently provide assistance from two staff members when assisting him/her with bed mobility.During a telephone interview on 09/18/25 at 4:23 P.M., Certified Nurse Aide (CNA) #1 said she was aware that Resident #1's Care Plan indicated that he/she required assistance from two staff members with bed mobility. CNA #1 further said that she believed she could move Resident #1 on her own if he/she helped. CNA #1 said that during rounds on 08/17/25, before 5:00 A.M. (exact time unknow), she rolled Resident #1 in bed, without assistance from another staff member because she was too busy to get help. CNA #1 said that Resident #1 stopped helping while she was rolling him/her and that she (CNA #1) would have stopped rolling him/her when asked but continued because she did not want to hurt her own back. CNA #1 said she did not mean to hurt Resident #1 during care.During an interview on 09/16/25 at 4:30 P.M., the current Director of Nurses (DON) #2 said that CNAs have access to reference the care plan interventions in the electronic medical record where they document.DON #2 said that Resident #1's Care Plan indicated that he/she required assistance from two staff members for bed mobility, and that CNA #1 should not have rolled Resident #1 without assistance from a second staff member.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on records reviewed and interviews, for two of four sampled employee personnel files (Certified Nurse Aide, (CNA) #2 and CNA #4), the Facility failed to ensure CNA #2 and CNA #4 received training upon orientation that included the prohibition of all forms of abuse, neglect, exploitation and misappropriation of resident property as required by Federal Regulations, and in accordance with Facility Policy.Findings include: Review of the Facility Policy titled Abuse Prohibition, dated as revised 10/24/22, indicated that abuse prohibition training and reporting obligations would be provided to all employees at orientation and a minimum of annually.Review of Certified Nurse Aide (CNA) #2's personnel file indicated that she was hired on 07/07/24. Further review of the File indicated that there was no documentation to support CNA #2 had received education on abuse during orientation, in accordance with the Facility's Abuse Prohibition Policy. Review of Certified Nurse Aide (CNA) #4's personnel file indicated that she was hired on 08/12/25. Further review of the File indicated that there was no documentation to support CNA #2 had received education on abuse during orientation, in accordance with the Facility's Abuse Prohibition PolicyDuring an interview on 09/16/25 at 4:30 P.M., the Administrator said that he had no documentation to support that CNA #2 and CNA #4 had received education on Abuse Prohibition, in accordance with the Facility's Policy.