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	01/20/2026

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 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 records reviewed and interviews, for one of three sampled residents (Resident #2), who was severely cognitively impaired, and was transferred to the hospital Emergency Department (ED) for an evaluation after hitting a staff member, the facility failed to ensure Resident #2 was allowed to return to the Facility once cleared by the hospital, and considered him/her discharged at the time of transfer.Findings include:Review of the Facility Assessment (document that includes an evaluation of the resident population and its needs based on evidence based, data driven models) dated last activity, 01/14/25, indicated the [NAME] Unit (Memory Care) provided specialized care to residents with all types of dementia including Alzheimer's, vascular, frontotemporal, and mixed dementia. The Facility Assessment indicated that Memory Care staff had specialized education and training in the care of individuals with dementia and that the Facility utilized a mental health agency for behavior management interventions including psychotherapy and medication management.Review of the facility policy titled, Resident Transfer and Discharge, dated 2025, indicated that residents have a right to remain in the Facility and that discharging a resident is a violation of this right unless the Facility can demonstrate that the conditions that allow for a transfer or discharge are met and that each resident is permitted to remain in the Facility unless it can demonstrate that the condition that allow for a transfer or discharge are met.Documentation in the resident's medical record shall include the basis for the transfer, the resident needs that cannot be met in the Facility, the Facility's attempt to meet the resident's needs, and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the Facility.Residents who are sent to an acute care setting such as a hospital, whether for an emergency or routine treatment/planned procedures, shall be permitted to return to the Facility.Without an assessment of the resident status and needs at the time of proposed return to the Facility, there can be no determination that the resident's needs cannot be met and/or that the safety or health of individuals would be endangered.The Facility shall document the danger that the failure to transfer or discharge would pose to other residents.Because the Facility was able to care for the resident prior to the hospitalization or therapeutic leave, documentation related to the basis for discharge shall clearly show why the Facility can no longer care for the resident.The Facility shall develop and implement policies for bed-hold and permitting residents to return following hospitalization or therapeutic leave. These policies shall apply to all residents, regardless of their payment source and provide that residents who seek to return to the Facility within the bed-hold period defined in the State plan are allowed to return to their previous room, if available.The Facility shall notify the resident and the resident's representative(s) of the transfer or discharge and the reason for the move in writing in a language and manner they understand. Resident #2 was admitted to the Facility in November 2025, diagnoses included encephalopathy (altered brain function) vascular dementia with behavioral disturbance, transient (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ischemic attack (TIA-temporary blockage of blood flow to the brain causing stroke like symptoms), alcohol abuse and wandering.Review of Resident #2's Minimum Data Set (MDS) assessment, dated 12/09/25, indicated he/she was severely cognitively impaired and required supervision for eating, hygiene, dressing and ambulation.Review of Resident #2's Medical Record indicated the Resident had an invoked Health Care Proxy.Review of Resident #2's Payor Information indicated his/her primary payer source was Medicaid.Review of Resident #2's Nurses Progress Note, dated 12/15/25, indicated the Resident hit Certified Nurse Aide (CNA) #1 on the head and neck. The Note indicated that it was decided by management and Nurse #2, that Resident #2 was to be sent out of the facility to the Emergency Department (ED) for evaluation and possible referral to a different facility. The Note indicated Resident #2 was transferred to the hospital.During a telephone interview on 01/21/26 at 11:05 A.M., the Hospital Case Manager (CM) said that Resident #2 had remained at the hospital since his/her transfer from the Facility on 12/15/25 (38 days). The CM said the Hospital contacted the facility on 12/16/26 and 12/18/25 regarding the Resident's ability to return to the Facility when medically ready for discharge and the Facility said they would not readmit him/her. The CM said that on 01/6/26 and on 01/7/26, the Facility was contacted again regarding Resident #2's return to the Facility but that the Facility had not responded. The CM said that Resident #2 was cooperative with care, walking the hallways with supervision, and had been medically stable for discharge for a very long time.During a telephone interview on 01/28/26 at 3:30 P.M. the Facility Business Office Manager (BOM) said Resident #2's payor source was Medicaid and that he/she had been eligible for a 20-day bed-hold when he/she was transferred to the hospital on [DATE]. The BOM said that Resident #2 had initially been placed on a Hospital Leave Bed Hold on 12/15/25, but a few days later his/her status was changed to discharged , effective 12/15/25.Review of the Facility Bed Availability Report, for the months of December 2025 and January 2026, indicated the Facility had a gender specific bed available (for Resident #2) from 12/16/25 through 01/07/26 and 01/09/26 through 1/20/26.During a telephone interview on 01/22/26 at 7:54 A.M., the Ombudsman said that a few days after Resident #2 was transferred from the Facility to the Hospital, she had received telephone calls from the Hospital Case Manager and Family Member #2 indicating the Facility would not readmit Resident #2 when he/she was ready for discharge. The Ombudsman said she contacted the Facility, and the Administrator told her that the Facility would not readmit Resident #2.Review of Resident #2's Medical Record indicated there was no documentation to support that the Facility had determined that Resident #2's needs could not have been met in the Facility or the attempts the Facility had made to meet his/her needs.During an interview on 01/20/26 at 4:15 P.M., the Director of Social Service (DSS) said she was unable to provide documentation related to which of Resident #2's needs that could not have been met in the Facility or the attempts the Facility had made to meet his/her needs. The DSS was unable to provide any documentation to support that that either Health Care Agent had been notified in writing of the reason for transfer or plan to discharge.During a telephone interview on 01/21/26 at 9:06 A.M., Family Member #1 said the Facility had called him a few days after Resident #2 was transferred to the Hospital ED and informed him that the Facility did not think they could meet Resident #2's needs. Family Member #1 said he did not know why the Facility could not meet Resident #2's needs, or what the Facility had done to try to meet his/her needs. Family Member #1 said he had not received any written notification regarding Resident #2's transfer and discharge.During a telephone interview on 01/27/26 at 4:35 P.M., Family Member #2 said she had requested that Resident #2 be re-admitted to the Facility upon discharge from the hospital. Family Member #2 said after the Hospital Case Manager informed them that Resident #2 would not be allowed to return to the Facility, she contacted the State Ombudsman's office. Family Member #2 said (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #2 remains stuck at the hospital and that she would like a place for Resident #2 to live. Family Member #2 said she had not been contacted by the facility or provided written notification regarding Resident #2's transfer and discharge.During an interview on 01/20/26 at 5:00 P.M., the Administrator said that the interdisciplinary team and himself had reviewed the incident that had occurred with Resident #2 on 12/15/25 and determined that they could not handle him/her and that Resident #2 could not come back to the Facility. The Administrator said that an admission Clinical Liaison (a Facility staff member that reviews potential admissions to a facility) went to the Hospital to see Resident #2 and had met with the Case Manager prior to the decision not to readmit Resident #2. The Administrator said he was unable to provide documentation of communication between the admission Clinical Liaison and the hospital, and he was unable to provide documentation indicating what needs Resident #2 had that could not be met at the Facility.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #2), the facility failed to ensure they notified the resident and the resident's representative(s) of the intent to transfer and/or intent to discharge and the reasons for the move in writing, and failed to send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman, as required.Findings include:Review of the Facility Policy titled, Resident Transfer and Discharge Policy and Procedure, dated, 2025, indicated that before the Facility transfers or discharges a resident, the Facility shall notify the resident and the resident representative(s) of the transfer or discharge and the reason for the move in writing and in a language and manner they understand.The Facility shall send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman and maintain evidence that the notice was sent.Contents of the notice shall include a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such request; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. The notice will include the name, address and telephone number of the Office of the State Long-Term Care Ombudsman.Notice shall be made as soon as practicable before transfer or discharge when an immediate transfer or discharge is required by the resident's urgent medical needs.Resident #2 was admitted to the Facility in November 2025, diagnoses included encephalopathy (altered brain function) vascular dementia with behavioral disturbance, transient ischemic attack (TIA-temporary blockage of blood flow to the brain causing stroke like symptoms), alcohol abuse and wandering.Review of Resident #2's Nursing Progress Note, indicated that he/she was transferred from the Facility and admitted to the hospital on [DATE] and again on 12/15/25.Review of Resident #2's Medical Record indicated there was no documentation to support that the Facility provided written notification of transfer and/or discharge to the resident and/or resident representative or provided a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for Resident #2's transfers from the facility occurring on 11/26/25 and 12/15/25.During an interview on 01/20/26 at 4:05 P.M., the Director of Social Services said she could not provide any documentation to support that the Facility had provided written notification of the intent to transfer and/or discharge to the resident and/or resident representative or to the Office of the State Long-Term Care Ombudsman for Resident #2's transfers occurring on 11/26/25 and 12/15/25, as required.