Printed: 07/06/2025 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED
	225290	B. Wing	04/06/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Haverhill Rehabilitation and Healthcare Center		126 Monument Street Haverhill, MA 01832	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.		
or potential for actual harm	15024		
Residents Affected - Few	 Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who was moderately cognitively impaired, the Facility failed to ensure Resident #1 was treated in a dignified and respectful manner, when on 03/18/23, during the day shift (exact time unknown), in response to Reside #1's request for assistance during a meal, Certified Nurse Aide (CNA) #1 yelled at and used profane language while interacting with him/her resulting in Resident #1 feeling hurt and scared by how CNA #1 treated him/her. Findings include: Review of the Facility's Policy titled Resident Rights and Responsibilities, dated January 2021, indicated 		
every effort will be made to respect, promote and protect the rights and the dignity of our res Review of Resident #1's medical record indicated his/her diagnoses included Dementia.			
	Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 02/16/23, indicated he/she had moderately impaired cognition, and displayed behavioral symptoms not directed toward others.		
	Review of Resident #1's Care Plan related to Activities of Daily Living, dated 02/28/23, indicated he/she had self care deficits due to weakness and reconditioning. The Care Plan indicated he/she required set up help with meals.		
	Review of Resident #1's Care Plan related to behaviors, dated 02/28/23, indicated he/she displayed socially inappropriate/disruptive behavioral symptoms by yelling out even when needs are met, and could be verbally abuse toward staff and other residents. The Care Plan indicated interventions for Resident #1 included that staff maintain a calm, slow understandable approach and redirect when exhibiting socially inappropriate/disruptive, that staff provide comfort measures for basic needs.		
	(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

Facility ID: 225290

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER Haverhill Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 126 Monument Street Haverhill, MA 01832	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	 the day shift (exact time unknown) yelling. Nurse Aide #1 said she hear you. Nurse Aide #1 said as she and words to the effect of stop making u #1 meant by the statement. Nurse a that CNA #1's face was red and she on Resident #1, his/her eyes were a During an interview on 04/06/23 at part of the day shift (exact time unk room when she heard CNA #1 yell are other people who need help. Cl said a few minutes later, she entered #2 said Resident #1 told her words During an interview on 04/06/23 at approximately 9:00 A.M., Resident already on the meal tray in front of exactly what she said to Resident #1 told her words During an interview on 04/06/23 at approximately 9:00 A.M., Resident already on the meal tray in front of exactly what she said to Resident #1 told her words During an interview on 04/06/23 at approximately 9:100 A.M., Resident already on the meal tray in front of exactly what she said to Resident #1 told her words During an interview on 04/07/23 at occurred at approximately 9:15 A.M been observed in the past. Nurse #1 that despite two CNAs not coming to CNA #1 replied she would try. Nurse #1 said at approximately 09: aggressive tone of voice that startle Aide #1, who had come out from th CNA #1 yell stop making us look lik lying in bed with the privacy curtain 	12:30 P.M., Nurse Aide #1 said that or she heard Certified Nurse Aide (CNA) ard CNA #1 say words to the effect of fid d Nurse #1 proceeded toward Resident us look like those people. Nurse Aide # Aide #1 said upon reaching Resident # e appeared to be crying. Nurse Aide (CNA) mown), she was approximately 20 to 30 words to the effect of you're not the on NA #2 said she saw Nurse Aide #1 ent ed Resident #1's room and asked Resi to the effect of l'm scared and my feeli 8:20 A.M., Certified Nurse Aide (CNA) #1 asked for a few things, and then as him/her. CNA #1 said she reacted loud #1. CNA #1 said she may have sworn, ve said words to mean that Resident # ecall Resident #1's reaction. CNA #1 said take a break and to not reenter Reside e and attitude toward Resident #1. CNA tasks and a few people were unable to the effect to reassure CNA #1 had a negative attitude and t1 said she tried to reassure CNA #1 th to work, and if she needed any help, st 15 A.M., while she was at the nurses se ad her. Nurse #1 said she proceeded d the dining room. Nurse #1 said at Reside to bad people, we are not bad people. I partially drawn blocking view of his/he NA #1) walked out of the room she stat	 #1's voice, and that CNA #1 was uck you, not everything is about t #1's room, she heard CNA #1 say: 1 said she did not know what CNA '1's room, she saw CNA #1 exiting. 1 said when she went in to check ed or scared. #2 said on 03/18/23 during the firs: 0 of feet away from Resident #1's ly one on this fucking floor, there er Resident #1's room. CNA #2 dent #1 if he/she was okay. CNA ings are hurt. #1 said on 03/18/23 at ked for his/her spoon, which was lly to this request, but did not recal but did not recal saying the words 1 was not the only person at the hid she remembered shortly ent #1's room. A #1 said she was very stressed out come to work that day. CNA #1 of locate the spoon, she reacted B, just prior to the incident that appeared more stressed than had at she would get through the day, he would help her. Nurse #1 said tation, she heard a loud, own the hallway along with Nurse ent #1's open doorway she heard Nurse #1 said Resident #1 was r face. Nurse #1 said CNA #1

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	 #1's first name accurately. Nurse # bitch, if she has any kids, I'd feel ba if he/she was hurt. Nurse #1 said R Nurse #1 said she told CNA #1 she to return to Resident #1's room. Nu to being contacted at approximately the DON spoke with CNA #1, sent Nurse #1 said it was not until then 1 #1. During an interview on 04/06/23 at presence of the Administrator, said that CNA #1 yelled and swore at Re in this place. The DON, said she w. spoke with CNA #1 on the telephor and admitted she yelled at Resider but that it was not nice so they imm During an interview on 04/12/23 at Facility's investigation, although the 3/18/23 that Certified Nurse Aide # 	te the room, Resident #1 said do you k 1 said Resident #1 stated words to the ad for them, she just hollered at me. No Resident #1 replied stating words to the a could not speak to Resident #1 that w irrse #1 said although she intended to, s y 2:00 P.M. on 03/18/23 by the Directo her home and requested she (Nurse # that she became aware that CNA #1 w 10:00 A.M. and at 12:40 P.M., the Directo is Nurse Aide #1 reported to her at appre- esident #1 stating words to the effect of as not in the facility when she was notif the. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she at #1. The DON said CNA #1 told her she the that she see the second to the second	effect of boy, she is a grumpy urse #1 said she asked Resident #1 effect of no, just my feelings. vay, told her to take a break and not she did not report the incident prior r of Nurses (DON). Nurse #1 said 1) obtain statements from the staff. as overheard swearing at Resident ector of Nurses (DON), in the oximately 2:30 P.M. on 03/18/23 f Fuck you you're not the only one fied, but said she immediately got very angry, it was a tough day call what she said to Resident #1, ment pending investigation. or of Nurses (DON) said based the ng what time during the day shift on n at Resident #1, said it was

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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	Develop and implement policies an	d procedures to prevent abuse, negled	t, and theft.
Level of Harm - Minimal harm or potential for actual harm	15024		
Residents Affected - Few	Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was moderately cognitively impaired, the Facility failed to ensure that staff implemented and followed their al policy related to the need to immediately report an allegation of potential verbal abuse to the Administra Director of Nurses in an effort to protect other residents from potential abuse. When on 3/18/23 during the first part of the day shift, staff members overheard Certified Nurse Aide (CNA) #1 engage in verbal altercation with Resident #1, but the incident was not reported to Administration until several hours later		
	Findings include:		
	Exploitation, dated October 2022, in indicated when alleged violations in notify the Administrator, or in the Ad- indicated that an immediate report Supervisor, b) Administrator, c) Dirr Services. The Policy indicated that	use, Neglect, Mistreatment, Misapprop ndicated the resident has the right to be ivolving abuse is reported to or suspect dministrator's absence, to follow the ch should be made, following the chain of ector of Nurses, d) House Manager, ar any person who is accused or suspect or area or department until an initial inve	e free from abuse. The Policy ted by an employee, immediately ain of command. The Policy command to: a) Immediate d e) the Director of Social ed of patient abuse may be
	Review of Resident #1's medical record indicated his/her diagnoses included Dementia.		
	Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 02/16/23, indicated he/she had moderately impaired cognition, and displayed behavioral symptoms not directed toward others.		
	inappropriate/disruptive behavioral toward staff and other residents. Th calm, slow understandable approace	related to behaviors, dated 02/28/23, i symptoms by yelling out even when ne he Care Plan indicated that interventior ch, and redirect when exhibiting socially #1 begins to become socially inappro	eeds are met, and verbal abuse is included for staff to maintain a y inappropriate behaviors. The
	shift, she heard Certified Nurse Aid words to the effect of fuck you, not proceeded toward Resident #1's ro those people, but said she did not I reaching Resident #1's room, she s	12:30 P.M., Nurse Aide #1 said on 03/ e (CNA) #1's voice yelling. Nurse Aide everything is about you. Nurse Aide #1 om, she heard CNA #1 say words to th know what CNA #1 meant by the stater saw CNA #1 exiting, CNA #1's face was t #1's eyes were open wide and he/she	#1 said she heard CNA #1 state said as she and Nurse #1 e effect of stop making us look lik nent. Nurse Aide #1 said upon s red and she appeared to be
	(continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/06/23 at day shift on 03/18/23, she was app CNA #1 yell words to the effect of y need help. CNA #2 said she notice later, she entered Resident #1's rot told her words to the effect of I'm so CNA #2 said she and Nurse Aide # replied she that she would. CNA #2 and continued to work on the Unit. Nurse Aide #1 texted the Director of thereafter on the telephone to infor- incident, CNA #1 was sent home. Nurse Aide #1 said at approximate alleged verbal abuse, she contacte During an interview on 04/06/23 at approximately 9:00 A.M., Resident already on the meal tray in front of exactly what she said to Resident # fuck you. CNA #1 said she may har Facility. CNA #1 said she did not re thereafter Nurse #1 asked that she continued to work with other Reside suspended her employment. CNA #1 said she regretted her tone that day, that there were too many instead of remembering that Resider During an interview on 04/07/23 at at the nurses desk she heard a lour proceeded down the hallway along said at Resident #1's open doorwar bad people. Nurse #1 said CNA words to the effect of fucking days. Nurse #1 said as she stepped insid #1's first name accurately. Nurse #1	2:25 P.M., Certified Nurse Aide (CNA) roximately 20 to 30 feet away from Res- you're not the only one on this fucking f d Nurse Aide #1 enter Resident #1's ro- om and asked Resident #1 if he/she was cared and my feelings are hurt. A asked Nurse #1 if she intended to re- 2 said they expected CNA #1 to have b CNA #2 said since it did not appear that of Nurses (DON) at approximately 2:00 m her of the allegation. CNA #2 said af by 2:30 P.M. on 03/18/23, since CNA # d and reported the incident to the Direct 8:20 A.M., Certified Nurse Aide (CNA) #1 asked for a few things, and then as him/her. CNA #1 said she reacted loud #1. CNA #1 said she may have sworn, ve said words to mean that Resident # scall Resident #1's reaction. CNA #1 said take a break and to not reenter Reside ents on the Unit until the DON contacted e and attitude toward Resident #1. CNA tasks and a few people were unable to ent #1 had Dementia and could not loc 12:42 P.M., Nurse #1 said on 03/18/23 d, aggressive tone of voice that startled with Nurse Aide #1, who had come ou y she heard CNA #1 yell stop making u tt #1 was lying in bed with the privacy of #1 appeared flustered, and as she wa le the room, Resident #1 said do you k 1 said Resident #1 stated words to the ad for them, she just hollered at me. No	#2 said during the first part of the sident #1's room when she heard loor, there are other people who som. CNA #2 said a few minutes as okay. CNA #2 said Resident #1 een sent home, but she was not at Nurse #1 reported the incident, P.M. and then spoke to her shortly there the DON became aware of the 1 had not been suspended for ctor of Nurses by telephone. #1 said on 03/18/23 at ked for his/her spoon, which was lly to this request, but did not recal but did not recal saying the words 1 was not the only person at the aid she remembered shortly ent #1's room. CNA #1 said she ad her at 2:30 P.M. on 03/18/23 an A #1 said she was very stressed ou o come to work. CNA #1 said as he the spoon, she reacted rudely. B at approximately 09:15 A.M., whild her. Nurse #1 said people, we are not curtain partially drawn blocking view liked out of the room she stated now that girl? and provided CNA effect of boy, she is a grumpy
			inse # i said she asked Resident

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 said although she intended contacted at approximately 2:30 P.I. CNA #1, and sent her home. Nurse #1 said it was not until then that she During an interview on 04/06/23 at of the Administrator, said Nurse Aid and swore at Resident #1 stating w DON said since she was not in the said CNA #1 told her she got very a DON said CNA #1 told her she got very a DON said CNA #1 did not recall wh immediately suspended CNA #1's e The DON said Nurse #1 should hav #1. The DON said if she had been a incident occurred, CNA #1 would hav	ed to, she was very busy and did not re M. by the Director of Nurses (DON). No #1 said the DON requested she obtain e became aware that CNA #1 was over 10 A.M. and at 12:40 P.M., the Directo de #1 reported at approximately 2:30 P ords to the effect of Fuck you you're no facility, she immediately spoke with CN angry, it was a tough day and admitted hat she said to Resident #1, but it was r employment pending investigation. we immediately reported to her that CN notified immediately by Nurse Aide #1, ave been immediately suspended pend icated on 03/18/23 she arrived at the F	port the incident prior to being urse #1 said the DON spoke with a statements from the staff. Nurse theard swearing at Resident #1. r of Nurses (DON), in the presence .M. on 03/18/23 that CNA #1 yelled to the only one in this place. The JA #1 on the telephone. The DON she yelled at Resident #1. The not nice. The DON said she A #1 was heard yelling at Resident CNA #2 or Nurse #1 right after the ling investigation.

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F 0609 Level of Harm - Minimal harm or	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.		
potential for actual harm	15024		
Residents Affected - Few	 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was alleged to have been subjected to verbal abuse by a staff member, the Facility failed to ensure they submitted a report to the Department of Public Health within the required timeframe, when their report regarding the allegation was not submitted until approximately 46 hours later. Findings include: Review of Facility's Policy titled Abuse, Neglect, Mistreatment, Misappropriation of Resident Property and Exploitation, dated October 2022, indicated the resident has the right to be free from abuse. The Policy indicated when alleged violations involving abuse is reported to or suspected by an employee, immediately notify the Administrator, or in the Administrator's absence, to follow the chain of command. The Policy indicated the Administrator of Designee will submit an initial report via the web based Health Care Facility Reporting System (HCFRS) to the Department, immediately following an alleged or actual case of abuse. 		
	Review of Resident #1's medical record indicated his/her diagnoses included Dementia.		
	Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 02/16/23, indicated he/she had moderately impaired cognition, and displayed behavioral symptoms not directed toward others.		
	of the Administrator, said Nurse Aid Nurse Aide (CNA) #1 yelled and sw only one in this place. The DON sai CNA #1 told her she got very angry	10 A.M. and at 12:40 P.M., the Directo le #1 reported at approximately 2:30 P vore at Resident #1 stating words to the id she immediately spoke with CNA #1 r, it was a tough day and admitted she e said to Resident #1, but that it was no employment pending investigation.	.M. on 03/18/23 that Certified e effect of Fuck you you're not the on the telephone. The DON said yelled at Resident #1. The DON
	Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS) indicated the facility submitted the report regarding the allegation of verbal abuse at 12:13 P.M. on 03/20/23, approximately 46 hours after the DON had been notified of the alleged incident by Nurse Aide #1 (at 2:30 P. M. on 3/18/23).		
	allegations of suspected abuse nee via HCFRS. The DON said althoug	11:35 A.M., the Director of Nurses (DC eded to be reported within two hours to h she became aware of the allegation (3/18/22, she did not report the alleged /23.	the Department of Public Health CNA #1 verbally abused Resident
	1		