STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225269	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Day Brook Village Senior Living	298 Jarvis Avenue Holyoke, MA 01040

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had an invoked Health Care Proxy (HCP), and whose Health Care Agent (HCA) had submitted a written request for copies of his/her medical record, the facility failed to ensure the records were provided timely as required, when the HCA waited three weeks to get the requested copies.Findings include:Review of the Facility Policy titled Residents' Rights, dated as revised on 10/4/23, indicated:-The resident has the right to access personal and medical records pertaining to him or herself.-The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable.Resident #1 was admitted to the Facility in January 2023, diagnoses included Diabetes and Chronic Kidney Disease.Review of Resident #1's Medical Record included a Health Care Proxy (HCP), dated 01/09/23, which listed his/her son as his/her Health Care Agent (HCA).Review of Resident #1's current Physician's Orders indicated his/her HCP had been activated on 12/30/24 and his/her HCA (Family Member #1) was invoked.During a telephone interview on 09/23/25 at 11:30 A.M., Family Member #1 said he requested copies of Resident #1's medical records in writing via email to the Facility late in the day on 09/04/24 and still (as of 09/23/25) had not received them despite multiple emails and telephone calls to the Facility.Review of email correspondence between Family Member #1 and the Executive Director, provided by the Executive Director on 09/24/25, indicated the following:-09/04/25 at 1:29 P.M. - The Executive Director indicated to Family Member #1 that he was in receipt of Family Member #1's email requesting copies of Resident #1's medical records (originally sent to the Business Office Manager), indicated the team will work with the Medical Records Coordinator to complete his request, and indicated to expect the Medical Records Coordinator to follow up with him to complete the required Medical Record Request Form.-09/08/25 at 3:34 PM. - Family Member #1 replied to the Executive Director indicating that, as Resident #1's Legal Representative, he was entitled to access his/her medical records within 24 hours of his written request excluding weekends and holidays, and this right was not contingent on the completion of an internal facility form. Family Member #1 indicated he submitted his written request on 09/04/25 and indicated as of the date of this email (09/08/25), he had not received the records, nor had the Business Office Manager contacted him as he was told in a previous email. Family Member #1 indicated he was requesting all wound care records, physician/nursing notes, treatment documentation, wound care team assessments, photographs, staging reports, progress notes, any incident reports or internal communications related to Resident #1's pressure ulcer.-09/10/25 at 3:18 P.M. - Family Member #1 indicated he was deeply disappointed with how his recent request for Resident #1's medical records and care information had been managed.-09/10/25 at 5:16 P.M. - The Executive Director indicated he was unexpectedly out of work, asked Family Member #1 if he had the opportunity to complete the facility's Medical Record Request Form indicating it only takes a few minutes and indicated the form was an important piece of documentation.Review of Resident #1's Electronic Medical Record indicated it included a scanned copy of a Massachusetts Medical Records Release Form, signed and dated by Family Member #1 on 09/12/25.During a telephone interview on (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/23/25 at 1:05 P.M., the Long-Term Care Ombudsman said Family Member #1 called her upset about Resident #1's care and told her that he requested copies of his/her medical records repeatedly from the Facility without results.The Long-Term Care Ombudsman said she left messages with the Facility to have somebody contact her about the lack of response to Family Member #1, and she was finally able to reach the Social Worker on 09/23/25.The Long-Term Care Ombudsman said the Social Worker told her that the Facility had 30 days to provide Resident #1's medical records to Family Member #1. The Long-Term Care Ombudsman said she informed the Social Worker that the records should have been provided to Family Member #1 within 24-48 hours, as written in the regulations. During an interview on 09/24/25 at 2:00 P.M., the Administrative Assistant said Resident #1's medical records were mailed to Family Member #1 on 09/23/25 and provided a copy of the postal receipt to the surveyor that indicated an expected delivery date of 09/29/25. During an interview on 09/24/25 at 2:00 P.M., the Medical Records Coordinator said she was aware of Family Member #1's request for copies of Resident #1's medical records, and that she was notified by email by the Executive Director.The Medical Records Coordinator said she emailed a Medical Record Request Form to Family Member #1, which was completed by him and emailed back to the facility.After reviewing the completed Medical Records Request form with the surveyor, the Medical Records Coordinator said the Form was signed by Family Member #1 on 09/12/25, and scanned into Resident #1's Electronic Medical Record on 09/16/25 at 9:26 A.M.The Medical Records Coordinator said she believed the facility's policy was to release medical records within 30 days of receipt of the request, and that she was unaware of any regulation that stated otherwise.During an interview on 09/24/25 at 2:50 P.M., the Executive Director said that Family Member #1 emailed the Business Office Manager on 09/03/25 at 8:50 P.M. requesting Resident #1's medical records. The Executive Director said the Business Office Manager subsequently forwarded the email to both him and the Social Worker on 09/04/25 at 7:52 A.M., and at that time, he notified the Medical Records Coordinator to begin to print/copy Resident #1's medical records.The Executive Director said they require a Medical Record Release Form to be completed by whoever is requesting the medical records prior to releasing them, but the process can still begin prior to receiving the signed release form.The Executive Director said he offered to have Family Member #1 or his designee view Resident #1's medical records on or around 09/10/25, but Family Member #1 declined, and that the medical records were mailed to Family Member #1 on 09/23/25.During an interview on 09/25/25 at 3:15 P.M., the Quality Improvement Manager (QIM) said the Facility did not release Resident #1's medical records to Family Member #1 in a timely manner.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had an activated Health Care Proxy (HCP) and had developed a pressure injury that was new, the Facility failed to ensure nursing notified his/her Health Care Agent (HCA) when he/she was first assessed to have an alteration in his/her skin integrity, and when the pressure injury deteriorated.Findings include:Review of the Facility Policy titled Health and Medical Condition, Informing Residents of, dated as revised 01/05/17 indicated:-Each resident or resident representative admitted to our facility will be informed of his/her total health status and medical condition on an ongoing basis in a language that he/she can understand.-The resident will be advised of any significant change in his/her medical condition, medication, or treatment orders.-The resident's family/resident representative and the physician will be notified when there is a medical change in the resident's condition.Resident #1 was admitted to the Facility in January 2023, diagnoses included Diabetes and Chronic Kidney Disease.During a telephone interview on 09/23/25 at 11:30 A.M., Family Member #1 said Resident #1 was admitted to the Facility in 2023 without any pre-existing skin issues and to his knowledge he/she did not have any skin breakdown prior to April 2025, when Resident #1 was admitted to the Hospital for stomach issues.Family Member #1 said Hospital Nursing Staff alerted him that they completed an admission skin assessment on Resident #1 and found him/her to have a pressure injury on his/her lower back. Family Member #1 said when he brought this up to the Facility staff (exact person unknown), they told him that Resident #1 did not have this wound when he/she went to the hospital and that he/she returned from the hospital with the pressure injury. Family Member #1 said he brought his concern to the Executive Director who told him that the pressure injury did not start at the Facility, and that Resident #1 likely developed it while at the Hospital.Family Member #1 said Resident #1's wound worsened over time after returning to the Facility, and while he had regular contact with the Nursing staff via telephone, nobody informed him of the marked deterioration of Resident #1's wound until late August 2025 when he received a call from the Facility's Wound Nurse requesting his consent to debride (removal of damaged tissue using sharp instruments) his/her wound to facilitate healing.Review of Resident #1's New Onset Skin Assessment, dated 03/26/25, indicated Nursing staff assessed him/her to have an open area, defined as Moisture Associated Skin Damage (MASD).Review of Resident #1's Interdisciplinary Progress Notes included a Nursing Note, dated 03/26/25, that indicated that he/she was assessed to have an area of MASD, and that nursing staff notified his/her Provider and obtained treatment orders. Review of Resident #1's Medical Record indicated there was no documentation to support the nurse notified Family Member #1 (HCA) of this new wound. Review of Resident #1's Ongoing Skin Condition Assessment Records indicated:07/14/25 - wound progress was noted to be deteriorated - date family notified: HCP (health care proxy) aware, treatment changed.07/29/25 - wound progress was noted to be deteriorated - date family notified: AWARE, seen by Wound Nurse Practitioner, treatment changed.08/05/25 - wound progress was noted to be deteriorated (now with undermining, not present on 07/29/25) - date family notified: NA. Treatment changed today, see new orders.08/11/25 - wound progress noted to be deteriorated, with a treatment change and wound culture sent to the lab to rule out infection, antibiotics were ordered - date family notified: to update today.During a telephone interview on 10/01/25 at 2:46 P.M., the Wound Nurse said when a Resident develops a wound or skin alteration, it is the responsibility of the nurse that discovers the wound to complete an incident report, contact the Provider, and contact the resident's representative, and she said all of that information should be documented in a Nursing Progress Note and on the Incident Report.The Wound Nurse said if a wound deteriorates and/or if treatments change significantly, the resident's representative should be notified.The Wound Nurse said that Family Member #1 should have been notified on 03/26/25 when Resident #1 first developed MASD and should have been notified when the wound was assessed to have deteriorated on (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/14/25, 07/29/25, and 08/05/25.The Wound Nurse said when she calls residents' family members or representatives, she usually documents the phone call in a Progress Note (Skin-Wound Note). The Wound Nurse she said she did not recall if she called Family Member #1 when she assessed there to be a deterioration in his/her wound on 07/14/25 and 07/29/25, when she documented HCP Aware and that she needed to work on improving her documentation.The Wound Nurse said when Resident #1's wound deteriorated further on 08/05/25, if there wasn't a Skin-Wound Note in the Interdisciplinary Progress Notes and N/A documented on the Ongoing Skin Condition Assessment Record, that Family Member #1 was not notified, but that he should have been.During an interview on 09/25/25 at 12:52 P.M., Unit Manager #1 said Staff Nurses are responsible to complete weekly skin assessments on every resident, and if there is a new skin issue, they are responsible for notifying the resident's representative. During a telephone interview on 09/26/25 at 4:06 P.M., Unit Manager #2 said the resident's primary nurse is responsible for completing weekly skin assessments and if there is a new area of concern, or worsening of a wound, nurses are required to notify the resident's representative.During an interview on 09/25/25 at 3:15 P.M., with the Director of Nurses (DON) and the Corporate Quality Improvement Manager (QIM), the DON, QIM and the surveyor reviewed Resident #1's Interdisciplinary Progress Notes and Ongoing Skin Condition Assessment Records.The DON said she did not see any Nursing Progress Notes that indicated Nursing notified Family Member #1 after discovering he/she developed a wound on 03/26/25, or after the wound was assessed to have deteriorated on 07/14/25, 07/29/25, and 08/05/25. Both the DON and QIM said there was no evidence on the Ongoing Skin Condition Assessment that the Wound Nurse notified Family Member #1 of Resident #1's worsening wound on 08/05/25. On 09/24/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 09/17/25, which addressed the area of concern as evidenced by:A) On 08/26/25, an Interdisciplinary Progress note included a Skin/Wound Note, dated 08/26/26 that indicated Resident #1's Representative was contacted regarding his/her worsening wound.B) On 09/12/25, the Director of Nursing completed a Facility-wide audit to determine the notification process was followed for all Residents in the Facility that had developed wounds and/or had significant changes to wounds (including treatment changes). C) On 09/19/25, 09/26/25, the Unit Managers conducted Facility-wide audits to ensure that Resident Representatives have been notified for any Resident that have had any changes related to wound status or treatment of wounds. D) From 09/12/25 through 09/24/25, the Director of Nursing completed Nursing education, titled Notification Protocol for Residents with Change in Wound Status or Treatment, including review the Facility policies titled, Informing Residents of Health and Medical Condition, and Physician Notification.E) The Facility's Unit Managers will continue to perform weekly audits to ensure Physicians and Resident Representatives are notified of changes with wound status, as appropriate, and after 100% compliance has been attained weekly, random audits will continue until deemed otherwise.F) The deficient practice and audit results will be presented at the Monthly Quality Assurance Performance Improvement (QAPI) meeting on 10/08/25.G) The Director of Nursing and/or their Designee are responsible for overall compliance.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on records reviewed and interviews for one of three sampled Residents (Resident #1), the facility failed to ensure they maintained a complete and accurate medical record when Nursing documentation related to wound treatments and Certified Nurse Aide (CNA) documentation related to skin integrity and bathing were incomplete.Findings include:Review of the Facility's Policy titled, Clinical Documentation, dated as last revised 10/31/23, indicated:-Medication and Treatment: The licensed nurse notes the time and date of all medications and treatments administered on the Medication Administration Record (MAR) and or Treatment Administration Record (TAR). The nurse who administers the medication and/or treatment must document it on the resident's record. -Nursing Assistant Documentation: Completed at Point of Care using the Electronic Health Record (EHR). Resident #1 was admitted to the Facility in January 2023, diagnoses included Diabetes and Chronic Kidney Disease.Review of Resident #1's July 2025 TAR indicated he/she had new orders for treatments as follows: -Sacrum Wound: Apply collagen powder particles to wound bed and cover with calcium alginate/silver (a type of absorbent dressing) and foam dressing. Change daily. Initiated 07/01/25, stop date 07/14/25.Further review of the TAR indicated a code of M documented under this treatment on 07/11/25 and 07/12/25.-Sacrum Wound: Apply Santyl (an ointment that helps remove dead tissue from wounds), dime sized amount to wound base and cover with Aquacel (a type of absorbent dressing), initiated 07/14/25. Further review of the TAR indicated a code of M documented under this treatment on 07/16/25 and 07/18/25.Review of the code legend on the last page of the TAR did not include a code of M as a choice for nursing to enter or why the code would be used.During a telephone interview on 10/07/25 at 3:20 P.M., the Director of Nursing (DON) said she reviewed Resident #1's July TAR and she said she was not sure what the M on the TAR represented because there was no M listed as a choice on the code legend. The DON said she interviewed the nursing staff who were responsible to perform Resident #1's treatments on the days where M was documented and she said she determined that the nursing staff did not document they completed Resident #1's ordered treatments on 07/11/25, 07/12/25, 07/16/25, and 07/18/25, as required. Review of Resident #1's Skin Care by Day Reports (CNA Documentation that indicated whether CNAs were applying protective skin lotions/creams) indicated for the following shifts were left blank:June 2025Night Shift (11:00 P.M. - 7:00 A.M.) 3 out of 30 opportunities left blankDay Shift (7:00 A.M. - 3:00 P.M.) 7 out of 30 opportunities left blankEvening Shift (3:00 P.M. - 11:00 P.M.) 1 out of 30 opportunities left blankJuly 2025Night Shift: 5 out of 31 opportunities left blankDay Shift: 7 out of 31 opportunities left blankEvening Shift: 2 out of 31 opportunities left blankAugust 2025Night Shift: 3 out of 31 opportunities left blankDay Shift: 1 out of 31 opportunities left blankEvening Shift: 1 out of 31 opportunities left blankSeptember 2025Night Shift: 3 out of 26 opportunities left blankDay Shift: 11 out of 26 opportunities left blankEvening Shift: 7 out of 25 opportunities left blankReview of Resident #1's Bathing and Hygiene by Day Report (CNA Documentation that indicated whether the CNA's assisted Resident #1 with bathing and shampooing) indicated that following shifts and tasks were left blank:June 2025:Bathing and ShampooingNight Shift: 3 out of 30 opportunities left blankDay Shift: 7 out of 30 opportunities left blankEvening Shift: 1 out of 30 opportunities left blankJuly 2025:Bathing and ShampooingNight Shift: 5 out of 31 opportunities left blankDay Shift: 6 out of 31 opportunities left blankEvening Shift: 2 out of 31 opportunities left blankAugust 2025:Bathing and ShampooingNight Shift: 3 out of 31 opportunities left blankDay Shift: 1 out of 31 opportunities left blankEvening Shift: 2 out of 31 opportunities left blankSeptember 2025:Bathing and ShampooingNight Shift: 3 out of 25 opportunities left blankDay Shift: 11 out of 25 opportunities left blankEvening Shift: 7 out of 25 opportunities left blankDuring an interview on 09/24/25 at 1:05 P.M., Nurse #1 said Nursing and CNAs must document all their treatments and tasks in the computer and the documentation must be done by the end of their shift.During an interview on 09/24/25 at 10:30 A.M., CNA #1 said CNAs are required to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document all the care they provide to the residents in the computer, and all the documentation needs to be entered by the end of their shift. CNA #1 said there are codes we can enter if a resident refuses or if they are out of the building, so there should be no blank spaces on our reports, and if there are, that means the CNA did not enter their documentation.During an interview on 09/24/25 at 4:45 P.M., CNA #2 said all CNA document the care they provide to the residents in the computer, and this documentation must be done by the end of the shift.During a telephone interview on 09/26/25 at 2:50 P.M., CNA #3 said CNAs document all care they provide to the residents in the computer, and the charting must be completed before they leave for the day.During a telephone interview on 10/01/25 at 1:20 P.M., CNA #4 said all CNA documentation is located in the computer and should be completed by the end of the shift. CNA #4 said if there are any blank spaces on the CNA reports, that meant that CNA documentation was not done. During a telephone interview on 10/07/25 at 9:30 A.M., the Director of Nursing (DON) reviewed the CNA Documentation she faxed to the surveyor and she said anywhere there are blank spaces, the CNA should have entered the appropriate code for the task. The DON said if there are any blank spaces, that meant the CNA did not complete their documentation, as required.