STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225352	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Manor on Cabot	279 Cabot Street 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 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. 37227 Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who requested staff assistance with toileting care needs, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when on 10/05/24, Resident #1 used the call light to request assistance to walk to the bathroom, and a Certified Nurse Aide (later identified as CNA #1) refused his/her request and told him/her that he/she could use the bed pan or urinate in his/her bed. Resident #1 said he/she was in a position where he/she had to rely on other people to help him/her, and that CNA #1's response made him/her feel humiliated. Findings include: Review of the Facility Policy titled Resident Rights Under Federal Law, dated as revised 02/01/23, indicated residents have the fundamental right to considerate care that safeguards their personal dignity along with respecting cultural, social and spiritual values. The Policy indicated its purpose was to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her self-esteem and self-worth. Resident #1 was admitted to the Facility in September 2024, diagnoses included myocardial infarction (heart attack) and osteoarthritis in the right hip. Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 09/28/24, 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 MDS Assessment indicated he/she was frequently incontinent of bowel and bladder and required substantial assistance from staff with toileting care needs and ambulation. Review of the Facility's Internal Investigation, undated, indicated that on 10/05/24 during the 11:00 P.M. to 7:00 A.M. shift (exact time unknown), when Resident #1 asked CNA #1 for assistance to walk to the bathroom, CNA#1 refused and told him/her that he/she could either go in the bed pan or in his/her bed. Further review of the Investigation indicated that Resident #1's roommate (Resident #4) witnessed the incident. Review of Resident #4's Medical Record indicated he/she was cognitively intact. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225352	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Manor on Cabot	279 Cabot Street Holyoke, MA 01040

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/24 at 8:50 A.M., Resident #1 said that when he/she activated the call light during the overnight shift on 10/05/24, and asked CNA #1 to assist him/her in the bathroom, CNA #1 responded No, you are going to use the bed pan. Resident #1 said that when he/she told CNA #1 that he/she did not want to use a bed pan, she responded, you either go [urinate] in the bed pan or you go in your bed. Resident #1 said that he/she reluctantly used the bed pan, and that when he/she could not urinate due to discomfort, CNA #1 told him/her I guess now you will have to go in your bed. Resident #1 said that although he/she eventually used the bathroom and did not have to urinate in his/her bed, the incident with CNA #1 left him/her feeling distraught and humiliated. Resident #1 said tearfully I don't like to talk about it [the incident]. The Surveyor was unable to interview Certified Nurse Aide (CNA) #1 as she did not respond to the Department of Public Health's telephone or letter requests for an interview. During a telephone interview on 10/31/24 at 12:05 P.M., Resident #4 said he/she witnessed an altercation between CNA #1 and Resident #1, and that he/she did not recall the exact date of the altercation, although he/she remembered it occurred during the overnight shift, on a weekend. Resident #4 said that when CNA #1 responded to the call light, Resident #1 asked for assistance to get out of his/her bed and walk to the bathroom. Resident #4 said CNA #1 told Resident #1 that it had been less than two hours since he/she had last used the bathroom and that his/her choices were to go in a bed pan or go in the bed. Resident #4 said that Resident #1 tried using the bed pan, and that when he/she was unsuccessful because it was pinching, CNA #1 told him/her that he/she would have to go in his/her bed. During an interview on 10/31/24 at 10:50 A.M., the Social Worker said that on 10/07/24, when she interviewed several residents on CNA #1's assignment, two residents complained about a female CNA (who fit CNA #1's description) on the overnight shift, that was tough acting and could be rough with care. During an interview on 10/31/24 at 12:45 P.M., the Administrator said the outcome of the Facility's Internal Investigation was that CNA #1 did not treat Resident #1 in a dignified and respectful manner during care.