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	09/22/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, records reviewed, and interviews, the facility failed to provide treatment and care for an indwelling urinary catheter in accordance with the Physician's orders for one Resident (#6), of 2 applicable residents, out of a total sample of 12 residents, which resulted in a delay in care and increased the Resident's risk for indwelling urinary catheter associated complications. Specifically, the facility failed to: -change Resident #6's indwelling urinary catheter in a timely manner, per the Physician's order, when the Resident's indwelling urinary catheter was leaking urine and the Resident was dependent on staff for urinary catheter care, placing the Resident at risk for alteration in skin condition. -change Resident #6's indwelling urinary catheter using the Physician ordered balloon size, which resulted in the Resident experiencing short-term pain and increased the Resident's risk for catheter associated trauma. Findings include: Review of the facility's policy titled Catheter - Indwelling Urinary - Care of, dated 6/1/96 and revised 2/1/23, indicated the following: -Inspect the catheter system to ensure connections are secure and there is no leakage. -If disconnections or leakage occur, replace drainage system. Resident #6 was admitted to the facility in December 2020 with diagnoses including Neuromuscular Dysfunction of Bladder, Acute Kidney Failure (AKF), Multiple Sclerosis (MS), and Hereditary Spastic Paraplegia. Review of Resident #6's Skin Breakdown Risk Care Plan, last revised 4/1/24, indicated the Resident was at risk for skin breakdown related to history of . MS, .neuropathy, .denuded MASD (moisture-associated skin damage) to buttocks. Review of Resident #6's Activities of Daily Living (ADL) Care Plan, last revised 7/23/25, indicated the following: -The Resident was at risk for decreased ability to perform . bed mobility, transfers, toileting, and locomotion. -Provide extensive assist of two for bed mobility. -Dependent on two staff, total lift (mechanical lift) for transfers. -Extensive assist of one staff for dressing. -Extensive [assist] of staff for toileting. -Electric wheelchair in the facility Review of Resident #6's Indwelling Catheter Care Plan, last revised 7/23/25, indicated the following: -The Resident required an indwelling catheter due to Neurogenic Bladder, Urinary Retention from MS. -18 Foley (type of indwelling urinary catheter), 10 cc (cubic centimeters: unit of measurement) balloon. Review of Resident #6's active Physician orders indicated: -Perform Foley catheter care every day and evening shift, dated 3/29/22 -Perform Foley catheter care as needed, dated 3/29/22. -Replace drainage system if disconnections or leakage occur, dated 3/29/22. -Change Foley catheter when occluded or leaking; Foley catheter 18 Fr (French) with 10 cc balloon to bedside straight drainage, dated 6/24/22. Review of the Minimum Data Set (MDS) Assessment, dated 8/7/25 indicated Resident #6: -was dependent on staff for toileting, lower body bathing, and lower body dressing. -had impaired range of motion (ROM) to bilateral lower extremities. -had an indwelling urinary catheter. Review of Resident #6's Nursing Skilled Evaluation Note, dated 9/8/25 and written by Nurse #2, indicated the following: -Catheter character: Non patent. Urinary catheter intact. -F/C [Foley catheter] leaking. -When assessed 10 cc balloon only had 8 cc in it. -8 cc fluid removed and 10 cc added. -Remained patient [sic.] through the night. -Instructed pt. (patient: Resident) to let us now if F/C leaks again so that we can insert a new one if need be. Review of Resident #6's Nursing Progress Note dated 9/9/25 and written by Nurse #2 at 3:30 A.M., indicated the following: -F/C requires changing due to leakage, even (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after troubleshooting. -Pt. requires 30 cc balloon to maintain patency without leakage, as he/she has had F/C in for years. -18 Fr with 30 cc [balloon] inserted without any urine output. -Catheter flushed with 20 cc sterile H2O (water) without resistance and still no output. -Catheter removed . large clot noted at tip of catheter. -Pt. agreed to a second attempt. -New 18 Fr with 30 cc balloon inserted . + (positive) hematuria returned in moderate amount, . then flow stopped. -Flushed several times. Sometimes easy to flush and other times catheter blocked. -Blood noted from meatus (passage or hole at the end of the urethra where urine exits the body) in small amount. -Catheter left in place for Director of Nursing (DON) . to troubleshoot catheter. Review of Resident #6's clinical record failed to indicate any instructions to flush the Resident's indwelling urinary catheter. Review of Resident #6's Transfer Note, dated 9/9/25 and written at 8:00 A.M., indicated the Resident was transferred to the hospital due to inability to catheterize. On 9/18/25 at 8:30 A.M., the surveyor observed the following from the hallway outside of Resident #6's room: -the Resident was positioned in bed. -clear plastic catheter tubing extended out from under the Resident's bed sheets, leading to a catheter collection bag which was secured to the bed frame on the door-side of the Resident's room and visible from the hallway. -amber colored urine was present in the Resident's catheter collection bag. Immediately following the observation, the surveyor entered Resident #6's room. During an interview at the time, Resident #6 said he/she had an indwelling urinary catheter for approximately six years, and that he/she had experienced recent complications with the urinary catheter. During an interview on 9/18/25 at 3:13 P.M., Nurse #2 said she was responsible for providing care to Resident #6 on the 11:00 P.M. through 7:00 A.M. (11-7) shifts from 9/7/25 through 9/8/25 and 9/8/25 through 9/9/25. Nurse #2 said she noticed Resident #6's urinary catheter leaking urine on 9/8/25 and that upon assessing the Resident's catheter, she noticed the 10 cc balloon only had 8 cc of fluid in it. Nurse #2 said she deflated the balloon, then reinflated the balloon to 10 cc using sterile water. Nurse #2 then said she alerted the oncoming (7:00 A.M. through 3:00 P.M.: 7-3) shift nursing staff that Resident #6's urinary catheter had been leaking and that if it continued to leak, the catheter would need to be changed. Nurse #2 said when she came in for the next 11-7 shift, the 3:00 P.M. through 11:00 P.M. (3-11) Nurse reported that neither the 7-3 nor 3-11 shift Nurse had gotten the opportunity to replace Resident #6's indwelling urinary catheter, and that the Resident's catheter was still leaking. Nurse #2 then said another Nurse told her the Resident used to have a 30 cc balloon and could not understand why the Resident was ordered for a 10 cc balloon. Nurse #2 said she removed Resident #6's catheter around 2:30 A.M. to 3:00 A.M. on 9/9/25 and replaced the catheter with a size 18 Fr/30 cc balloon because she thought the 10 cc balloon was too small, causing the Resident's catheter to leak. Nurse #2 said leaking urine was not good for Resident #6, and that it was important for the Resident to be kept clean and dry. Nurse #2 said when she replaced the Resident's catheter, the Resident had no urine output. Nurse #2 said she then removed the catheter, and a large blood clot came out of the Resident when the catheter was removed. Nurse #2 said she made a second attempt to insert a size 18 Fr urinary catheter with a 30 cc balloon for Resident #6, and that when she inserted the catheter, there was no urine output. Nurse #2 said she then attempted to flush the catheter, but there was too much resistance to flush the catheter, and there was still no urine output. Nurse #2 said she called the DON to alert her of the Resident's urinary catheter complications and that the DON came in to assess the Resident's catheter function. During an interview on 9/18/25 at 3:45 P.M., the DON said Nurse #2 called her around 6:30 A.M. on 9/9/25 and alerted her that the Resident's urinary catheter had been replaced and was not functioning. The DON said she arrived at the facility around 7:00 A.M. on 9/9/25 and assessed Resident #6. The DON said that she observed blood coming out of the Resident, around his/her urinary catheter, so she removed the catheter, and the Resident was transferred to the hospital to be evaluated. During a follow-up interview on 9/19/25 at 12:26 P.M., Nurse #2 said she did not think that Resident #6's urinary catheter complications were emergent, so she had waited to contact the DON until later in the morning because she did not want to wake the DON up. Nurse #2 said she was hesitant to contact people during the 11-7 shift. Nurse #2 said (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6's urinary catheter was till leaking on the 9/8/25-9/9/25 11-7 shift. Nurse #2 said she tried to flush the Resident's catheter, but the catheter continued to leak, so she attempted to replace the catheter. Nurse #2 said the Resident had some urinary output in the catheter collection bag and that there was also urine in the Resident's bed from the catheter leaking. Nurse #2 said she first attempted to replace Resident #6's urinary catheter around 2:30 A.M. to 3:00 A.M. Nurse #2 said that upon her second attempt to change the Resident's catheter, she inserted the catheter and there was no urine output. Nurse #2 said she waited a while to see if urine would start to pass through the catheter, and when no urine passed through, she attempted to inflate the 30 cc balloon, and the Resident had pain. Nurse #2 said she then immediately deflated the balloon to 20 cc and the Resident's pain resolved. Nurse #2 said she left the urinary catheter in place, with the balloon inflated to 20 cc, for the rest of the shift. Nurse #2 also said after she replaced the urinary catheter a second time at 3:00 A.M. until the end of the shift (7:00 A.M.), the Resident had no urine output into the catheter collection bag and no urine leakage in the bed. Nurse #2 then said the only leakage she observed from the Resident was the small amount of sterile water she used in attempt to flush the catheter and some bloody drainage from the Resident's meatus. During a follow-up interview on 9/19/25 at 2:28 P.M., the DON said Nurse #2 called her around 6:30 A.M. on 9/9/25 to alert her of Resident #6's urinary catheter complications. The DON said that staff should have replaced Resident #6's indwelling urinary catheter according to the Physician's order, including the ordered catheter and balloon size, when the urinary catheter was identified to be leaking. The DON said replacing the catheter may cause discomfort, but inflating the balloon should not cause pain. The DON also said she was always available for facility staff to contact her and that Nurse #2 should have called her sooner when the Resident's urinary catheter was not functioning. Please Refer to F726.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on records reviewed, and interviews, the facility failed to ensure licensed nursing staff (Nurse #2) was assessed for and demonstrated competency and skill sets to provide indwelling urinary catheter care for one Resident (#6) out of a total sample of 12 residents, resulting in the Resident experiencing a delay in care.Specifically, the facility failed to ensure Nurse #2's skills relative to indwelling urinary catheter care had been assessed for competency when: -The facility identified its ability to care for residents with indwelling urinary catheters in the Facility Assessment. -Nurse #2 was assigned to care for Resident #6, who had an indwelling urinary catheter. -Resident #6: >Experienced urinary leakage from his/her indwelling urinary catheter. >Required the urinary catheter to be replaced. -Nurse #2, who had not been assessed for and demonstrated competency for urinary catheter care, did not intervene timely with Physician ordered interventions when the Resident experienced leakage from his/her indwelling urinary catheter. Findings include: Review of the facility's policy titled Catheter - Indwelling Urinary - Care of, dated 6/1/96 and revised 2/1/23,ˆindicatedˆthe following:^^-Inspect the catheter system to ensure connections are secure and there is no leakage.^^ -If disconnections or leakage occur, replace drainage system.^^ ^^ Review of the Centers for Disease Control and Prevention (CDC) guidelines titled: Guideline for Prevention of Catheter-Associated Urinary Tract Infections at Summary of Recommendations | Infection Control | CDC, dated 2009 and last reviewed 3/25/24,ˆindicatedˆthe following:ˆ -Ensure that healthcare personnel and others who take care of catheters are given periodic in-service trainingˆregardingˆtechniques and procedures for urinary catheter insertion, maintenance, and removal. Provide education about CAUTI, other complications of urinary catheterization, and alternatives to indwelling catheters.ˆ -Maintain unobstructed urine flow.ˆ -If obstruction occurs and it is likely that the catheter material is contributing to obstruction, change the catheter.ˆ ^^ Review of the Cleveland Clinic document titled Urinary Catheter,ˆlocatedˆat Urinary Catheter: Purpose, Types, Placement & Complications and last reviewed 5/1/25,ˆindicatedˆthe following catheter associated complications:ˆ -UTIs (urinary tract infections)ˆ -Bladder muscle spasmsˆ -Leakagesˆ -Bleedingˆ ^^ Review of the facility's document titled Facility Assessment, dated 2025,ˆindicatedˆthe following:ˆ -Care Requirements for bowel/bladder included intermittent or indwelling orˆotherˆurinary catheter.ˆ -The facility provided care for residents with diseases and conditions including renal failure, neurogenic bladder, Multiple Sclerosis (MS), and paraplegia.ˆ -Treatments provided included indwelling catheter treatment.ˆ -Staff training/competencies/skill sets for catheterization wereˆindicatedˆas sufficient.ˆ ^^^ Resident #6 was admitted to the facility in December 2020 with diagnoses including Neuromuscular Dysfunction of Bladder, Acute Kidney Failure (AKF), Multiple Sclerosis (MS), and Hereditary Spastic Paraplegia.^^ ^^^ Review of Resident #6's Indwelling Catheter Care Plan, last revised 7/23/25,ˆindicatedˆthe following:^^ -The Residentˆrequiredˆan indwelling catheter due to Neurogenic Bladder, Urinary Retention from MS.^^ -18 Foley (type of indwelling urinary catheter), 10 cc (cubic centimeters: unit of measurement) balloon.^^ ^^^ Review of Resident #6's active Physician Ordersˆindicatedˆthe following:^^ -Replace drainage system if disconnections or leakage occur, dated 3/29/22.^^ -Change Foley catheter when occluded or leaking; Foley catheter 18 Fr (French) with 10 cc balloon to bedside straight drainage, dated 6/24/22.^^ ^^^^^ Review of Resident #6's Nursing Skilled Evaluation Note, dated 9/8/25 and written by Nurse #2 at 5:25 A.M.,ˆindicatedˆthe following:^^ -Catheter character: Non patent. Urinary catheter intact.^^ -F/C [Foley catheter] leaking.^^ -When assessed 10 cc balloon only had eight cc in it.^^ -Eight cc fluid removed and 10 cc added.^^ -Remained patient [sic] through the night.^^ -Instructed pt. (patient: Resident) to let us now if F/C leaks again so that we can insert a new oneˆif need be.^^ ^^^ Review of Resident #6's Nursing Progress Note dated 9/9/25 and written by Nurse #2 at 3:30 A.M.,ˆindicatedˆthe following:^^^ -F/C requires changing due to leakage, even after (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	troubleshooting.^^ -Pt. requiresˆ30 cc balloonˆtoˆmaintainˆpatency without leakage, as he/she has had F/C in for years.^^ -18 Fr 30 cc [balloon] inserted without any urine output.^^ -Catheter flushed with 20 cc sterile H2O (water) without resistance and still no output.^^ -Catheter removed . large clot noted at tip of catheter.^^ -Pt. agreed to a second attempt.^^ -New 18 Fr/ 30 cc balloon inserted . + (positive) hematuria (blood in urine) returned in moderate amount, . then flow stopped.^^ -Flushed several times. Sometimes easy to flush and other times catheter blocked.^^ -Blood noted from meatus (passage or hole at the end of the urethra where urine exits the body) in small amount.^^ -Catheter left in place for Director of Nursing (DON) . to troubleshoot catheter.^^ ^^ Review of Resident #6's clinical record failed to indicate: -anyˆPhysicianˆordersˆtoˆflush the Resident's indwelling urinary catheter.^^ -any Physician order for a 30 cc balloon. ^^ Review of Resident #6's Transfer Note, dated 9/9/25 and written at 8:00 A.M.,ˆindicatedˆthe Resident was transferred to the hospital due to inability to catheterize.^^ ^^^ During an interview on 9/18/25 at 8:30 A.M., Resident #6 said he/she had an indwelling urinary catheter for approximately six years, and that he/she had experienced recent complications with the urinary catheter.^^ ˆ Review of Nurse #2's Education File failed to include any evidence the Nurse had been assessed for competencyˆrelativeˆto indwelling urinary catheter care.ˆ ^^^ During an interview on 9/18/25 at 3:13 P.M., Nurse #2 said she noticed Resident #6's urinary catheter leaking urine on 9/8/25 and that she did not replace the Resident's urinary catheter when sheˆidentifiedˆthe catheter to be leaking urine. Nurse #2 said she did not replace the Resident's urinary catheter until the following 11-7ˆshift, when she identified theˆResident's catheter was still leaking. Nurse #2 said another Nurse told her the Resident used to have a 30 cc balloon, so Nurse #2 replaced the Resident's catheter with a size 18 Fr/ 30 cc balloon, not the orderedˆ10 ccˆballoon. Nurse #2 said she thought the ordered 10 cc balloon was too small, causing the Resident's catheter to leak. Nurse #2 said she replaced the Resident's urinary catheter between 2:30 and 3:00 A.M. on 9/9/25, and when she inserted the catheter, there was no urine output for the remainder of the shift. Nurse #2 said she did not want to call the DON too early in the morning, so she waited until she knew the DON would be awake to alert her of the Resident's urinary catheter complications. ^^^ During an interview on 9/18/25 at 3:45 P.M., the DON said Nurse #2 called her around 6:30 A.M. on 9/9/25 and alerted her that the Resident's urinary catheter had been replaced and was not functioning. The DON said she arrived at the facility around 7:00 A.M. on 9/9/25 and assessed Resident #6. The DON said that sheˆobservedˆblood coming out of the Resident, around his/her urinary catheter, so she removed the catheter, and the Resident was transferred to the hospital to be evaluated.^^The DON said if a Resident experienced urinary leakage around a urinary catheter, the catheter should be changed. The DON also said the facility would not assess a nurse's competency for indwelling urinary catheter care unless identified as necessary and that nurses should alreadyˆpossessˆthe skills to care for indwelling urinary catheters.^^ ^^^ During a follow-up interview on 9/19/25 at 12:26 P.M., Nurse #2 said that she had worked at the facility for almost one year and could not recall whether any education or competency assessments relative to indwelling urinary catheters had been completed for her since she began working at the facility.ˆ ^^^ During a follow-up interview on 9/19/25 at 2:28 P.M., the DON said that Nurse #2 should have replaced Resident #6's indwelling urinary catheter according to the Physician's order, including the ordered catheter and balloon size, when the urinary catheter wasˆidentifiedˆto be leaking on 9/8/25. The DON also said she was always available for facility staff to contact her and that Nurse #2 should have called her when the Resident's urinary catheter was not functioning and the DON would either have come in to assess the Resident or instruct Nurse #2 to contact the Physician.ˆ ˆ During an interview on 9/22/25 at 11:39 A.M., with the DON and the Regional Clinical Manager, the DON said the facility provided care and services to residents with indwelling urinary catheters. The Regional Clinical Manager said there was no competency evaluation for Nursesˆrelativeˆto indwelling urinary catheter care and that Nurses were expected to tell the facility managers if they did not have competency for catheter care and services. The DON said Nurse #2 was hired with extensive nursing experience and (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should already have known how to provide care and services for a resident with an indwelling urinary catheter.