

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2025
NAME OF PROVIDER OR SUPPLIER Mission Care at Holyoke		STREET ADDRESS, CITY, STATE, ZIP CODE 35 Holy Family Road 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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>37227</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who was cognitively intact, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when on 12/09/24 during the day shift, Maintenance Assistant #1 hugged Resident #1 and kissed him/her on the mouth, without his/her consent, which made him/her feel uncomfortable.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Resident Rights and Responsibilities, dated as revised July 2017, indicated the Facility will protect and promote the rights of each resident as set forth in the Resident [NAME] of Rights, which includes the right to be treated with respect and dignity.</p> <p>Resident #1 was admitted to the Facility in March 2021, diagnoses included Chronic Obstructive Pulmonary Disorder (COPD), anxiety disorder, Post-Traumatic Stress Disorder (PTSD), major depressive disorder with psychotic symptoms, and schizoaffective disorder.</p> <p>Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 11/03/24, 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).</p> <p>Review of Resident #1's Medical Record indicated he/she had a court appointed guardian and treatment plan, dated as renewed on 09/09/24.</p> <p>Review of the Facility's Investigation Report, dated 12/09/24, indicated that Resident #1 had reported to staff that he/she was uncomfortable with a situation involving a staff member. The Report indicated that staff reported Resident #1's concern to the Social Worker and the Administrator.</p> <p>The Report indicated that Resident #1 told the Administrator that Maintenance Assistant (MA) #1, had hugged him/her on multiple occasions and that earlier that morning, on 12/09/24 (exact time unknown), he hugged and kissed him/her, making him/her feel uncomfortable.</p> <p>The Report indicated that Maintenance Assistant (MA) #1 told the Administrator that he hugged and kissed Resident #1, on the morning of 12/09/24, to comfort him/her after Resident #1 had told him that he/she was depressed.</p> <p>(continued on next page)</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/02/25 at 11:02 A.M., Resident #1 said that Maintenance Assistant (MA) #1 had hugged and kissed him/her on two other occasions and that he/she had been afraid to say anything to anyone about it. Resident #1 said that the last time Maintenance Assistant (MA) #1 had come to his/her room to say hello, he/she was still in bed, and that MA #1 was flirty during their conversation. Resident #1 said MA #1 leaned over and hugged him/her and gave him/her a 'mushy' kiss on the mouth without his/her consent. Resident #1 said the kiss didn't feel right and triggered his/her PTSD. Resident #1 said that he/she reported the incident to staff because he/she was afraid of it happening again.</p> <p>During an interview on 01/09/25 at 11:39 A.M., Maintenance Assistant #1 said that on the morning of 12/09/24 he had hugged Resident #1 and kissed him/her on the mouth. Maintenance Assistant #1 said that his behavior was inappropriate and that he regretted the incident.</p> <p>During an interview on 01/02/25 at 1:58 P.M., Laundry Assistant #1 said that on the morning of 12/09/24 (exact time unknown), she saw Maintenance Assistant #1 standing at Resident #1's bedside, and that MA #1 was laughing and conversing with him/her.</p> <p>During an interview on 01/02/25 at 12:50 P.M., the Director of Social Services said that when she spoke with Resident #1, on 12/09/24, he/she was weepy, fearful and reluctant to discuss the details of the incident that occurred with Maintenance Assistant #1 that morning.</p> <p>Review of the Notes from the Administrator and Director of Nurses (DON's) interview with Maintenance Assistant #1, dated 12/09/24 and signed by Maintenance Assistant #1, indicated that he told them he had stopped to say hello to Resident #1 that morning, while he was doing a routine water temperature check. The Notes indicated that Maintenance Assistant #1 told the Administrator and DON that Resident #1 told him that he/she was depressed, and that he gave him/her a hug and a kiss. The Notes indicated that Maintenance Assistant #1 told the Administrator and DON that he had kissed Resident #1 on the lips and he described it as just a peck.</p> <p>The Notes indicated that Maintenance Assistant #1 told the Administrator and DON that he considered Resident #1 a friend, that he had hugged him/her on other occasions, and that the morning of 12/09/24 was the only time that he had kissed him/her. The Notes indicated that when the Administrator asked Maintenance Assistant #1 if he acknowledged that what he had done was wrong, if he realized that he had crossed the line, and that he (Maintenance Assistant #1) responded yes.</p> <p>During an interview on 01/02/25 at 3:00 P.M., the Administrator said that Maintenance Assistant #1 admitted to hugging Resident #1 and kissing him/her on the mouth, on the morning of 12/09/24. The Administrator said that Maintenance Assistant #1 was suspended during the investigation and was later terminated based on his inappropriate actions toward a resident.</p>		