STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225480	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Care at Holyoke	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)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48138 Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose care plan interventions included dependent with staff member assistance while eating, and that all food items were required to be pureed in consistency due to dypshagia (difficulty swallowing), the Facility failed to ensure nursing consistently implemented and followed interventions identified in his/her care plan related to eating. On [DATE] around 7:45 P.M., Certified Nurse Aide (CNA) #1 delivered Resident #1 a peanut butter and jelly sandwich as an evening snack to him/her in his/her room, CNA #1 did not remain with Resident #1 to assist him/her while he/she ate the sandwich, and left Resident #1 unsupervised with the sandwich, which was not the correct conisistency per his/her care plan. Fifteen minutes later, Resident #1 was found by staff unresponsive and without a pulse, CPR was initiated, 911 was activated, however Resident #1 was pronounced dead at the facility. Findings Include: Review of the Facility's Policy, titled Comprehensive Care Plan, dated as revised [DATE], indicated that the care plan is as follows: - Developed by the Interdisciplinary Team for each resident includes measurable objectives and timelines to accommodate preferences, and identified special medical, nursing and psychosocial needs. - Provides residents with all necessary care and services to enable them to achieve the highest quality of life. - Right to receive the services or items in the care plan. Resident #1 was admitted to the Facility in [DATE], diagnosis included dementia with agitation, dysphagia (difficulty swallowing), and schizophrenia. Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident #1 was cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 2 out of 15 (,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired cognition, and ,d+[DATE] suggests a resident is cognitively intact). The MDS further indicated Resident #1 was dependent for eating. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Physician's Orders, dated as effective [DATE] (and remained active on his/her [DATE], physician's order), indicated he/she was on a Pureed/National Dysphagia Diet Level 1 (NDD1), consisting of only pureed textured foods related to dysphagia. Review of article related to Standardization for Optimal Care, by the American Dietetic Association; titled National Dysphagia Diets, indicated the following: - NDD1-Level 1 diet consists of foods that are pureed, homogenous (uniform structure throughout) and cohesive (how food stays together). -Foods should be pudding-like. -Foods that require bolus formation, controlled manipulation and chewing are not allowed. Review of Resident #1's Care Plan titled, Dysphagia, reviewed and renewed with the [DATE] MDS, indicated he/she was at risk for aspiration and interventions included the following: - dependent on one staff member for assistance for eating due to hand tremors, - provide him/her with the diet as ordered, NDD1 with thin liquids, -alternating small bites of pureed food, and sips of liquids. Review of Resident #1's Activities of Daily Living (ADL) Care Plan related to Eating, reviewed and renewed with the [DATE] MDS, indicated he/she had cognitive loss, and to provide dependent level assistance of one staff member for eating. Review of Resident #1's Care Card (utilized by the CNA's to ensure required level of care is provided to individual residents on a CNA's assignment), dated [DATE], indicated he/she was dependent with assistance of one staff member for eating, alternate small bites and sips of liquids, teaspoon for eating, instruct him/her to eat in upright position, and eat slowly. Review of the Facility's Investigation Report, dated [DATE], at 9:00 P.M., indicated on [DATE], Resident #1 died after aspirating (inhaling food or liquid into the lungs instead of esophagus) on a sandwich in his/her room, experienced a medical event and education began immediately for staff on diet levels. Review of CNA #3's Witness Statement, dated [DATE], (as documented by facility Administrative Staff during a telephone interview) indicated that (on [DATE]) at around 8:00 P.M., she entered Resident #1's room, saw that he/she was pale, his/her lips were blue, he/she had no pulse and she called for the nurse. Review of CNA #1's Witness Statement, dated [DATE], (as documented by facility Administrative Staff during a telephone interview) indicated that (on [DATE]) at around 7:45 P.M. (snack time), she gave Resident #1 a peanut butter and jelly sandwich and exited the room. The Statement indicated she (CNA #1) did not check Resident #1's CNA care card prior to providing him/her the snack. (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 12:58 P.M., CNA #1 said she has worked at the facility for [AGE] years, had taken care of Resident #1 in the past, but that it had been a few months since she last had him/her on her assignment. CNA #1 said that on [DATE] at around 7:45 P.M., she gave Resident #1 a peanut butter and jelly sandwich for his/her evening snack, that she did not check the CNA Care Card for level of supervision he/she required or his/her diet, left him/her unattended in his/her room and then continued passing out snacks to other residents on the unit. CNA # 1 said she knew how to check the residents' CNA Care Cards in the Electronic Medical Record (EMR) and that she should have checked it before handing out the snacks. During an interview on [DATE], at 12:16 P.M., the Rehabilitation Director (who is also the Speech Language Pathologist (SLP) said they last had Resident #1 on speech therapy caseload in November of 2023, and his/her diet was downgraded to pureed at that time. The Rehab Director said Resident #1 required close supervision with 1:1 provided by a staff member while eating. The Rehab Director said Resident #1 required a staff member present for safety reasons due to him/her eating too quickly, even on the pureed diet. The Rehab Director said Resident #1 was on a full a pureed diet and should not have been given a peanut butter and jelly sandwich. During an interview on [DATE], at 12:09 P.M., the Dietician said Resident #1 was dependent for eating, and was on a pureed consistency diet for safety while eating. The Dietician said Resident #1 should not have been left unattended with any food items and should not have been given a peanut butter and jelly sandwich. During an interview on [DATE], at 12:27 P.M. Nursing Supervisor #1 said Resident #1 was on a pureed diet, was dependent on staff for assistance when eating due to decreased cognition levels and should not have been given a sandwich or left alone with a food item. During an interview on [DATE] at 12: 30 P.M., the Director of Nurses said that CNA #1 should have reviewed and followed interventions from Resident #1's Plan of Care/Card, which included only giving him/her pureed food items, and that CNA #1 should have remained with Resident #1 in his/her room while he/she was eating. On [DATE], the Facility presented the Surveyor with a Plan of Correction that addressed the areas of concern identified in this survey; the Plan of Correction provided is as follows: A. On [DATE], an investigation along with the education of staff was initiated by the evening Nursing Supervisor on diet levels immediately following the incident with Resident #1. B. On [DATE], an AD HOC Quality Assurance Performance Improvement (QAPI) meeting was conducted, Resident #1's choking incident was reviewed and corrective action plan was developed. C. On [DATE], a Facility wide audit was initiated by the Director of Nursing to ensure all Residents had the correct consistency and required level of staff assistance with meals and snacks, accurately indicated on CNA Care Cards and Care Plans. D. The following changes (per the Director of Nursing) were immediately implemented related to the process for meal and snack tray delivery: - Dietary labels bins and separates snacks according to diet consistency (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Education to dietary staff when loading the snack cart in the Kitchen and Nourishment Rooms on the units that they are assembled with identified sections that correlate by snack consistency and laminated lists of appropriate food items for specific diet levels. -Education to Nursing, Activities and Rehabilitation Staff on the updated process of checking diet orders and level of supervision required on the CNA Point of Care I-Pad tablet. E. On [DATE], Facility Administrative staff, Staff Development Coordinator (SDC) completed Education of all nursing staff, activity staff and rehabilitation staff on meal tray service policy, and snack policy which includes bringing the Point of Care tablet when passing snacks and meal trays prior to serving the resident's meal or snack and checking for current diet orders and consistency and providing the correct level of assistance needed. F. The Director of Nursing and or designee will conduct audits of the tray meal service, and snacks to ensure staff are providing the correct meal/diet and level of supervision. -Daily audits to be completed for one week , then three times weekly x two weeks, two times weekly x two weeks, weekly x two weeks, biweekly for one month then monthly x three months or until substantial compliance. The audits will be brought to quarterly QAPI meetings. G. The Director of Nursing and/or Designee are responsible for overall compliance.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48138 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had a diagnosis of dysphagia (difficulty swallowing), with diet orders for pureed foods only and was dependent on staff to provide assistance when eating, the Facility failed to ensure he/she was provided with the necessary level of staff assistance while eating to maintain his/her safety to prevent an incident of choking. On [DATE] at around 7:45 P.M., Certified Nurse Aide (CNA) #1 delivered Resident #1 an evening snack which consisted of a peanut butter and jelly sandwich, to him/her in his/her room. CNA #1 did not remain with Resident #1 to assist him/her while he/she was eating, and left Resident #1 unsupervised with the sandwich. Fifteen minutes later, Resident #1 was found by staff unresponsive and without a pulse, CPR was initiated, 911 was activated, however Resident #1 was pronounced dead at the facility. Findings Include: Review of the Facility's Policy, titled Reportable Events-Reporting Allegations and Incidents/Investigation (MA), dated as reviewed [DATE], indicated that a death that is unanticipated, not related to the natural course of the residents illness, or is the result of an error, an event that is inconsistent with facility policy that causes death or serious injury, or that places the resident in imminent danger of serious harm is reportable. Review of the Facility's Policy, titled Modified Texture Foods, dated as revised [DATE], indicated that foods requiring modification to a puree texture will have a smooth texture. Review of the Facility's Investigation Report, dated [DATE], at 9:00 P.M., indicated on [DATE], Resident #1 died after aspirating (inhaling food or liquid into the lungs instead of esophagus) on a sandwich in his/her room, experienced a medical event and education began immediately for staff on diet levels. Resident #1 was admitted to the Facility in [DATE], diagnoses included dysphagia, dementia with agitation, and schizophrenia. Review of Resident #1's Physician's Orders, dated as effective [DATE] (and remained active on his/her [DATE], physician's order), indicated he/she was on a Pureed/National Dysphagia Diet Level 1 (NDD1), consisting of only pureed textured foods related to dysphagia. Review of article related to Standardization for Optimal Care, by the American Dietetic Association; titled National Dysphagia Diets, indicated the following: - NDD1-Level 1 diet consists of foods that are pureed, homogenous (uniform structure throughout) and cohesive (how food stays together). -Foods should be pudding-like. -Foods that require bolus formation, controlled manipulation and chewing are not allowed. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident #1 was cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 2 out of 15 (,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired cognition, and ,d+[DATE] suggests a resident is cognitively intact). The MDS further indicated Resident #1 was dependent for eating. Review of Resident #1's Care Plan titled, Dysphagia, reviewed and renewed with the [DATE] MDS, indicated he/she was at risk for aspiration and interventions included the following: - dependent on one staff member for assistance for eating due to hand tremors, - provide him/her with the diet as ordered, NDD1 with thin liquids, -alternating small bites of pureed food, and sips of liquids. Review of Resident #1's Activities of Daily Living (ADL) Care Plan related to Eating, reviewed and renewed with the [DATE] MDS, indicated he/she had cognitive loss. Interventions included, to provide dependent level assistance of one staff member for eating. Review of Resident #1's Nursing Progress Note, dated [DATE] at 08:40 A.M., indicated he/she was Dependent for eating. Review of CNA #3's Witness Statement, dated [DATE], (as documented by facility Administrative Staff during a telephone interview) indicated that (on [DATE]) at around 8:00 P.M. she entered Resident #1's room, he/she looked pale, his/her lips were blue, and she called for the nurse. The Statement indicated that CNA #3 said she saw a quarter piece of a sandwich on Resident #1's nightstand, and that Resident #1 usually gets pudding or yogurt for a snack. Review of CNA #1's Witness Statement, dated [DATE], (as documented by facility Administrative Staff during a telephone interview) indicated that (on [DATE]) at around 7:45 P.M. (snack time), she gave Resident #1 a peanut butter and jelly sandwich and exited the room. The Statement indicated that CNA #1 said she did not check the CNA Care Card prior to providing Resident #1's snack. During a telephone interview on [DATE] at 12:58 P.M., CNA #1 said she has worked at the facility for [AGE] years, had taken care of Resident #1 before, but said it had been a few months since she last had him/her on her assignment. CNA #1 said that on [DATE] around 7:45 P.M., she was handing out the evening snacks to the residents on Resident #1's unit. CNA #1 said she gave Resident #1 a peanut butter and jelly sandwich for his/her snack, without first checking his/her diet orders and CNA Care Card for level of assistance he/she required. CNA #12 said she left Resident #1 unattended in his/her room with the sandwich and continued to pass out snacks to other residents on the unit. CNA # 1 said she knew how to check the residents' CNA Care Cards in the Electronic Medical Record (EMR) and that she should have checked it before handing out the snacks. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 12:16 P.M., the Rehabilitation Director (who is also the Speech Language Pathologist (SLP) said they last had Resident #1 on speech therapy caseload in November of 2023, and his/her diet was downgraded to pureed at that time. The Rehab Director said Resident #1 required close supervision with 1:1 provided by a staff member while eating. The Rehab Director said Resident #1 required a staff member present for safety reasons due to him/her eating too quickly, even on the pureed diet. During an interview on [DATE], at 12:09 P.M., the Dietician said Resident #1 was dependent for eating, that a staff member had to be with him/her when eating, and that he/she had been on a pureed consistency diet for his/her safety for almost a year. The Dietician said Resident #1 should not have been left unattended with food and should not have been given a peanut butter and jelly sandwich. During an interview on [DATE], at 12:27 P.M. Nursing Supervisor #1 said she responded to Resident #1's room when the Code Blue was called, assisted in the resuscitation efforts until EMS arrived and took over care. Nursing Supervisor #1 said Resident #1 was on a pureed diet and was dependent on staff being with him/her for assistance while eating due to decreased cognition levels, and dysphagia. During an interview on [DATE] at 12: 30 P.M., the Director of Nurses (DON) said that CNA #1 should have checked to see what Resident #1's Physician's Diet Order was, should have checked his/her CNA Care Card prior to giving him/her a snack, and should have remained with Resident #1 while he/she was eating, but did not. The DON said CNA #1 had worked at the facility for twenty years and was very experienced. On [DATE], the Facility presented the Surveyor with a Plan of Correction that addressed the areas of concern identified in this survey; the Plan of Correction provided is as follows: A. On [DATE], an investigation along with the education of staff was initiated by the evening Nursing Supervisor on diet levels immediately following the incident with Resident #1. B. On [DATE], an AD HOC Quality Assurance Performance Improvement (QAPI) meeting was conducted, Resident #1's choking incident was reviewed and corrective action plan was developed. C. On [DATE], a Facility wide audit was initiated by the Director of Nursing to ensure all Residents had the correct consistency and required level of staff assistance with meals and snacks, accurately indicated on CNA Care Cards and Care Plans. D .The following changes (per the Director of Nursing) were immediately implemented related to the process for meal and snack tray delivery: - Dietary labels bins and separates snacks according to diet consistency - Education to dietary staff when loading the snack cart in the Kitchen and Nourishment Rooms on the units that they are assembled with identified sections that correlate by snack consistency and laminated lists of appropriate food items for specific diet levels. -Education to Nursing, Activities and Rehabilitation Staff on the updated process of checking diet orders and level of supervision required on the CNA Point of Care I-Pad tablet. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	E. On [DATE], Facility Administrative staff, Staff Development Coordinator (SDC) completed Education of all nursing staff, activity staff and rehabilitation staff on meal tray service policy, and snack policy which includes bringing the Point of Care tablet when passing snacks and meal trays prior to serving the resident's meal or snack and checking for current diet orders and consistency and providing the correct level of assistance needed. F. The Director of Nursing and or designee will conduct audits of the tray meal service, and snacks to ensure staff are providing the correct meal/diet and level of supervision. -Daily audits to be completed for one week , then three times weekly x two weeks, two times weekly x two weeks, weekly x two weeks, biweekly for one month then monthly x three months or until substantial compliance. The audits will be brought to quarterly QAPI meetings. G. The Director of Nursing and/or Designee are responsible for overall compliance.