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	11/25/2025

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 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). Based on records reviewed and interviews, for one of three sampled residents (Resident #1) whose diagnoses included Post Traumatic Stress Disorder (PTSD) and anxiety, with behaviors that included repeatedly entering and exiting his/her room and pacing on the unit when anxious, the Facility failed to ensure that he/she was free from involuntary seclusion by means of confinement, when on 10/14/25 during the evening shift, Nurse #1 prevented Resident #1 from exiting his/her room by physically holding the door shut. Resident #1's anxiety escalated while he/she was confined to his/her room and he/she was heard crying, banging on the door and yelling to be let out.Findings include:Review of the Facility Policy titled Resident Abuse (Screening, Training, Prevention, Reporting, Investigation)-MA, dated as effective 11/03/20, indicated it is the policy of the Facility that abuse, neglect, exploitation, and/or mistreatment of residents or misappropriation of resident property is prohibited. Further review of the Policy indicated it included the following definition of involuntary seclusion: the separation of a resident from other residents or from his/her room against the resident's will or the will of the resident's legal representative. Review of the Facility's Investigation Summary, undated, indicated that Resident #1 reported, and two alert and oriented residents also said that on 10/14/25 at around 6:45 P.M., they witnessed Nurse #1 closing and holding Resident #1's room door closed while Resident #1 [who was confined inside] was asking to leave the room. The Summary further indicated that based on resident and staff interviews, Facility administration substantiated the allegation that Nurse #1 prevented Resident #1 from leaving his/her room, against his/her will and that Nurse #1's employment was terminated.Resident #1 was admitted to the Facility in April 2025, diagnoses included neurocognitive disorder with Lewy bodies (a degenerative brain disorder also known as Lewy body dementia), post-traumatic stress disorder (PTSD) and anxiety disorder. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated as completed 10/05/25, indicated he/she was cognitively intact with a score of 13 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 indicated Resident #1 ambulated independently and required the use of a walker.Review of Resident #1's Behavioral Care Plan, reviewed and revised on 10/06/25, indicated that he/she had the potential to scream at others, swear and have flashbacks of early trauma related to Lewy body dementia, Parkinsonism, PTSD and ineffective coping skills. The Care Plan indicated the following interventions were to be implemented when Resident #1 becomes agitated:-intervene before agitation escalates-guide away from source of distress-engage calmly in conversation.-if Resident #1's response is aggressive, staff is to calmly walk away, and approach later.Resident #1's written statement, (as told by him/her to the Director of Nurses (DON)), dated 10/16/25, indicated that not last night, but the night before Nurse #1 shut the door to his/her (Resident #1's) room despite his/her stated preference to leave the door open. The Statement indicated that when Resident #1 attempted to open the door, he/she was unable to do so because Nurse #1 was holding the door shut. Resident #1 was on Medical Leave of Absence (unrelated to this incident) from the facility at the time of survey and was therefore unavailable to be interviewed. Review of the DON's investigation notes (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0603 Level of Harm - Actual harm Residents Affected - Few	indicated that CNA #1 told the DON that she observed Nurse #1 standing in front of Resident #1's closed door at the time of the incident, but that CNA #1 could not recall whether or not Nurse #1 was holding the door shut. Review of Resident #2's admission MDS assessment, dated as completed 10/06/25, indicated he/she was cognitively intact with a score of 13 out of 15 on the BIMS. Review of Resident #3's admission MDS assessment, dated as completed 09/17/25, indicated he/she was cognitively intact with a score of 13 out of 15 on the BIMS. During an interview on 11/25/25 at 1:20 P.M., Resident #2 said that he/she witnessed an incident between Nurse #1 and Resident #1 more than a month ago (exact date unknown). Resident #2 said he/she was watching television in the common area at the end of the hall when he/she heard loud banging and raised voices in the hallway and heard Resident #1 yelling, Open the door. Resident #2 said that when he/she went into the hallway to investigate the commotion, he/she observed Nurse #1 holding Resident #1's door closed with both hands. Resident #2 said that Nurse #1 was grasping onto the doorknob, had both feet firmly planted on the floor, and was leaning his body away from the door to maintain leverage, preventing Resident #1 from exiting his/her room. Resident #2 said that while Nurse #1 held the door shut, he/she could hear Resident #1, who was inside the room, yelling, crying, and banging on the door, attempting to get out. Resident #2 said that after a few minutes, Nurse #1 released the door after he/she (Resident #2) confronted him, Resident #2 said he/she asked Nurse #1 how he would feel if the same thing occurred to his family member. Resident #2 also reported that CNA #1 was present during the altercation. During an interview on 11/25/25 at 1:15 P.M., Resident #3 said that he/she observed Nurse #1 hold Resident #1's door shut while he/she was seated across the hall. Resident #3 said that prior to the incident, Resident #1 had been yelling in the hallway regarding something he/she wanted, and Nurse #1 instructed him/her (Resident #1) to return to his/her room. Resident #3 said this sequence occurred two or three times, with Resident #1 returning to his/her room briefly before exiting again. Resident #3 said that on the third occasion when Resident #1 attempted to leave his/her room, Nurse #1 closed the door (while Resident #1 was still in the room) and held it firmly for a few minutes before reopening it. Resident #3 said that Resident #1 appeared to be pulling on the door from the inside to open it while Nurse #1 held it closed. Resident #3 said the incident lasted a few minutes. Resident #3 further said that another resident, Resident #2, who was present, yelled at Nurse #1 for keeping the door closed and asked Nurse #1, How would you feel if that was your family member? During an interview on 11/25/25 at 2:50 P.M., Certified Nurse Aide (CNA) #2 said that despite working at the Facility for only a few months, she was familiar with Resident #1's behavior because she worked full time from 7:00 A.M. to 7:00 P.M. on Resident #1's unit. CNA #2 said that Resident #1 often paced in the hallway and perseverated about when his/her next medications were scheduled. CNA #2 said that limit-setting and redirection were not always effective interventions for Resident #1. CNA #2 said that on the evening of 10/14/25, Resident #1's anxiety began to escalate prior to mealtime and that he/she continued pacing the unit after dinner. CNA #2 said that around 6:45 P.M., while she was providing care to a resident a few doors away, she heard a commotion in the hallway involving Resident #1 and Nurse #1. CNA #2 said she heard banging on a door, consistent with someone rattling a door and attempting to open it. CNA #2 said that when she entered the hallway, she observed Nurse #1 releasing the handle of Resident #1's door. CNA #2 said she did not witness whether Nurse #1 had been holding the door shut. CNA #2 said that Resident #2 was in the hallway, appeared very upset and had yelled at Nurse #1, stating that he should not have held Resident #1's door shut because he/she was not well and did not know any better. CNA #2 said she provided care to Resident #1 immediately after the incident and assisted him/her back to bed. CNA #1 said that during care, Resident #1 appeared overwhelmed and very upset. During an interview on 11/25/25 at 1:33 P.M., Nurse #2 said that she was working from 7:00 A.M. to 7:00 P.M. on Resident #1's unit on 10/14/25. Nurse #2 said that shortly before shift change that evening, she was on the opposite end of the unit passing medications when she heard Nurse #1 tell Resident #1 to return to his/her room. Nurse #2 said she heard a commotion between Resident #1 and Nurse #1, but siad she was not in a (continued on next page)

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Mission Care at Holyoke	35 Holy Family Road Holyoke, MA 01040

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F 0603 Level of Harm - Actual harm Residents Affected - Few	position to see what occurred. Nurse #2 said that approximately 15 minutes later, when she arrived back on that end of the unit, she overheard Resident #2 on his/her cell phone stating that he/she had witnessed a Nurse holding a resident's door shut. During a telephone interview on 11/26/25 at 10:43 A.M., Nurse #1 said that on the evening of 10/14/25, Resident #1 was very anxious, agitated and repeatedly requesting assistance from a CNA to make his/her bed. Nurse #1 said that he informed Resident #1 several times that staff were occupied with providing care to other residents but assured him/her that someone would assist him/her as soon as possible. Nurse #1 said he redirected Resident #1 to go back to his/her room several times; however, he/she continued to leave the room and repeatedly voiced the same concern. Nurse #1 said that at one point Resident #1 began to exit his/her room through the partially closed door, and that he held the door open to allow him/her to pass safely. Nurse #1 said he did not at any time hold the door closed to prevent Resident #1 from exiting. During an interview on 11/25/25 the Director of Nurses (DON) said that Nurse #1 was suspended on 10/15/25, pending investigation. The DON said that the Facility's investigation substantiated the allegation of involuntary seclusion and as a result and said that Nurse #1 employment with the Facility was terminated.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on records reviewed and interviews, for two of four sampled residents (Resident #1 and Resident #4), the Facility failed to ensure staff implemented and followed their Abuse Policy related to the need to immediately report an allegation of abuse to Facility administration, when: 1.) On 10/14/25, Nurse #2 and Nurse #3 became aware during the evening shift, of an allegation of involuntary seclusion by means of confinement, when Nurse #1 prevented Resident #1 from exiting his/her room at will, however, neither of them reported the allegation immediately, as required. 2.) Certified Nurse Aide (CNA) #4 reported an allegation of verbal abuse involving Nurse #1 and Resident #4 on 10/02/25 to the Charge Nurse, however, Facility administration was not notified until a few days later, on 10/04/25. Findings include:Review of the Facility Policy titled Resident Abuse (Screening, Training, Prevention, Reporting, Investigation)-MA, dated as effective 11/03/20, indicated it is the policy of the Facility that abuse, neglect, exploitation, and/or mistreatment of residents or misappropriation of resident property is prohibited. The Policy indicated it included the following definition of involuntary seclusion: the separation of a resident from other residents or from his/her room against the resident's will or the will of the resident's legal representative. Further review of the Policy indicated the staff member who hears an allegation of abuse, or suspects or witnesses abuse will report immediately to their supervisor in person or by phone. The Policy indicated the Administrator or on-call designee and Director of Nursing Services are to be notified immediately.1). Review of the Facility's Investigation Summary, undated, indicated that Resident #1 reported, and two alert and oriented residents said that on 10/14/25 at around 6:45 P.M., they witnessed Nurse #1 closing and holding Resident #1's door closed while Resident #1 [who was confined inside] was asking to leave the room. The Summary further indicated that based on resident and staff interviews, the Facility administration substantiated the allegation that Nurse #1 prevented Resident #1 from leaving his/her room against his/her will and that Nurse #1's employment was terminated.Resident #1 was admitted to the Facility in April 2025, diagnoses included neurocognitive disorder with Lewy bodies (a degenerative brain disorder also known as Lewy body dementia), post-traumatic stress disorder (PTSD) and anxiety disorder. Resident #1's written statement, (as told by him/her to the Director of Nurses (DON)), dated 10/16/25, indicated that not last night, but the night before Nurse #1 shut the door to Resident #1's room despite his/her stated preference to leave the door open. The Statement indicated that when Resident #1 attempted to open the door, he/she was unable to do so because Nurse #1 was holding the door shut. During an interview on 11/25/25 at 1:33 P.M., Nurse #2 said that she was working from 7:00 A.M. to 7:00 P.M. on Resident #1's unit on 10/14/25. Nurse #2 said that shortly before shift change that evening, she was on the opposite end of the unit passing medications when she heard Nurse #1 tell Resident #1 to return to his/her room. Nurse #2 said she heard a commotion between Resident #1 and Nurse #1, though she was not in a position to see what occurred. Nurse #2 said that approximately 15 minutes later, when she arrived back at that end of the unit, she overheard Resident #2 on his/her cell phone stating that he/she had witnessed a Nurse holding a resident's door shut. Nurse #2 said she did not report the incident to Facility administration.During an interview on 11/25/25 at 1:20 P.M., Resident #2 said that he/she witnessed an incident between Nurse #1 and Resident #1 more than a month ago (exact date unknown). Resident #2 said he/she was watching television in the common area at the end of the hall when he/she heard loud banging and raised voices in the hallway and heard Resident #1 yelling, Open the door. Resident #2 said he/she observed Nurse #1 holding Resident #1's door closed with both hands, and Nurse #1 was grasping onto the doorknob, had both feet firmly planted on the floor, and was leaning his body away from the door to maintain leverage, preventing Resident #1 from exiting his/her room. During a telephone interview on 12/04/25 at 1:44 P.M., (which also included a review of her written witness statement dated 10/15/24) Nurse # 3 said that while she was the acting Supervisor during the evening shift on 10/14/25, Resident #2 reported to her that he/she witnessed an altercation between (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 and Nurse #1. Nurse #3 said that around 8:00 P.M., Resident #2 reported that earlier that evening, he/she saw Nurse #1 hold Resident #1's door closed, while he/she (Resident #1) was inside the room, preventing him/her from leaving the room. Nurse #3 said she observed that Resident #1 was in bed, watching television and appeared safe, therefore she did not further investigate the allegation and did not report it to Facility administration. During an interview on 11/25/25 at 2:00 P.M., the Director of Nurses (DON) said that Nurse #2 and Nurse #3 did not immediately report the allegation to Facility administration as required. The DON further said that she was not notified about the incident until it was reported to her by Resident #2 on the morning of 10/15/25. 2). Resident #4 was admitted to the Facility in April of 2021 with diagnoses including moderate dementia with mood disturbance, major depressive disorder and anxiety disorder.Review of Resident #4's Quarterly MDS assessment, dated as completed 09/07/25, indicated he/she was moderately cognitively impaired with a score of 9 out of 15 on the BIMS. Review of Certified Nurse Aide (CNA) #4's Written Statement, dated 10/04/25, indicated that on the previous Thursday (10/02/25), when CNA #4 attempted to provide care to Resident #4, he/she refused care and was yelling loudly. The Statement indicated that Nurse #1 told Resident #4, You are a faggot racist and that is why you won't let her clean you.During an interview on 11/25/25 at 2:47 P.M., CNA #4 said that one day she had worked in early October 2025, she reported to Nurse #1 that Resident #4 had refused care. CNA #4 said that Nurse #1 responded by confronting Resident #4, accusing him/her of being racist, and called him/her a faggot. CNA #4 said that she reported the incident to the Charge Nurse. CNA #4 further said that although she could not recall the date of the incident during the interview, it was documented in the written witness statement that she provided to Unit Manager #1.CNA #4 said that (10/02/25) was not the first time she had witnessed Nurse #1 call Resident #4 a faggot racist although she could not recall details or dates for any of the previous incidents and further said that she had not reported them to her supervisor.During an interview on 11/25/25 at 3:44 P.M., Unit Manager #1 said that while she was acting as the weekend supervisor on 10/04/25, a Charge Nurse reported that CNA #4 told her that Nurse #1 had called Resident #4 a faggot racist. Unit Manager #1 said that the Charge Nurse did not report the allegation to Facility administration immediately as required.Unit Manager #1 said that both the Charge Nurse and CNA #4 should have reported the allegation to Facility administration immediately. During an interview on 11/25/25 at 4:28 P.M., the Director of Nurses (DON) said that on 10/04/25 Unit Manager #1 reported CNA #4's allegation involving Nurse #1 and Resident #4, and that CNA #4 could not recall the exact date of the incident. The DON said that it wasn't until she reviewed CNA #1's written statement, dated 10/04/25, that she noticed the incident had occurred on the previous Thursday, (two days earlier).During an interview on 11/25/25 at 4:45 P.M. the Administrator said the expectation is for all allegations of suspected abuse to be reported to Facility administration immediately.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on records reviewed and interviews, for one of four sampled residents (Resident #4), who was moderately cognitively impaired, the Facility failed to ensure that an allegation of verbal abuse was reported to the Massachusetts Department of Public Health (DPH) as required, when on 10/04/25, the Director of Nurses (DON) was made aware of the allegation made by Certified Nurse Aide #4 against Nurse #1, however, the Facility had not reported the allegation to DPH as of 11/25/25 (52 days later).Findings include:Review of the Facility Policy titled Resident Abuse (Screening, Training, Prevention, Reporting, Investigation)-MA, dated as effective 11/03/20, indicated it is the policy of the Facility that abuse, neglect, exploitation, and/or mistreatment of residents or misappropriation of resident property is prohibited. Further review of the Policy indicated allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property are to be reported to the Massachusetts Department of Public Health:a. Immediately but not later than two hours after the allegation is made if the allegations involve abuse or result in serious bodily injury or if there is reasonable suspicion of a crime as defined by the Elder Justice Act.b. No later than 24 hours if it does not involve abuse or serious bodily injury.Resident #4 was admitted to the Facility in April of 2021 with diagnoses including moderate dementia with mood disturbance, major depressive disorder and anxiety disorder.Review of Resident #4's Quarterly Minimum Data Set (MDS) assessment, dated as completed 09/07/25, indicated he/she was moderately cognitively impaired with a score of 9 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). Review of Certified Nurse Aide (CNA) #4's Written Statement, dated 10/04/25, indicated that on the previous Thursday (10/02/25), when CNA #4 attempted to provide care to Resident #4, he/she refused care and was yelling loudly. The Statement indicated that Nurse #1 told Resident #4, You are a faggot racist and that is why you won't let her clean you. During an interview on 11/25/25 at 2:47 P.M., CNA #4 said that in early October 2025, she had reported to Nurse #1 that Resident #4 had refused care. CNA #4 said that Nurse #1 responded by confronting Resident #4, accusing him/her of being racist, and called him/her a faggot. CNA #4 said that she reported the incident to the Charge Nurse. CNA #4 further said that although she could not recall the date of the incident during the interview, it was documented in the written witness statement that she provided to Unit Manager #1.Review of the Health Care Facility Reporting System (HCFRS), indicated that between 10/02/25 and up to the date of survey (11/25/25) the Facility had not reported any incidents involving Nurse #1 and Resident #4.During an interview on 11/25/25 at 3:44 P.M., Unit Manager #1 said that while she was acting as the weekend supervisor on 10/04/25, a Charge Nurse reported that CNA #4 had alleged that when she told Nurse #1 that Resident #4 had been combative during care, Nurse #1 had confronted Resident #4, accused him/her of being racist, and called him/her a faggot. Unit Manager #1 said that when she spoke to Resident #4, he/she was unable to recall any incidents with Nurse #1, and only told her, That Nurse (#1) doesn't like me. Unit Manager #1 said she instructed CNA #4 to complete a written witness statement about the incident, and she reported the allegation to the Director of Nurses (DON).During an interview on 11/25/25 at 4:28 P.M., the Director of Nurses (DON) said that on 10/04/25, she was notified that CNA #4 had witnessed Nurse #1 direct a derogatory slur at Resident #4, and that CNA #4 said she could not recall the exact date the incident occurred. The DON said that when she reviewed CNA #4's Written Witness Statement, she felt it conflicted with her (CNA #4's) verbal statement, and that she (the DON) did not feel it was specific enough to investigate or to report to DPH.