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	12/03/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews for one of three sampled residents (Resident #1) who was cognitively impaired and was dependent on staff to meet his/her care needs, the Facility failed to ensure nursing notified the Provider when he/she was observed to have a new area of bruising around the corner of his/her right eye, of unknown origin.Findings include:Review of the Facility's policy titled, Physician Notification-Change of Condition, review date 10/15/25, indicated:-It is the policy of this facility to notify the physician when the residents' condition or status changes unexpectedly or substantially. -If a resident is evaluated by a charge nurse to have a change in condition, the charge nurse will notify the RN Supervisor on duty.-The RN Supervisor will do a follow-up assessment to ensure that the assessment is documented and reported to the Physician.-The Physician will (or alternate) will be contacted to report findings. Resident #1 was admitted to the facility May 2024, diagnoses included vascular dementia, depression, age-related osteoporosis (bone disease causing weak, brittle bones), history of cerebral infarction (stroke) and aphasia (speech impairment).Review of Resident #1's Nurse Progress Note, dated 11/04/25, indicated he/she had a red-purple, non-tender bruise on his/her right eye. There was no documentation to support that the Provider had been notified by nursing staff of a new right eye bruise.During an interview on 12/03/25 at 1:30 P.M., Nurse #1 said that she had discovered that Resident #1 had a new bruise above his right eyebrow while she was making rounds at the start of her 7:00 A.M to 3:00 P.M. shift on 11/04/25. Nurse #1 said that she could see the bruise as soon as she saw Resident #1, even with the light off. Nurse #1 said that she notified the Unit Manager as soon as he came to work and he helped her to complete the Incident Report, New Skin Tear or Bruise Report, and obtain witness statements. Nurse #1 said that she was unable to determine how Resident #1 had obtained the bruise. Nurse #1 said that she did not notify the Physician of Resident #1's new eye bruise of unknown origin.During an interview on 12/03/25 at 2:00 P.M., the Unit Manager said that Nurse #1 had notified him that Resident #1 had a bruise surrounding his eye. The Unit Manager said that he assessed the bruise to be at the corner of Resident #1's right eye. The Unit Manager said he instructed Nurse #1 to complete the Skin/bruise packet and to get statements from staff. The Unit Manager said he had not notified the Provider or the Director or Nursing of Resident #1's eye bruise of unknown origin.Review of the Facility Skin Tear or Bruise Report, dated 11/04/25, indicated Resident #1 was observed to have a 2 centimeter (cm) by 2 cm red-purplish, round bruise on the corner of his/her right eye. The Report indicated the Resident was unable to say how the bruise had happened.Review Resident #1's Nurse Progress Note, dated 11/05/25, indicated he/she had a bruise on his/her right eye. Review of Resident #1's Nurse Progress Notes, dated 11/04/25 through 11/09/25, indicated there was no documentation to support nursing notified the Provider that he/she had a new area of bruising on the corner of his/her right eye.Review of Resident #1's Physician Assistant (PA) Note, dated 11/09/25, indicated Nursing staff notified the PA of Resident #1's altered mental status and self-removal of an indwelling urinary catheter. The Note indicated Resident #1 was to be transferred to the Hospital Emergency Department (ED) for evaluation.There was no documentation in the PA's Progress note to support that the PA was aware of and/or had been notified by nursing staff of the bruise to Resident #1's right eye.During a telephone interview on 12/05/25 at 9:50 A.M., Physician #1 said that he not been notified by the Facility that Resident #1 had new bruise on his/her right eye and had learned about the bruise during the Facility's investigation. Physician #1 said the nursing staff should have notified the Provider of the new eye or facial bruise because if there was a concern for facial injury, the resident would have been sent to the ED for an evaluation.Review of the Report submitted by the Facility via the Health Care Reporting System (HCFRS), dated 11/11/25, indicated [after transferring Resident #1 to the ED for evaluation for altered mental status and self-removal of his/her indwelling catheter] the Facility was notified by the hospital that Resident #1 had a CT (computed tomography or CAT scan) that indicated he/she had a right anterior temporal bone (upper section forming the side of the skull) nondisplaced fracture and subarachnoid hemorrhage (brain bleed). Review of Resident #1's Hospital Neurosurgery Consult note, dated 11/10/25, indicated he/she had a right non-displaced temporal skull fracture with subarachnoid hemorrhage and no reported trauma. During an interview on 12/03/25, at 3:00 P.M., the Director of Nursing (DON) said that on 11/11/25, she had been notified by the Hospital that Resident #1 had a skull fracture and subarachnoid hemorrhage. The DON said that on 11/11/25 she started an investigation including a review of Resident #1's clinical record which indicated that on 11/04/25 nursing staff had observed Resident #1 with a new bruise on his/her face by his/her right eye. The DON said that nursing staff should have notified herself

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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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1) the Facility failed to ensure that after being made aware that Resident #1 had an injury of unknown origin on 11/11/25 by the Hospital, that they reported the injury to the Department of Public Health (DPH) within two hours as required, when it was not reported to DPH until 11/17/25, (6 days later).Findings include:Review of the Facility's policy titled, Resident Abuse (Screening, Training, Prevention, Reporting, Investigation), dated as reviewed 10/15/25, included but was not limited to the following: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 allegation involves abuse or resulting 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 does not involve abuse or serious bodily injury.Review of the Report submitted by the Facility via the Health Care Reporting System (HCFRS), dated 11/17/25, indicated the Facility was notified by the hospital that Resident #1 had a CT [computed tomography or CAT scan] that indicated he/she had a right anterior temporal bone [front part of the bone on the right side of the skull} non displaced fracture and subarachnoid hemorrhage [brain bleed]. The Report indicated the Facility had conducted an investigation including a review of the medical record that indicated a Nurses' Note, dated 11/04/25, described a purple/red bruise to Resident #1's right eye [injury of unknown origin]. The Report indicated that Resident #1 said he/she did not know what had happened to cause the bruise. The Report indicated that staff interviews were obtained without identifying a cause for the bruise to Resident #1. Resident #1 was admitted to the facility May 2024, diagnoses included vascular dementia, depression, age-related osteoporosis (bone disease causing weak, brittle bones), history of cerebral infarction (stroke) and aphasia (speech impairment).Review of Resident #1's Nurse Progress Note, dated 11/04/25, indicated he/she had a red-purple, non-tender bruise on his/her right eye. Review of the Facility Incident Report, dated 11/04/25, indicated the Nurse had noted a bruise on the side of Resident #1's right eye. The note indicated the bruise was described as [above his/her right eyebrow] purple-red and without bleeding. The Report indicated a warm compress was applied.Review of Nurse #1's written statement, dated 11/11/25, indicated that Nurse #1 had shown Resident #1 a picture of his/her bruise, and that Resident #1 stated he/she did not know what had happened. The Statement indicated that Nurse #1 had asked Certified Nurse Aides (CNA's) and an Activity Aide, if they knew what had happened but was told that none of them had noticed anything. During an interview on 12/03/25 at 1:30 P.M., Nurse #1 said that she had discovered that Resident #1 had a bruise above his right eyebrow while she was making rounds at the start of the 7:00 A. M. to 3:00 P.M. shift on 11/04/25. Nurse #1 said that she could see the bruise as soon as she saw him/her, even with the light off. Nurse #1 said she had not heard that Resident #1 had a bruise in report and that she did not find that a bruise had been documented in his/her medical record. Nurse #1 said that she reported to bruise to the Unit Manager as soon as he came to work and he helped her to assess Resident #1 and complete the Incident Report and obtain staff statements. Nurse #1 said that Resident #1 did not have side rails on his/her bed and that she was unable to determine how Resident #1 had obtained the bruise. Nurse #1 said she was unaware that an injury of unknown origin should be reported to DPH.During an interview on 12/03/25 at 2:00 P.M., the Unit Manager said that Nurse #1 had notified him that Resident #1 had a bruise on his/her eye. The Unit Manager said that he assessed the bruise to be at the corner of Resident #1's right eye. The Unit Manger said that he had seen Resident #1 on the previous day and he/she did not have a bruise. The Unit Manager said he instructed Nurse #1 to complete the Skin/bruise packet and to get statements from staff. The Unit Manager said that he had been under the impression that Resident #1 had side rails on his/her bed but learned afterwards that he/she did not. The Unit Manager said that he did not know how Resident #1 had obtained the bruise on his/her right eye [above the eyebrow]. During an interview on 12/03/25, at 3:00 P.M., the Director of Nursing (DON) said the facility policy is that any bruise or injury of unknown origin is investigated immediately and reported to DPH within two hours. The DON said the Nursing staff should have notified her of Resident #1's eye bruise of unknown origin immediately which then should have been reported to DPH within two hours but had not been. Although the DON was made aware of Resident #1's injury by the hospital on [DATE], and started an investigation, the injury of unknown origin {which was first found by nursing staff on 11/04/25] was not reported to DPH until 11/17/25 (6 days later). On