

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/23/2026
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)		
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 one of three sampled residents (Resident #1), who had been allegedly witnessed by a staff member on 5/10/26 to have been subjected to verbal abuse by another staff member, the Facility failed to ensure staff consistently implemented and followed their Abuse Policy related to the requirement to immediately report an allegation of abuse to Facility Administration when the Director of Nursing was not notified until 06/01/26 about the incident, which had occurred several weeks earlier. Findings include: Review of the Facility Policy titled Resident Abuse (Screening, Training, Prevention, Reporting, Investigation), 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 property is prohibited. The Policy indicated it included the following definition of verbal abuse as: any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families or within their hearing distance, to describe residents regardless of their age, ability to comprehend, or disability. 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 that the administrator or on-call Designee and Director of Nursing Services are to be notified immediately. Review of the Facility's Investigation Summary, undated, indicated that on 05/31/26 at 9:20 P.M., (the correct date was 06/01/26 per interview with the Director of Nursing (DON), the DON was notified that a Certified Nurse Aide (later identified as CNA #1) had accused Nurse #1 of having called Resident #1 a derogatory name. Further review of the Investigation Summary indicated it included a written statement from the DON, dated 06/05/26, that indicated Human Resources (HR) notified her on the evening of 05/31/26, (which per the DON, was a typographical error and the date she was notified 06/01/26), CNA #1 sent an e-mail communication to HR with multiple concerns about Nurse #1 going back to the beginning of May 2026, one of which was an allegation of potential verbal abuse. The DON's statement indicated a report was made to the Department of Public Health (DPH) and an investigation was initiated at that time. Review of CNA #1's e-mailed statement to HR, dated 06/01/26 at 7:53 P.M., indicated that on 05/10/26 (exact time not provided), she (CNA #1) witnessed Nurse #1 call Resident #1 a motherfucker and told him/her that he/she stinks. Resident #1 was admitted to the Facility in April 2024, diagnoses included unspecified dementia with unspecified severity and agitation. Review of Resident #1's most recent Minimum Data Set (MDS) Assessment, dated 05/03/26, indicated he/she was moderately cognitively impaired with a score of 11 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). During an in-person interview on 06/23/26 at 11:00 A.M., Resident #1 said he/she did not remember an incident where Nurse #1 called him/her a motherfucker or being told he/she stinks. During a telephone interview on 06/23/26 at 2:25 P.M. and a follow up telephone interview on 06/24/26 at 4:00 P.M., CNA #1 said on 05/10/26 at around 8:00 P.M. (exact time unknown), Nurse #1 was at the medication cart and Resident #1 was seated in a chair nearby. CNA #1 said Resident #1 constantly asks for staff to pour him/her water, so much so that they place a pitcher of water with cups accessible to him/her so he/she could pour it him/herself, which he/she is able to do. CNA #1 said on the evening of 5/10/26, despite this (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention, Resident #1 continued to ask Nurse #1 to pour water for him/her. CNA #1 said at one point Nurse #1 responded to Resident #1 in a rude manner and called him a stinky motherfucker. CNA #1 said Resident #1 became angry and stood up from his/her chair and in response, Nurse #1 shouted over the facility intercom that she was assaulted and needed muscle. CNA #1 said a male CNA from a different unit responded to the overhead page and escorted Resident #1 to his/her room with no further incidents the rest of the shift. CNA #1 said she reported this incident in detail to Nursing Supervisor #1 twice on 05/10/26. CNA #1 said she initially notified Nursing Supervisor #1, explaining in detail the interaction with Nurse #1 and Resident #1, about the incident around 8:43 P.M. and said she specifically told Nursing Supervisor #1 that Nurse #1 was verbally abusive toward Resident #1. CNA #1 said she thought about the incident all night long and said when she saw Nursing Supervisor #1 seated at the reception desk in the lobby as they were clocking out on 05/11/26 at 7:23 A.M., said she brought up the incident to her again. CNA #1 said Nursing Supervisor #1 told her that she would report the alleged incident to the DON. During a telephone interview on 06/24/26 at 10:11 A.M., Nursing Supervisor #1 said on 05/10/26, CNA #1 told her that Nurse #1 was verbally abusive toward Resident #1, said she was not sure of the exact time CNA #1 made the report, and said she thought it was after Nurse #1 went home for the evening after 11:00 P.M. Nursing Supervisor #1 further said the more she thought about it, said that CNA #1 did not report this incident to her until 05/11/26 at shift change (exact time unknown). Nursing Supervisor #1 said when the DON arrived that morning (05/11/26) she told her that CNA #1 reported to her that she (CNA #1) was concerned that Nurse #1 was verbally abusive towards Resident #1. During an interview on 06/23/26 at 3:50 P.M., the Director of Nursing (DON) said on the morning of 05/11/26, Nursing Supervisor #1 told her that CNA #1 was unhappy with Nurse #1 and had not specifically reported that CNA #1 had alleged that Nurse #1 had verbally abused Resident #1. The DON said the first she heard of the verbal abuse allegation was after HR contacted her (on 06/01/26) to inform her they had received an e-mail from CNA #1 with multiple concerns about Nurse #1, including an allegation that Nurse #1 had verbally abused Resident #1 on 05/10/26. The DON said if CNA #1 had a concern that Nurse #1 verbally abused Resident #1, it was the expectation that CNA #1 inform Nursing Supervisor #1 immediately. The DON further said once Nursing Supervisor #1 was made aware of a verbal abuse allegation, it was expected that Nursing Supervisor #1 implement the Facility's Abuse Policy and inform either herself or the Administrator immediately. The DON said Facility staff did not implement their Abuse Policy regarding reporting allegations of Abuse immediately. On 06/23/26, the Facility presented the Surveyor with a Plan of Correction with an effective date of 06/03/26, that addressed the areas of concern identified in this survey. The Plan of Correction is as follows: A. Resident #1 was assessed, he/she showed no signs of distress or change in behavior as a result of the alleged incident, and he/she continues to be monitored and supported by staff as needed. B. On 06/01/26 and weekly thereafter, the Director of Nurses interviewed residents that resided on the unit where Nurse #1 was employed to determine whether there were any further allegations of verbal abuse and to assess their overall well-being, with no additional instances found or reported. Random resident interviews will continue to be conducted bi-weekly for two months, then monthly for two months by the Director of Nurses. C. On 06/02/26, the Director of Nurses immediately initiated an investigation into the allegation, and the facility was unable to substantiate the allegation of verbal abuse. D. On 06/02/26, the Personnel Development Coordinator and/or her designee completed re-education (Topic: Reporting) and reviewed the Facility's abuse policy with all Facility staff. E. On 06/03/26, Social Services and Behavioral Health staff interviewed and assessed Unit 3 (where the allegation of verbal abuse occurred) residents to determine whether they felt safe in their environment, and random interviews will continue as needed, and ongoing support and monitoring for mood and behavior changes will be provided. F. The results of the resident interviews will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for four months. G. The Director of Nurses and/or designee are responsible for overall compliance.		