

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/28/2026
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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who had a diagnosis of dementia with agitation and was looking for assistance from staff, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when on 06/26/26, a staff member witnessed Certified Nurse Aide (CNA) #1 interact with Resident #1 in a demeaning and derogatory manner. Findings include: Review of the Facility Policy titled Resident Rights and Responsibilities, dated as revised July 2015, indicated the facility will protect and promote the rights of each resident as set forth in the Resident [NAME] of Rights. Further review of the Policy indicated that residents had the right to be treated with consideration, respect and full recognition of their dignity and individuality. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 06/26/26, indicated that Resident #1 was agitated and yelling around 4:00 P.M. The Report indicated that a staff member alleged that CNA #1 responded (to this behavior) by telling Resident #1 to stop yelling like an idiot. The Report further indicated that a few moments later, when Resident #1 complained that staff had not responded quickly enough to his/her request for assistance, CNA #1 explained that she had been assisting another resident. The Report indicated that Resident #1 responded, fuck them, and CNA #1 replied, Well, fuck you too. Resident #1 was admitted to the Facility in June 2021, diagnoses included dementia with agitation, Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 05/23/26, indicated Resident #1 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 was wheelchair-bound and dependent on staff for mobility and Activities of Daily Living (ADLs). Review of Resident #1's Behavior Care Plan, reviewed and renewed with his/her Quarterly MDS, completed 05/23/26, indicated that Resident #1 should be approached in a calm and reassuring manner during incidents of increased anger or agitation. During an interview on 07/28/26 at 11:20 A.M., Certified Nurse Aide (CNA) #2 said that she witnessed a verbal altercation between Resident #1 and CNA #1 on 06/26/26 around 4:00 P.M. CNA #2 said that Resident #1 was agitated and distressed after experiencing an episode of bowel incontinence and was yelling loudly that he/she wanted a shower. CNA #2 said that CNA #1 responded to Resident #1 by telling him/her to stop yelling like an idiot. CNA #2 further said that Resident #1 required the assistance of two staff members for care, so she offered to assist CNA #1. CNA #2 said that after Resident #1's shower was completed, he/she was crying and complaining that staff had taken too long to assist him/her. CNA #2 said that CNA #1 explained to Resident #1 that she had been assisting another resident and he/she responded, fuck them! CNA #2 said that CNA #1 responded to Resident #1 by saying, well, fuck you too! Review of the Director of Nurses (DON's) Written Summary of her interview with Resident #1, dated 06/29/26, (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident #1 told her that the CNA who provided his/her shower on Friday (later identified as CNA #1) had called him/her an idiot. The Summary further indicated that Resident #1 told the DON that CNA #1 also used the word fuck while addressing him/her. The Summary indicated Resident #1 was pleased that CNA #1 would no longer provide him/her with care. Resident #1 declined the surveyor's request for an interview. During a telephone interview on 07/28/26 at 12:41 P.M., Certified Nurse Aide (CNA) #1 said that on 06/26/26 during the evening shift, Resident #1 was agitated and yelling loudly and demanding a shower. CNA #1 said that she and CNA #2 assisted Resident #1 with the shower. CNA #1 further said she did not recall using profanity or telling Resident #1 to stop yelling like an idiot. During an interview on 07/28/26 at 1:15 P.M., the Director of Nurses (DON) said that the Facility's investigation concluded that Certified Nurse Aide (CNA) #1 failed to treat Resident #1 with dignity and respect during an interaction on 06/26/26. The DON said the conclusion was based on consistent witness statements provided by CNA #2 and Resident #1.		