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	04/02/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observation, interview and record review, the facility failed to provide respiratory care and services consistent with professional standards of practice for one Resident (#44) out of a total sample of 24 residents. Specifically, the facility staff failed to: -Implement a schedule for cleaning and storage of Resident #44's BiPAP mask (a mask used in conjunction with a BiPAP device [non-invasive ventilation machine that is capable of generating two adjustable pressure levels), placing the Resident at risk for nosocomial (healthcare associated) infections. -Clean and maintain the Resident's oxygen concentrator (medical device that uses air in the atmosphere, filters it, and delivers air that is 90 - 95% oxygen concentrated) filter in accordance with professional standards and placing the Resident at risk for impaired oxygen delivery and equipment malfunction. Findings include: Review of the facility policy titled Concentrator Maintenance, undated, indicated the following: It is the facility policy that all respiratory therapy and oxygen equipment must be cleaned in order to prevent nosocomial infections and ensure proper function. Concentrator filters should be pulled from the side and cleaned by: 1. manually removing dust by wiping with towel and/or shaking particles free, 2. vacuuming the dust from the filter, or 3. placing the filter in warm soapy water and allow to air dry. (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

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 04/02/2024
NAME OF PROVIDER OR SUPPLIER: Mission Care at Holyoke		STREET ADDRESS, CITY, STATE, ZIP CODE: 35 Holy Family Road Holyoke, MA 01040	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #44 was admitted to the facility in February 2022 with diagnoses including: Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease that causes obstructed airflow and breathing problems), Chronic Respiratory Failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body) with Hypoxia (means decreased perfusion of oxygen to the tissues) and Obstructive Sleep Apnea (OSA - refers to apnea syndromes due primarily to collapse of the upper airway during sleep). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #44 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total score of 15. Review of Resident #44's Physician's orders for March 2024 and April 2024 indicated: -Oxygen - 2 liters per minute (LPM) via nasal cannula (a device that delivers supplemental oxygen through a tube and into the nose) continuous. -BiPAP setting 25 centimeters water (cm/H2O)/5 cm/H2O: apply at bedtime and remove with morning care. -BiPAP mask and tubing to be bagged after use. -BiPAP mask to be cleaned daily with appropriate wipe or soap/water on day shift. -Clean oxygen concentrator filter weekly on Thursdays, 11:00 P.M. Review of Resident #44's Respiratory Care Plan initiated 2/3/23 indicated the following interventions: -BiPAP mask to be cleaned daily with soap and water on 7-3 shift -BiPAP mask and tubing to be bagged after use on 7-3 shift as ordered -Change oxygen tubing and clean filter on concentrator weekly as ordered During observation on 3/28/24 at 12:30 P.M. the surveyor observed the Resident's BiPAP mask laying face down on the bed and was not placed in a bag as required. During an interview at the time, the Resident said the BiPAP mask had not been cleaned and that the staff had never cleaned the BiPAP mask. During observation and interview on 3/28/24 at 4:10 P.M., the surveyor observed the Resident's BiPAP mask laying face down on the Resident's bed, without a protective covering bag. During an interview at the time, the Resident said that he/she asked staff for wipes to clean the BiPAP mask, but no wipes had been provided as requested. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/2/24 at 8:57 A.M., the surveyor observed Resident #44 with Oxygen being administered via a nasal cannula connected to the oxygen concentrator and the Resident's BiPAP mask laying on the bed with dried yellow and white debris on the inside of the mask. The surveyor also observed a plastic storage bag hanging from the oxygen concentrator with a dried white substance coating the inside of the bag. The surveyor further observed that the oxygen concentrator filter was coated with a thick, gray, fibrous layer of dust over the filter surface. During an interview at the time, the Resident said that the dried white substance was dried saliva/spit in the BiPAP mask and staff has never cleaned the mask. During an interview on 4/2/24 at 10:01 A.M., Nurse #1 said that Resident #44's BiPAP mask should be cleaned and placed in a plastic bag, with the bag being changed weekly by the night shift staff. Nurse #1 said the storage bag for the Resident's BiPAP mask was dirty and he was unable to tell when the storage bag in Resident #44's room was last changed because there was no date on the bag. Nurse #1 also said that the filter located on the oxygen concentrator was dirty and that the night shift Nurse was responsible for the cleaning of the oxygen concentrator filters every week. During an interview on 4/2/24 at 10:30 A.M., the Infection Control (IC) Nurse said the nursing staff was responsible for cleaning the Resident's BiPAP mask and oxygen concentrator filter. The surveyor and the IC Nurse observed the oxygen concentrator filter on Resident #44's concentrator and the IC Nurse said the filter was dirty, which was concerning because the air the Resident was inhaling would be dirty. The IC Nurse further said that the Resident's dirty BiPAP mask should be cleaned and placed into the protective bag when the mask was not in use. During an interview on 4/2/24 at 11:48 A.M., the IC Nurse said she spoke with a representative from the oxygen and respiratory supply company that serviced the facility and asked what the potential risks were related to having a dirty oxygen concentrator filter. The IC nurse said she was told by the representative the oxygen concentrator could overheat and then shut off. When the surveyor asked the IC Nurse if the oxygen would stop flowing to the Resident if the concentrator overheated and shut down, the IC nurse said yes. During an observation on 4/2/24 at 12:22 P.M., the surveyor observed Resident #44 seated in his/her wheelchair at his/her bedside. The surveyor also observed that the Resident's BiPAP mask remained face down on top of the bed linens, not protected by a storage bag. The surveyor further observed that the undated, dirty storage bag remained hanging from the oxygen concentrator and the filter on back of the oxygen concentrator was not cleaned and remained coated in a layer of thick, gray, fibrous dust.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observation, interview, and record review, the facility failed to provide dialysis services consistent with professional standards of practice for one Resident (#94) out of a total sample of 24 residents. Specifically, the facility failed to: -consistently communicate the facility Nurse's assessment of the Resident prior to him/her going to dialysis. -collaborate with applying EMLA (Lidocaine) cream to the dialysis access site prior to the Resident leaving the facility to prevent pain when the dialysis site is accessed in the dialysis facility. -implement recommendations made by the dialysis center to remove pressure dressings within 24 hours of dialysis treatments to prevent clotting of the dialysis access site. Findings include: Resident #94 was admitted to the facility in February 2022, with a diagnosis of End Stage Renal Disease (ESRD: when the kidneys no longer work as they should to meet the body's needs) and was dependent on dialysis treatments (a treatment that does the work of the kidneys by removing waste products and excess fluids from the blood). Review of the facility's dialysis policy titled, Hemodialysis, revised 3/19/08, included but was not limited to: -The Dialysis Communication Form (a form that contains pertinent assessment information, including recommendations, between the facility and the dialysis center, usually placed in a book that accompanies the residents to dialysis treatments) will be utilized to facilitate communication between the facility and the dialysis center. -The facility will evaluate the resident on return from the dialysis center and document the evaluation. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #94 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a score of 15, and the Resident received dialysis treatments. Review of the March 2024 Physician's orders indicated the following: -Dialysis on Tuesday, Thursday and Saturday every week, initiated 1/30/24 (continued on next page)

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

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Apply Lidocaine/Prilocaine 2.5 percent (%)/2.5% (numbing cream) externally every Tuesday, Thursday, and Saturday. Apply a dime sized amount to fistula site (area, usually an arm, where an artery and vein are surgically connected to provide an access site for the dialysis needles to puncture for dialysis treatment), initiated 1/20/24. -Hemodialysis, check access site left arm for signs of infection (warmth, redness, tenderness, swelling or bleeding) every shift, initiated 11/25/23. Review of the Resident's Dialysis Plan indicated the following: -Apply Lidocaine to left arm fistula before dialysis every Tuesday, Thursday and Saturday as ordered and cover with Tegaderm (a type of clear dressing), initiated 11/25/23 Review of the Resident's Dialysis Communication Forms included the following: -Tuesday, 1/16/24, a handwritten form placed inside the clear plastic outer front cover of the Dialysis Communication Book that read (exactly as written): >YOU MUST REMOVE THE BANDAGES OFF THE PATIENT'S ACCESS OR YOU WILL CLOT THE ACCESS OFF CAUSING THE PATIENT TO REQUIRE FURTHER SURGICAL INTERVENTION!!! >Also please apply EMLA (Lidocaine) cream to the access site before the patient leaves your facility for dialysis. It HURTS him to get his needles which was signed by a dialysis Nurse. -Saturday 1/20/24, the top half of the Dialysis Communication Form that should have included the facility Nurse's assessment of the Resident prior to going to dialysis was blank. >The bottom half of the form completed by the dialysis staff indicated: PLEASE TAKE THE DRESSINGS OFF WITHIN IN 24 HOURS. THE PATIENT'S ACCESS WILL CLOT!! IT WILL ALSO CAUSE MAJOR DAMAGE. >ALSO PLEASE MAKE SURE TO APPLY HIS/HER EMLA CREAM TO NUMB HIS/HER ACCESS SITE SO IT DOES NOT HURT HIM/HER SO MUCH. -Thursday 2/8/24 included a notation from the dialysis center that indicated, Please remove the bandages the next day!! Bandages were left on the Resident and caused indentations on the access site. -Thursday 2/22/24 indicated no assessment information (was left blank) was completed by the facility Nurse prior to sending the Resident for dialysis treatment. -Saturday 3/9/24 indicated no assessment information (was left blank) was completed by the facility prior to sending the Resident for dialysis treatment. -Thursday 3/21/24 included a notation from the dialysis center that indicated, The Resident had dressings from the last dialysis treatment and no Lidocaine cream over the access site. Please remove the dressings within 24 hours of dialysis treatments. The access may clot if the dressings continue to stay on the arm over 24 hours. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Saturday 3/23/24 included a handwritten note from the dialysis center that indicated, No communication book came with Resident today. Dressings need to be taken off within 24 hours of dialysis treatment. Resident came to dialysis on 3/21/24 and 3/23/24 with dressings on his/her arm and no Lidocaine cream over access. This may cause fistula to clot. During an observation and interview on 3/29/24 at 9:41 A.M., the Resident said he/she goes to dialysis every Tuesday, Thursday, and Saturday and has a place on his/her left upper arm for dialysis treatment access. The surveyor observed a white bandage wrapped snugly around the Resident's left upper arm. During an interview on 3/29/24 at 2:09 P.M., the Dialysis Facility Administrator said the dressings that the dialysis staff apply to the Resident's arm after dialysis treatment were pressure dressings and should be removed prior to the Resident going to bed, approximately six to eight hours after treatment. The Dialysis Facility Administrator said if pressure dressings remained in place too long, the fistula could clot, thus rendering the fistula unusable. The Dialysis Facility Administrator also said the pressure dressing should never be left on for more than 24 hours. The Dialysis Facility Administrator further said the fistula may still bleed when the facility Nurse removed the pressure dressing, bleeding should be minimal and the Resident may still require a smaller dressing to cover the dialysis access areas, but not a pressure dressing. During an interview on 3/29/24 at 2:50 P.M., Unit Manager (UM) #1 said prior to sending Resident #94 to dialysis, the facility Nurse should ensure Lidocaine cream was applied to Resident #94's fistula to prevent discomfort when the dialysis nurse accesses the fistula site with needles. UM #1said the facility Nurse should also ensure the facility portion of the Dialysis Communication Form was completed. UM #1 said that the Resident's fistula should be assessed regularly for bruit (a whooshing sound heard when a stethoscope is placed on the fistula) and thrill (a vibration felt when fingers are placed on the fistula) which ensure that the fistula is patent (working). UM #1 said bruit and thrill should be assessed every shift and the fistula should be assessed for excessive bleeding once the Resident returns back to the facility from dialysis. UM #1 said she tended to leave Resident #94's pressure dressing in place until the next morning because he/she takes a blood thinning medication and UM #1 was worried about the Resident experiencing excessive bleeding. UM #1 said the Dialysis Communication Form should be reviewed by the facility Nurse upon the Resident's return from dialysis to check for any updates or recommendations made by the dialysis team. On 3/29/24 at 3:00 P.M., the surveyor observed the Resident lying in bed, with a pressure dressing in place on the left upper arm from his/her dialysis treatment on 3/28/24. During an interview on 3/29/24 at 4:00 P.M., the Director of Nurses (DON) said that a Nurse cannot properly assess a dialysis site for infection or complications when the access site was covered with a pressure dressing. The DON said there was a problem related to communication between the dialysis facility and the nursing facility that needed to be addressed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview 3/29/24 at 4:15 P.M., the surveyor and Nurse #5 observed that Resident #94's left upper arm pressure dressing remained in place from his/her dialysis treatment on 3/28/24. Nurse #5 said she preferred to keep the Resident's dressing in place until the following day because she was concerned about the Resident bleeding too much because he/she takes a blood thinning medication. Nurse #5 said in order to assess the fistula for complications and infection, the pressure dressing would have to be removed. The surveyor then observed Nurse #5 remove the pressure dressing from the Resident's left upper arm. After removing the tape and two small, square gauze bandages covering the access sites, the surveyor observed indentations on the Resident's skin where the tape was removed as well as deep pits on the Resident's arm where the gauze squares had been, approximately one half to three-quarters of an inch deep. The surveyor also observed a scant amount of bleeding from one of the access sites. Nurse #5 said she understood the dialysis team wanted the pressure dressings removed within 24 hours, but Nurse #5 said she was worried that the Resident would have excessive bleeding and has had bleeding in the past. Nurse #5 said she had never communicated the Resident may have experienced excessive bleeding in the past to the dialysis team, but meant to write the dialysis team a note.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44129 Based on record review and interview, the facility failed to ensure that one Resident (#96) out of a total sample of 24 residents was free from a significant medication error. Specifically, the facility staff failed to: -discontinue an order for an antipsychotic medication (medication used to treat certain types of mental health problems whose symptoms include psychotic experiences) dosage of 20 milligrams (mg) of Abilify, before administering the newly ordered dosage of 25 mg of Abilify resulting in the Resident receiving an excessive dosage (45 mg) of the medication, which was greater than the recommended maximum dosage of 30 mg daily. Findings include: Resident #96 was admitted to the facility in February 2023 with a diagnosis of Schizophrenia (a chronic brain disorder with symptoms such as delusions, hallucinations, disorganized speech, trouble speaking, and lack of motivation). According to the Nursing Drug Handbook (2022), page 144, Aripiprazole (brand name Abilify, an antipsychotic medication) Indications and Dosage indicated but was not limited to: -for Schizophrenia: Initially 10-15 milligrams (mg) daily. Increase to maximum daily dose of 30 mg daily. Review of the March 2024 Physician's orders indicated: -Aripiprazole 20 mg tablet, administer one tablet orally at bedtime, order date 8/4/23 and discontinued 3/11/24. -Abilify 15 mg tablet by mouth once daily. Give with Abilify 10 mg tablet once daily for a total dose of 25 mg daily at 9:00 A.M., order date 3/5/24, started 3/6/24. Review of the Psychiatric Nurse Practitioner (NP) Visit Note dated 3/5/24 indicated: -Increase Abilify from 20 mg to 25 mg daily. Review of the Consultant Pharmacist Drug Regimen Review Report dated 3/6/24, indicated: -Please review/update diagnosis listed with Aripiprazole orders. -Currently lists Major Depressive Disorder (MDD - symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy) with morning orders (25 mg) and Catatonic Schizophrenia with evening orders (20 mg). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the March 2024 Medication Administration Record (MAR) indicated that the Resident received both the discontinued 20 mg dose of Abilify and the newly ordered 25 mg dose of Abilify from 3/6/24 through 3/10/24 (five days total). Review of a Nursing Progress Note dated 3/11/24, time stamped at 11:47 A.M., and authored by Unit Manager (UM) #1, indicated: After clarification with the Psychiatric NP, the Resident should only be taking Abilify 25 mg daily. During an interview on 3/29/24 at 2:42 P.M., UM #1 said she realized there was a medication error after reviewing the Consultant Pharmacist Recommendation referencing two separate doses of Abilify. UM #1 said she compared the Resident's chart, the MAR, and the Nursing Progress Notes and called the Psychiatric NP to clarify the order and it was determined that the Resident should not have received both the 25 mg and the 20 mg dose for a total daily Abilify dose of 45 mg (beyond the maximum daily recommended dose of 30 mg). UM #1 said the Nurse who failed to discontinue the Abilify 20 mg dose (the Nurse who was unavailable to interview during the survey) told UM #1 that she was distracted when she was transcribing the new order and forgot to discontinue the old (20 mg) order of Abilify, causing the Resident to receive an elevated dose (45 mg) of Abilify for five days.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42741 Based on record review and interview, the facility failed to accurately execute Advance Directives (written documents that tells your health care providers who should speak for you and what medical decisions should be made, if you become unable to speak for yourself) for two Residents (#30 and #79) out of a total sample of 24 residents. Specifically, the facility failed to ensure that the MOLST (Massachusetts Medical Order for Life-Sustaining Treatment) decisions were made by: 1. Resident #30, who had not been deemed as lacking capacity for informed decision making by the facility's Physician instead of their Health Care Proxy (HCP-a legally designated person who can make medical decisions for a person deemed by a medical professional to be unable to make their own medical decisions). 2. Resident #79, who was not determined by the Physician/ Nurse Practitioner (NP) as being unable to make their own medical decisions, instead of the HCP. Findings include: Review of the facility policy titled MOLST, last revised 2/19/21, indicated: -that if a resident (or if the resident lacks decision-making capacity, the legally recognized health care agent) wished to complete a MOLST for during the resident's stay, -provide a MOLST form for the Physician/Nurse Practitioner and the resident or the resident's legally designated health care agent to discuss, fill out and sign. -Notify the resident's Physician/Nurse Practitioner or the medical director that the resident or legally designated health care agent (if the resident lacks decision-making capacity), wishes to discuss the treatment options on the MOLST. 1. Resident #30 was admitted to the facility in April 2023, with diagnoses including Frontotemporal Neurocognitive Disorder (a type of Dementia resulting from damage to the neurons in the frontal and temporal lobes of the brain), Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy), Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and Delusional Disorder. Review of the Resident's medical record indicated a MOLST form signed and dated by the Resident's HCP on 8/9/23, and signed and dated by the facility Nurse Practitioner (NP). The date on which the NP signed the MOLST form was illegible. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Resident's medical record indicated at the time the MOLST was completed the Resident was not been deemed incapable by a medical professional to be unable to make his/her own health care decisions. Additional review of the Resident's medical record indicated no documentation that the Resident was involved in the discussion making process to complete and create the MOLST. During an interview on 4/1/24 at 5:02 P.M., with Social Worker (SW) #1 and SW #2, SW #2 said Resident #30's HCP had not been activated (done when the Resident is deemed to be unable to make his/her own health care decisions) until January 2024. SW #2 further said the HCP should not have completed a MOLST form as he/she did not have the authority to do so at the time the MOLST form was completed on 8/9/23. 45429 2. Resident #79 was admitted to the facility in July 2023, with diagnoses including Dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking) and catatonic disorder (a group of symptoms that can affect movement, communication, and behavior). Review of the clinical record revealed a MOLST form that was signed on 7/17/23 by the Resident's HCP. Further review of the clinical record failed to indicate that Resident #79 had been deemed by a Physician or Nurse Practitioner as lacking the capacity to make their own health care decisions pertaining to medical care. During an interview on 4/1/24 at 4:03 P.M., SW #1 said that there was no evidence that the HCP had been activated by a Physician or NP. SW #1 also said that the HCP should not have signed the MOLST form as he/she did not have the authority to do so at the time the MOLST form was completed on 7/17/23.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45429 Based on observation, interview, record and policy review, the facility failed to ensure that staff adhered to infection control standards for transmission-based precautions for two Residents #61 and #79, and on two Units (Unit One and Unit Three) out of three units observed to stop the spread of infection in the facility. Specifically, the facility failed to ensure: 1. On Unit One, for Residents #61 and #79, that staff wore the required personal protective equipment (PPE) when caring for COVID-19 positive residents, to mitigate the spread of infection during a COVID-19 outbreak in the facility. 2. On Unit Three, that staff performed hand hygiene after caring for a COVID positive resident, between contact with multiple residents to prevent contamination and mitigate the spread of infection during a COVID-19 outbreak in the facility. Findings include: Review of the facility policy titled Isolation Policy and Procedures dated 10/22/21, indicated the following: *Droplet Precautions: -In addition to standard precautions, use droplet precautions for residents known or suspected to be infected with a microorganism transmitted by droplets that can be generated by the resident sneezing, coughing, talking, etc. -Perform hand hygiene, apply a gown, mask, goggle/eye protection, and gloves upon entering the resident's room. -Remove gloves, goggle/eye protection, gown, mask, and dispose before leaving the resident's room. -Perform hand hygiene. *Contact Precautions: -In addition to standard precautions, use contact precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as environmental surfaces or resident care items. -Perform hand hygiene, apply a clean gown and gloves upon entering the resident's room. -Remove gloves, gown, and dispose before leaving the resident's room. -Perform hand hygiene. (continued on next page)

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 04/02/2024
NAME OF PROVIDER OR SUPPLIER: Mission Care at Holyoke		STREET ADDRESS, CITY, STATE, ZIP CODE: 35 Holy Family Road Holyoke, MA 01040	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Isolation Precautions sign, utilized by the facility, indicated the following: -Everyone must clean their hands, including before entering and when leaving the room. -Providers and staff must also put on a gown, gloves, N95 mask, eye protection (goggles or face shield) before room entry. -Discard gloves and gloves between each resident. 1a. Resident #61 was admitted to the facility in April 2021 with diagnoses including Dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking) and Heart Failure (when the heart is unable to pump blood as it should resulting in fluid buildup in the feet, arms, lungs and other organs). Review of Resident #61's care plan for testing positive for the COVID virus, dated 3/27/24 indicated the following interventions: -Maintain transmission-based precautions (TBP) until all symptoms resolve or 14 days after the onset of illness. -Provide me and the staff who care for me with PPE during care and visits in my room. Review of Resident #61's care plan titled, I have an active infectious disease of COVID-19 dated 3/28/24, indicated that the Resident was required to be in isolation and on Droplet Precautions. Review of the Resident's April 2024 Physician's orders indicated that Resident #61 was on Droplet Precautions due to testing positive for COVID-19, with a start date of 3/28/24. On 3/28/24 at 8:53 A.M., the surveyor observed CNA #1 entering Resident #61's room with a surgical mask to assist the Resident with his/her breakfast. The surveyor observed that there was an Isolation Precautions sign located next to the room's entrance and a bin containing the appropriate PPE supplies as listed on the Isolation Precautions sign. During an interview immediately following the observation, CNA #1 said that she should have been wearing an N95 mask prior to entering Resident #61's room but she was not wearing the appropriate mask. During an interview on 3/28/24 at 8:56 A.M., Nurse #4 said that CNA #1 should have been wearing an N95 mask while in Resident #61's room. 1b. Resident #79 was admitted to the facility in July 2023, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment) and catatonic disorder (a group of symptoms that can affect movement, communication, and behavior). Review of Resident #79's care plan for testing positive for the COVID virus, dated 3/28/24 indicated the following interventions: -Maintain transmission-based precautions until all symptoms resolve or 14 days after the onset of illness (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Provide me and the staff who care for me with PPE during care and visits in my room Review of Resident #79's care plan titled, I have an active infectious disease of COVID-19 dated 3/28/24, indicated that the Resident was required to be in isolation and on Droplet Precautions. Review of the Resident's April 2024 Physician's orders indicated that Resident #79 was on Droplet Precautions due to testing positive for COVID-19, with a start date of 3/28/24. On 3/28/24 at 9:38 A.M., the surveyor observed Nurse #4 and Unit Manager (UM) #1 enter Resident #79's room without eye protection to provide care for Resident #79. The surveyor observed that there was an Isolation Precautions sign located next to the room's entrance and a bin containing the appropriate PPE supplies as listed on the Isolation Precautions sign. During an interview immediately following the observation, Nurse #4 asked the surveyor if her eyeglasses were appropriate eye protection. Unit Manager #1 said that both Nurse #4 and UM #1 should have been wearing the appropriate eye protection in the Resident's room. During an interview on 3/28/24 at 9:43 A.M., the Regional Clinical Director said that the staff should have been wearing N95 masks and eye protection when entering the COVID-19 positive residents' rooms. On 4/1/24 at 8:39 A.M., the surveyor observed CNA #2 exiting Resident #79's room after providing care. The surveyor observed that CNA #2 did not remove her N95 mask or change her goggles upon exiting the room. The surveyor also observed that CNA# 2 pulled a pair of gloves out of her pocket versus getting gloves from the PPE bin outside the room, and entered another COVID-19 positive residents' room. During an interview immediately following the observation, CNA #2 said that she had been rushing, should have put on a new mask, cleaned, or changed her eye protection and should have taken clean gloves from the PPE bin instead of her pocket and she did not so as required. During an interview on 4/1/24 at 8:56 A.M., the Regional Clinical Director said that CNA #2 should have disposed of the N95 mask and eye protection, and utilized clean PPE from the bin prior to entering another COVID-19 positive room. 42741 2. Review of the facility policy titled Hand Hygiene, undated, indicated the following: *When to use alcohol hand sanitizer -After removing gloves -Before entering the residents' rooms -Before exiting the residents' rooms (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Mission Care at Holyoke		STREET ADDRESS, CITY, STATE, ZIP CODE 35 Holy Family Road Holyoke, MA 01040	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 3/28/24 at 9:29 A.M. on Unit Three, the surveyor observed CNA #3 exit a room with Isolation Precautions signage outside the door indicating the Resident was on precautions for COVID-19. CNA #3 doffed (took off) her PPE which included gloves, an N95 mask, and a gown but did not perform hand hygiene after doffing her PPE and exiting the room. The surveyor further observed CNA #3 leaving the COVID-19 precautions room and entering another Residents' room (who was not on precautions) without performing hand hygiene and touching the Resident on the hand. During an interview immediately following the observation, CNA #3 said she had been in the room where a Resident was COVID-19 positive and removed the COVID-19 positive Resident's meal tray from the room. CNA #3 further said that she should have performed hand hygiene after doffing her PPE but did not, as required.

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. 42741 Based on interview, policy and record review, the facility failed to implement the facility smoking policy one Resident (#22) out of a total sample of 24 residents. Specifically, for Resident #22 the facility failed to ensure that staff completed re-admission smoking evaluations after the Resident was hospitalized on two occasions. Findings include: Review of the facility policy titled Resident Smoking-MA, reviewed 2/14/23, indicated the following: -Smoking evaluations: Smoking evaluations should be done upon admission/re-admission and after significant change in resident status. Resident #22 was admitted to the facility in June 2021, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment) with severe mood disturbance and a history of a traumatic brain injury (TBI - a form of acquired brain injury that occurs when a sudden trauma causes damage to the brain). Review of list titled Smoking Group provided to the surveyors at the entrance conference on 3/28/24 indicated that Resident #22 was a smoker. Review of Resident #22's Smoking Care Plan, with a start date of 11/30/23 indicated the following intervention: -I will have smoking evaluations per facility policy, start date of 11/30/23. Review of the Nursing Progress Note dated 9/8/23, indicated that the Resident had been sent from the facility to the hospital. Review of the Nursing Progress Note dated 9/11/23, indicated that the Resident had returned to the facility after being hospitalized from 9/8/23 through 9/11/23. Review of the Nursing Progress Note dated 11/25/23, indicated that the Resident had been sent from the facility to the hospital. Review of the Nursing Progress Note dated 11/30/23, indicated that the Resident had returned to the facility after being hospitalized from 11/25/23 through 11/30/23. Review of the Resident's medical record indicated no documentation the Resident had a smoking evaluation completed upon his/her return from the hospital on 9/11/23 and 11/30/23. During an interview on 4/2/24 at 10:26 A.M., Nurse #3 said smoking evaluations should be completed at the time of admission and annually. (continued on next page)

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	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Care at Holyoke	35 Holy Family Road Holyoke, MA 01040

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/24 at 12:33 P.M., the Administrator said per the facility policy smoking evaluations are done at the time a resident is admitted to the facility, at the time the resident return to the facility post-hospitalization , and if the resident has a significant change in status. The Administrator further said for Resident #22, smoking evaluations were not completed when he/she was readmitted to the facility from the hospital on 9/11/23 and 11/30/23, and smoking evaluations should have been completed per facility policy.