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	06/10/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a dignified existence by recognizing the individuality of one Resident (#1), out of a total sample of 24 residents. Specifically, for Resident #1, the facility failed to promote the dignity of the Resident when staff walked by, looked into the Resident's room, and failed to intervene and cover the Resident's lower body when he/she was observed from the hallway to be uncovered in bed with his/her underwear briefs clearly visible. Findings include: Resident #1 was admitted to the facility in April 2021 with diagnoses including Dementia and Neurosyphilis. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of a possible score of 15. -was dependent on staff for lower body dressing. On 6/6/25 from 8:14 A.M. through 8:45 A.M., the surveyor observed the following: -Resident #1 was visible from the hallway lying in his/her bed, uncovered by the bedsheet, with his/her underwear brief visible. -at 8:14 A.M., CNA #2 was observed walking past Resident #1's room, paused to look into the room, and then continued on down the hallway. -at 8:34 A.M., CNA #3 was observed walking past Resident #1's room, paused to look into the room, and then continued on down the hallway. -at 8:45 A.M., Nurse #3 wheeled her medication cart outside Resident #1's doorway facing the door, looked into the room, and then began to prepare medications for administration. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225480	A. Building B. Wing	06/10/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/25 at 8:45 A.M., the surveyor, Nurse #3, and CNA #3, observed the Resident from the hallway. During an interview at the time, CNA #3 said she could see Resident #1 from the door and that the Resident was uncovered. Nurse #3 said the Resident throws off the covers frequently. CNA #3 and Nurse #3 both said that if the Resident is observed uncovered that they should offer to cover the Resident. At this time, CNA #3 and Nurse #3 then went into the room and assisted Resident #1 to cover up with the bedsheet without issue. During an interview on 6/6/25 at 11:00 A.M., Nurse Consultant #1 (the previous Director of Nursing [DON]) said that if a Resident is observed to be uncovered or have their briefs visible from the door, the expectation is that staff would cover or offer to cover the Resident. Nurse Consultant #1 further said that even if the Resident frequently removes the blankets (covers) an attempt to cover the Resident should be made.

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	06/10/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, record reviews, and interviews, the facility failed to ensure a clean and homelike environment was maintained for one Resident (#48) out of a total sample of 24 residents. Specifically, for Resident #48, the facility failed to maintain a clean and homelike environment relative to G-tube (gastrostomy tube: medical device inserted into the abdomen to deliver food, fluids, medications) feeding equipment and the surrounding space in the Resident's room. Findings include: Review of the facility policy titled 5&7 Step Daily Room Cleaning, undated, and utilized by the housekeeping staff indicated the following: -Spot clean all vertical surfaces/Clean IV (Intravenous) poles. -Spot clean walls. Resident #48 was admitted to the facility in March 2021 with diagnoses including Protein Calorie Malnutrition, history of diseases of the digestive system, Gastric Ulcer, Dysphagia and Adult Failure to Thrive. Review of Resident #48's Care Plans indicated the following in part: -Resident #48 was NPO (nothing by mouth) and a new G-tube was placed on 5/7/21 for severe Dysphagia. The surveyor observed the following while Resident #48 was lying in bed, on: -6/3/25 at 10:04 A.M. -6/5/25 at 10:34 A.M. -6/5/25 at 10:43 A.M. -The EnteraFlo (nutrition delivery system) pump (not in use), located to the left of the Resident's bed and attached to an IV pole, had a dried brownish colored substance built up, and was splattered on multiple spots including the pump, IV pole and the base of the IV pole. -The corkboard located on the wall to the left of Resident #48 had dried brownish color splatter marks. -The wall just beneath the corkboard had dried brownish color splatter marks. -The Resident's headboard of the bed had dried brownish color splatter marks on the left side. -The wall behind the Resident's bed had dried brownish color splatter marks. (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	06/10/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/25 at 10:43 A.M., Nurse #8 said the Resident's G-tube pump, wall, headboard of the bed, and corkboard behind the Resident's bed were dirty with some type of dried brownish substance and should be cleaned. Nurse #8 said she was not sure how something like that would happen and that these areas should have been cleaned at the time it (spill) occurred. Nurse #8 said she was not sure who was responsible to clean the Resident's G-tube pump but thought that housekeeping would be responsible for the wall, headboard of the bed, and corkboard. During a follow-up interview on 6/5/25 at 10:59 A.M., Nurse #1 (shift supervisor) said he learned that housekeeping was responsible for daily cleaning of the Resident's G-tube pump, the IV pole which the pump hung from and the area around it including the headboard to the bed, the wall and corkboard. During an interview on 6/5/25 at 1:14 P.M., the Administrator said the Resident's G-tube pump should be cleaned daily by housekeeping. The Administrator further said that if staff had dropped or spilled the G-tube bag containing the nutritional supplement, the staff should have cleaned it immediately or called housekeeping to address the spill but had not.

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	06/10/2025

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. Based on observations, interviews, and record reviews, the facility failed to notify the state mental health authority (Pre-admission Screening and Resident Review [PASRR] Office) promptly of the need for Resident Review for one Resident (#107) out of a total sample of 24 residents,when the Resident experienced a significant change in his/her mental condition from his/her initial Level I PASRR. Specifically, the facility failed to notify the PASRR Office of the need for Resident Review when Resident #107: -had diagnoses of Post Traumatic Stress Disorder (PTSD) and Personality Disorder. -newly expressed homicidal ideation (HI) and suicidal ideation (SI). -had psychotropic medication that was newly ordered and administered to the Resident to stabilize his/her mood. Findings include: Review of the facility's policy titled PASRR - MA (Massachusetts), dated 11/17/20, indicated the following: -The facility would follow Federal regulations and State required procedures for the screening of persons being admitted to, and residing in the facility for serious mental illness (SMI) . through the MA Department of Mental Health or its designee, the PASRR Unit, . -The facility would make post-admission referrals to the appropriate PASRR authority in accordance with the requirements of MassHealth Nursing Facility Bulletin 143 (July 2019). Resident #107 was admitted to the facility in July 2024, with diagnoses including Post-Traumatic Stress Disorder (PTSD) and Personality Disorder. Review of Resident #107's Level I PASRR, dated 6/26/24, indicated the following: -The Resident did not have any documented diagnosis of a mental illness or disorder (MI/D: Schizophrenia, Somatoform Disorder, Delusional Disorder, Mood, PTSD, Severe Anxiety/Panic Disorder, Schizoaffective Disorder, Other Psychotic Disorder, Paranoia, Personality Disorder, other mental disorder that may lead to chronic disability). -The Resident's screen for SMI was negative. -A Level II PASRR Evaluation was not indicated. Review of Resident #107's clinical record failed to indicate the Resident was ordered for any psychotropic medication when he/she was admitted to the facility. Review of Resident #107's Psychiatric Assessments indicated the following: (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	06/10/2025

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>7/29/24 - The Resident was seen for initial evaluation and had a diagnosis of Other Specified Depressive Episodes. The Resident denied feelings of depression and anxiety. No evidence of delusions, paranoia, agitation, or aggression. Does not receive psychotropic medication. >8/7/24 - Assessed for mood and behavior and was having difficulty adjusting to a new roommate. The Resident was not on any psychotropic medications. >8/27/24 - Assessed for increased behaviors: aggressive, refusal of medications, physical with residents and staff. The Resident was not sleeping and had depressive episodes. >9/17/24 - Assessed for being sexually inappropriate to residents of the opposite gender, attempted to leave, and hit staff. The Resident refused to discuss the use of a mood stabilizer. >9/26/24 - Assessed for mood and behavior, and continued to be aggressive, combative, and exit seeking. The Resident had no HI/SI. The Resident experienced depressive episodes. >10/1/24 - Assessed for increased behaviors and was positive for HI/SI and made the following statement: I'm going to stab myself and will mess up my roommate by stabbing [him/her] when [he/she] falls asleep. Further review of this note indicated the Behavioral Health Provider notified the Nursing Supervisor at the facility. >10/10/24 - The Resident was agreeable to start on a mood stabilizer and Lamotrigine (medication that can be used to treat Bipolar Disorder, prevent episodes of depression, mania, and other mood changes) was recommended. >10/31/24 - Positive for HI/SI. >11/1/24 - Consent for Lamictal (brand name for Lamotrigine) was obtained. >12/27/24 - Restless, agitated, preys on nonresponsive residents. Start Sertraline and discontinue Lamictal. Review of Resident #107's Physician orders indicated the following: -Lamotrigine Oral Tablet Chewable 25 milligram (mg), give one tablet by mouth one time a day related to Adjustment Disorder with Depressed Mood (start date 11/2/24, discontinued 12/27/24). -Sertraline HCl (antidepressant medication) 25 mg tablet, give one tablet by mouth one time a day for Depression related to Adjustment Disorder with Depressed Mood (start date 12/28/24, with no stop date). Review of Resident #107's clinical record failed to include any evidence that Resident #107 was referred to the PASRR Office for Resident Review when the Resident experienced a change in mental condition from his/her initial Level I PASRR, dated 6/26/24. (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	06/10/2025

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/25 at 9:33 A.M., Resident #107 said he/she was very depressed and was getting more depressed living in the facility. The surveyor observed the Resident with a furrowed brow and the Resident did not make eye contact with the surveyor during the interview. On 6/4/25 at 9:40 A.M., the surveyor observed Resident #107 use his/her wheelchair to move through the hallway toward the surveyor. During an interview when Resident #107 reached the surveyor, the Resident said, . If I can't get out of here, I will commit suicide . I don't care . I'm sick of living . I will show them, and I have a date . The surveyor immediately reported the statements made by Resident #107 to a staff member at the nurses station. During an interview on 6/5/25 at 4:03 P.M., the Social Worker (SW) said Resident #107 had not been referred to the PASRR Office for Resident Review when the Resident experienced a change in mental condition and required implementation of psychotropic medication. The SW said that the Resident's change in behavior and the implementation of medication to treat the Resident's symptoms was considered a significant change in the Resident's mental condition. The SW said if she had submitted a request for Resident Review when the Resident experienced a significant change in mental condition, the Resident would have screened positive for SMI and triggered the need for a Level II PASRR Evaluation.

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	06/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to safely provide feeding assistance for two Residents (#14 and #5), out of a total sample of 24 residents, when both Residents required assistance for eating, putting both residents at risk for aspiration. Specifically, 1. For Resident #14, the facility failed to ensure that safe swallow strategies recommended by the Speech Therapist (ST) were implemented and that liquids provided to the Resident were the ordered consistency. 2. For Resident #5, the facility failed to ensure the Resident was provided with nectar (mildly) thick beverages during the breakfast meal. Findings include: Review of the facility's Fluid Consistencies Chart, undated, indicated Honey consistency was described as a liquid that coats a fork and slowly sinks through the prongs (e.g. Yogurt, Honey). Review of the facility's Feeding (Dependent Feeding) Policy, revised 6/19/23, indicated the following: -Residents will be fed by staff that have appropriate training in feeding residents. -Prior to serving food, check diet slip to ensure proper resident and appropriate diet. -Cut or divide food into small portions and give resident a small amount at a time. -Give liquids slowly. -Alternate food and liquid. Review of the Facility Thick and Easy Honey Consistency Packet 6.5 grams (g) included the following directions: -Add 1 packet 6.5 g Thick and Easy Instant food and beverage thickening powder to 4 fluid ounces (fl.oz.) of liquid. -Stir with a spoon or fork for approximately 15 seconds or until thickener is dissolved. -Allow 1-4 minutes for product to reach desired thickness. 1. Resident #14 was admitted to the facility in January 2025, with diagnoses including Dysphagia, Frontotemporal Neurocognitive Disorder and Mild Intellectual Disability. (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	06/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's Minimum Data Set (MDS) dated [DATE], indicated the following: -Brief Interview of Mental Status (BIMS) Assessment score of 6 out a possible 15, indicating severe cognitive impairment. -required supervision for eating. -was prescribed a mechanically altered diet. Review of the Dysphagia Care Plan for Resident #14, initiated 1/15/25, indicated he/she was at risk of aspiration with the following interventions: -alternate small bites and sips. Use a teaspoon for eating. Do not use straws, effective 1/15/25. -instruct the Resident to eat slowly and to chew each bite thoroughly, effective 1/15/25. -provide with the dependent level of assistance for eating, revised 6/3/25 -provide him/her with honey thick liquids via teaspoon only, revised 6/4/25. -Resident to eat with dependent assistance of one staff member, revised 6/4/25. Review of a Nursing Progress Note dated 6/1/25, indicated Resident #14 was coughing during breakfast and breathing heavy and fast and the Provider was updated. Review of the Speech Therapy Evaluation and Plan of Treatment, start 6/2/25, indicated the following: -reason for referral: . Past medical history significant for dementia and dysphagia. Patient recently was diagnosed with Pneumonia following a suspected aspiration event. Patient is now on 2 Liters of Oxygen via Nasal cannula, is fully dependent for eating assistance and diet level is now NDD1 (National Dysphagia Diet Level 1- diet designed for people who have moderate to severe dysphagia, with poor oral phase abilities and reduced ability to protect their airway. Close or complete supervision and alternate feeding methods may be required) with Honey Thick liquids via teaspoon. -Recommendations Included: >Solids = Puree consistencies >Liquids = Honey Thick Liquids, Liquids by teaspoon. >Supervision for Oral Intake = Close Supervision Review of the Education Sign-In sheet dated 6/3/25, indicated Resident #14: -needed Honey Thick Liquids -was dependent for eating (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	06/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-staff were to give liquids by teaspoon. -the Education Form was signed by CNA #1. Review of the Provider Progress Note dated 6/3/25, indicated Resident #14: -had started on antibiotics for Pneumonia -diet had been downgraded -speech therapy was following -was on aspiration precautions Review of Resident #14's June 2025 Active Physician orders, indicated: -Honey thick consistency liquids and pureed food texture, effective 6/3/25. -Azithromycin (antibiotic) Tablet 250 mg for 5 days for infection, effective 6/3/25. Review of the Dietician Progress Note dated 6/4/25, indicated Resident #14: -was dependent on staff for eating -was on honey thick liquids -had Aspiration Pneumonia On 6/4/25 at 9:35 A.M., the surveyor observed the following during the breakfast meal: -CNA #1 was assisting Resident #14 with the breakfast meal (pureed eggs, pureed hashbrowns with onion, cream of wheat, pureed wheat toast, applesauce and 8 ounces of Lactaid milk). -CNA #1 was mixing hot food items with the applesauce on the spoon before giving the Resident bites. -CNA #1 poured the Lactaid milk into a cup, added 2 packets of thickener and immediately started providing Resident #14 large sips from the cup without verifying the consistency was appropriate. -Resident #14 was heard gulping his/her Lactaid milk from across the room. -CNA #1 gave Resident # 14 multiple over heaping teaspoons of food and only waited seconds in between bites (7 seconds/ 5 seconds/ 8 seconds/ 6 seconds/9 seconds), without verifying the Resident had tolerated the previous bite. -CNA #1 was observed providing Resident #14 bites of food before the Resident could fully swallow the previous bite. (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	06/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #14 was observed coughing and throat clearing during the meal. The surveyor observed when the Resident started coughing, CNA #1 lifted the cup of milk to Resident #14's mouth and gave him/her a swallow from the edge of the cup and instructed the Resident to take another sip. During an interview on 6/4/25 at 11:01 A.M., CNA #1 said that she was using applesauce to mix with some of the foods but did not tell anyone because she felt the pureed food was too dry. CNA #1 said she was not sure what the 'brown stuff' was on the tray and was unsure if the Resident knew what he/she was being fed. CNA #1 said that she did not have any concerns how Resident #14 had tolerated his/her breakfast and thought the Resident did well because he/she ate 100% of the meal. CNA #1 failed to recognize any concerning symptoms such as coughing or gulping and when the surveyor asked, said that there were no special feeding techniques to use for Resident #14, but you need to thicken his/her liquids to honey. CNA #1 said that during the breakfast meal she had forgotten that Resident #14 needed honey thick liquids and had given him/her some sips without thickening it first and did not tell anyone. CNA #1 said she added thickener to the milk and should have spoon fed it to Resident #14 but didn't, and realized the surveyor observed the Resident drink from the cup versus the spoon. CNA #1 said the Resident had Pneumonia but did not know why or what may have caused it. CNA #1 said that if a Resident had a change in diet or consistency, then the Speech Therapist would tell the staff. During an interview on 6/4/25 at 11:31 A.M., Nurse #1 said Resident #14 is prescribed antibiotics for Pneumonia and the CNAs are responsible for supervising meals and making sure liquids are thickened according to their order. Nurse #1 said if any Resident experiences coughing, not eating, swallowing hard or gulping, the Nurses should be told right away so they can evaluate the Resident and do a respiratory assessment. Nurse #1 also said that if any Resident receives honey thickened liquids, they should be spoon fed the thickened liquid. During an interview on 6/4/25 at 11:33 A.M., the Speech Therapist (ST) said Resident #14 liquid consistency was changed from nectar to Honey thick consistency on 6/3/25 because he/she was not tolerating the nectar well. The ST said staff including CNA #1 were educated on 6/3/25 about the change in fluid consistency and instructed that all honey liquids needed to be fed by teaspoon. The ST said the kitchen staff send up the thickener packets on the meal tray and the CNAs are responsible for thickening the liquids. The ST said Resident #14 has obvious oral motor manipulation [sic], and another bite should not be given unless he/she stops making those movements and his/her mouth is clear. The ST said the Resident should be offered teaspoon fed drinks in between bites. The ST said all feeding should be stopped if the Resident starts coughing or has throat clearing. The ST said staff should not be adding applesauce to other foods, because this alters the taste of foods and could be a quality-of-life issue. During an interview on 6/4/25 at 11:54 A.M., with Nurse Consultant (the previous Director of Nursing[DON]) #1 and Nurse Consultant (NC) #2, NC #1 said staff should be monitoring for signs and symptoms of aspiration during meal assistance, such as coughing or shortness of breath and update the Nurse right away. NC #1 said honey thick liquids should be spoon fed if directed by the ST, to avoid aspiration. NC #1 said CNA #1 was educated on 6/3/25 that Resident #14 required honey thick liquids by teaspoon, and CNA #1 should have used the teaspoon to give the Resident his/her drinks. NC #2 said that staff should wait to for Residents to swallow bites before giving another bite and that apple sauce should not have been mixed with Resident #14's other foods. (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	06/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #5 was admitted to the facility in March 2021, with diagnoses including pneumonitis due to inhalation of food and vomit, recurrent Pneumonia, acute respiratory failure with hypoxia, hypoxemia, dysphagia oropharyngeal phase, disturbances of salivary secretion, Dementia, and other frontotemporal neurocognitive disorder. Review of the Speech Therapy Evaluation and Plan of Treatment, completion date 4/16/24, indicated Resident #5: -had a diagnosis of dysphagia and was evaluated for swallowing function. -Goals of Care indicated: >that the Resident would tolerate the safest, least restrictive diet without signs or symptoms of aspiration. -The ST recommended the Resident be provided with a puree texture and nectar thick liquid consistency. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #5: -was severely cognitively impaired as eveidenced by a score of three out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. -had a diagnosis of dysphagia. -required a mechanically altered diet (pureed food, thickened liquids, etc.). -was dependent on a caregiver for eating assistance. Review of Resident #5's active Dysphagia Care Plan initiated 8/16/24, indicated: -was at risk for aspiration. -was dependent on staff for assistance with eating. -the goal of care was for the Resident to eat foods on his/her current diet and not have signs or symptoms of aspiration. -Interventions included: >If the Resident had an increased temperature, diminished breath sounds, coughing, or a gurgle sound to his/her voice, the Resident may have aspirated, initiated 8/16/24 -Diet was to be provided as ordered, initiated 8/16/24 Review of Resident #5's June 2025 Physician orders indicated the Resident was ordered for a house diet, pureed texture, and nectar thick consistency of liquids related to dysphagia, initiated 7/26/24. (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	06/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's breakfast dietary slip dated 6/6/25, indicated the Resident should be provided with a puree texture and nectar thick fluids. The dietary slip further indicated beverages would include nectar thick diet cranberry juice, nectar thick milk, nectar thick orange juice, and nectar thick chocolate health shake. On 6/6/25 at 9:23 A.M., during a dining observation, the surveyor observed Resident #5 lying in his/her bed, being assisted with the breakfast meal by Certified Nurses Aide (CNA) #4. During an interview at the time, CNA #4 said the Resident had just finished his/her breakfast meal. CNA #4 said the Resident drank all the beverages provided, as he/she typically did. The surveyor observed the beverage containers (cranberry juice, milk, orange juice, and health shake) were all empty. The surveyor observed the remaining few drops of cranberry juice to easily slide back and forth on the bottom of the empty cranberry juice container. CNA #4 said that the Resident's health shake was already available in a pre-thickened nectar thick consistency, and the other beverages would need to be thickened. When the surveyor asked CNA #4 if thickener was added to the Resident's cranberry juice, milk, and orange juice that were consumed, CNA #4 was observed to look around on the meal tray, pick up the plate and then pick up a packet of thickener that was located under the plate, and said that he had not seen the thickener. CNA #4 was observed adding the thickener to the Resident's empty milk container. The surveyor requested to speak with CNA #4 away from the Resident and asked if the thickener was added to the Resident's cranberry juice, milk, and orange juice before distributing to the Resident, and CNA #4 said he added thickener to the milk and the orange juice, but not to the cranberry juice. When the surveyor further asked CNA #4 why thickener had not been added to the cranberry juice, CNA #4 said he forgot to add the thickener. CNA #4 said Residents that drink thin/non-thickened liquids when they were ordered to have thickened liquids were at risk for aspiration. During an interview on 6/6/25 at 9:59 A.M., the surveyor discussed with Nurse #7 that Resident #5 drank non-thickened beverages during the breakfast meal. Nurse #7 said she believed the Resident was ordered a puree texture and nectar thick consistency diet. Nurse #7 said she would follow-up related to the Resident having received beverages that had not been thickened according to the Physician's order. During an interview on 6/6/25 at 10:10 A.M., the Director of Nursing (DON) said her experience in the facility was that residents' dietary slips were compared to their electronic medical records when the Nurses checked the meal trays and diets during meal pass. The DON said this process occurred with the Nurses standing alongside the CNA's. The DON said the kitchen provided thickener on the residents' trays, and sometimes there were more packets than were needed for the beverages on the tray. During an interview on 6/6/25 at 11:45 A.M., NC #1 said the staff assisting a Resident with eating would be responsible to ensure that liquids were thickened according to the Physician's order. NC #1 said providing the incorrect consistency of liquids to a Resident could pose a risk for aspiration, pneumonia, or illness.

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	06/10/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide nutrition and hydration services as required for one Resident (#75) out of a total sample of 24 residents. Specifically, for Resident #75, the facility failed to provide health shakes as ordered at the breakfast meal, putting the Resident at risk for compromised nutritional status. Findings include: Review of the facility policy titled Nourishments and Supplements, effective May 1995 and revised in January 2024, indicated but was not limited to the following: -Policy statement: High calorie food options .may be offered when a resident requires additional calories or nutrients. -Dining services will prepare nourishments as ordered. -Nursing staff will deliver nourishments/supplements to residents as ordered . Resident #75 was admitted to the facility in August 2021, with diagnoses including dysphagia, acquired absence of other specified parts of digestive tract, Dementia, and history of traumatic brain injury (TBI). Review of Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #75: -scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam, indicating the Resident's cognition was moderately impaired. -required set-up or clean-up assistance with meals. -had a significant weight loss (loss of five percent [%] or more in the last month or loss of 10% or more in the last six months) and was not on a Physician-prescribed weight loss regimen. -required a therapeutic diet. Review of Resident #75's Nutrition Progress Note dated 4/17/25, indicated: -the Resident had a 13.5 pound (lb.) weight loss over a four-month period, resulting in a weight loss percentage of 9.5%. -shakes would be added to the Resident's meal trays to increase calorie intake. Review of Resident #75's June 2025 Physician's orders indicated the Resident was ordered for one Mighty Shake (health shake) with meals for supplement, initiated 4/18/25. (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	06/10/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/25 at 8:35 A.M., Resident #75 was observed eating breakfast in his/her bedroom and no health shake was provided on the Resident's meal tray. During an interview at the time, Resident #75 said he/she received health shakes at lunch and dinner and that he/she liked the health shakes and drank them all. Resident #75 said he/she did not receive a health shake with breakfast at this time. During an interview on 6/6/25 at 8:42 A.M., Nurse #6 said health shakes were provided to Residents by the kitchen and should come up on the Residents' meal trays. Nurse #6 reviewed Resident #75's Physician orders and said the Resident was ordered for health shakes with meals. Nurse #6 then reviewed the Resident's meal tray and said there was no health shake on the meal tray, but that there should have been a health shake on the meal tray. Nurse #6 reviewed the Resident's dietary slip and said the health shake was not indicated on the dietary slip. On 6/10/25 at 8:26 A.M., Resident #75 was observed to be eating breakfast in his/her bedroom and no health shake was provided to the Resident on the meal tray. The surveyor observed that the dietary slip failed to indicate that a health shake should have been provided on the meal tray. During an interview at the time, Resident #75 said he/she did not receive a health shake this morning. Resident #75 also said he/she did not receive a health shake the previous morning. During an interview on 6/10/25 at 8:45 A.M., Certified Nurses Aide (CNA) #5 removed Resident #75's meal tray from his/her bedroom, and said the Resident did not receive a health shake with his/her breakfast. CNA #5 said nutritional supplements should be written on Residents' dietary slips and the nutritional supplements should be provided by the kitchen. CNA #5 said she is Resident #75's regular CNA and had worked at the facility for about one year. CNA #5 said the Resident does not typically receive a health shake on his/her breakfast tray. On 6/10/25 at 8:59 A.M., the surveyor observed CNA #5 providing a health shake to Resident #75. During an interview at the time, CNA #5 said she was prompted to provide the Resident with a health shake due to the surveyors' questions. CNA #5 said she could see in the Resident's electronic medical record (EMR) that he/she should have received a health shake with breakfast but he/she did not receive a health shake with breakfast. At this time, the Resident showed the surveyor the health shake and said thanks. During an interview on 6/10/25 at 9:05 A.M., Nurse #4 said Resident #75 had recent weight loss and was ordered to be provided with health shakes. Nurse #4 said the Resident did not receive the health shakes with meals, and she had called the kitchen to request the kitchen deliver the health shakes. Nurse #4 said when a Resident is ordered for a nutritional supplement, it is indicated on the Resident's dietary slip. Nurse #4 said when a Nurse entered a Physician's order for a nutritional supplement, the Nurse should also complete a Diet Requisition and Dietician Communication Form and submit this form to the kitchen so that the nutritional supplement was provided on the Resident's meal trays. During an interview on 6/10/25 at 9:23 A.M., Nurse #5 said when a Nurse entered an order to administer a nutritional supplement with meals, the Nurse completed the Diet Requisition and Dietician Communication Form and provided the completed form to the kitchen so that the order could be added to the Resident's dietary slip by the kitchen. (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	06/10/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/25 at 11:50 A.M., the Dietician said Resident #75 had experienced weight loss and the Dietician had recommended the Resident receive health shakes beginning in April 2025. The Dietician said the kitchen failed to indicate on Resident #75's breakfast dietary slip that he/she had been ordered to receive a health shake with breakfast. The Dietician also said the kitchen had indicated that Resident #75 had been ordered to receive a health shake with lunch and dinner only.

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	06/10/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interviews, and record reviews, the facility failed to address and implement licensed Pharmacist recommendations in a timely manner for two Residents (#106 and #117) of five applicable residents, out of a total sample of 24 residents. Specifically: 1. For Resident #106, the facility failed to implement the licensed Pharmacist's recommendation, which the Physician agreed with, to discontinue administration of a Multivitamin and initiate the use of Nephrocaps (vitamins for individuals with renal failure) when the Resident had a diagnosis of End Stage Renal Disease (ESRD) and administration of the Multivitamin was not recommended for use for individuals with an active ESRD diagnosis, increasing the Resident's risk for renal toxicity. 2. For Resident #117, the facility failed to ensure that the licensed Pharmacist's recommendation to evaluate the use of Acetaminophen-Codeine (medication used to treat pain) was addressed in a timely manner by the Physician when the Resident was on dialysis and Acetaminophen-Codeine was recommended to be avoided for dialysis patients. Findings include: Review of the facility policy titled Drug Regimen Review-Monthly indicated the following: -the Prescriber/Licensed Designee: >shall act upon the Drug Regimen Review findings/recommendations in a timely manner of 7-14 days or less. >shall document on the drug regimen review form whether he/she agrees or disagrees with the recommendation made and provide a brief clinical rationale if no change is to be made. 1. Review of the National Kidney Foundation guidance titled Vitamins and Minerals in Chronic Kidney Disease, 2025, reviewed at https://www.kidney. org/kidney-topics/vitamins-and-minerals-chronic-kidney-disease, indicated the following: -You may need to avoid some vitamins and minerals if you have kidney disease. -Some of these vitamins include Vitamin A, E, and K. -These vitamins are more likely to build up in your body and can cause harm if you have too much. -Over time, they can cause dizziness, nausea, and even death. Resident #106 was admitted to the facility in July 2024 with diagnoses including ESRD. Review of Resident #106's Physician orders, dated 10/3/24, indicated: (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	06/10/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Multivitamin Mineral Oils Tablet, give one tablet by mouth one time a day, related to Unspecified Protein-Calorie Malnutrition. Review of Resident #106's Medication Regimen Review (MRR), dated 10/3/24, indicated the following: -The Resident was currently receiving Multivitamin. -Multivitamin was not recommended for use with an active diagnosis of ESRD because it contains Vitamin A and E. -Please evaluate and switch to Nephrocaps . if appropriate. -The Provider/ Physician reviewed and agreed with the licensed Pharmacist's recommendation. -The date the Provider agreed with the recommendation was not indicated on the MRR Physician Referrals/Findings Form, but the signed form was uploaded into the Resident's electronic health record (EHR) on 11/26/24. Review of Resident #106's Medication Administration Records (MARs) from October 2024 through April 2025 indicated the following: >October 2024 - The Multivitamin Mineral Oils Tablet was administered to the Resident 24 times between 10/3/24 and 10/31/24. >November 2024 - The Multivitamin Mineral Oils Tablet was administered to the Resident 17 times between 11/1/24 and 11/30/24. >December 2024 - The Multivitamin Mineral Oils Tablet was administered to the Resident 24 times between 12/1/24 and 12/31/24. >January 2025 - The Multivitamin Mineral Oils Tablet was administered to the Resident 27 times between 1/1/25 and 1/31/25. >February 2025 - The Multivitamin Mineral Oils Tablet was administered to the Resident 28 times between 2/1/25 and 2/28/25. >March 2025 - The Multivitamin Mineral Oils Tablet was administered to the Resident 30 times between 3/1/25 and 3/31/25. >April 2025 - The Multivitamin Mineral Oils Tablet was administered to the Resident 28 times between 4/1/25 and 4/30/25. >May 2025 - The Multivitamin Mineral Oils Tablet was administered to the Resident 15 times between 5/1/25 and 5/21/25. Review of Resident #106's Medication Regimen Review (MRR), dated 5/13/25, indicated: -The Resident was currently receiving Multivitamin. (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	06/10/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Multivitamin was not recommended for use with an active diagnosis of ESRD because it contains Vitamin A and E. -Please evaluate and switch to Nephrocaps . if appropriate. -The Provider reviewed and agreed with the licensed Pharmacist's recommendation. Review of Resident #106's clinical record indicated: -The Multivitamin Mineral Oils Tablet was not discontinued until 5/21/25. -Nephrocaps were not started until 5/21/25. During an interview on 6/6/25 at 11:45 A.M., Nurse Consultant (NC) #1 (the previous Director of Nursing) said when the Physician agrees with the recommendations of the licensed Pharmacist, the nursing supervisor is required to transcribe the order into the Resident's clinical record. NC #1 said the orders based on the licensed Pharmacist's recommendations from October 2024 to discontinue the Multivitamin and initiate Nephrocaps were not implemented timely, so Resident #106 continued to receive the Multivitamin until 5/21/25. NC #1 also said Nephrocaps were not initiated for Resident #106 until 5/21/25. 2. Resident #117 was admitted to the facility in April 2025 with diagnoses including ESRD and Dependence on Renal Dialysis. Review of Resident #117's Physician orders from April 2025 through June 2025 indicated the following: -Acetaminophen-Codeine Tablet 300-30 mg, Give 2 tablets by mouth three times a day for pain, initiated 4/1/25 and discontinued 4/17/25 -Acetaminophen-Codeine Tablet 300-30 mg, Give 1 tablet by mouth three times a day for pain, initiated 4/17/25 and discontinued 4/28/25 -Acetaminophen-Codeine Oral Tablet 300-30 mg, Give 1 tablet by mouth three times a day, every Mon, Wed, Fri for pain, initiated 4/28/25 and active. Review of Resident #117's admission MRR dated 4/3/25, indicated: -the Resident was currently receiving Acetaminophen-Codeine 300-30 mg, 2 tablets TID (three times a day) for pain. -Recommended to avoid this medication in dialysis patients. Please evaluate. -Consider switch to alternative pain management such as Tramadol (opioid pain medication) if appropriate. -the Provider signature portion of the MRR document was left blank. (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	06/10/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #117's April 2025 MAR indicated: -the Resident received Acetaminophen-Codeine 300-30 mg, 2 tablets three times a day as ordered from 4/2/25 through 4/16/25. -the Resident received Acetaminophen-Codeine 300-30 mg, one tablet three times a day as ordered from 4/17/25 through 4/28/25. -the Resident received Acetaminophen-Codeine 300-30 mg, one tablet three times a day on dialysis days (Monday, Wednesday, Friday) on 4/30/25. Review of Resident #117's May 2025 MAR indicated: -the Resident received Acetaminophen-Codeine 300-30 mg, one tablet three times a day on dialysis days (Monday, Wednesday, Friday) as ordered. Review of Resident #117's June 2025 MAR indicated: -the Resident received Acetaminophen-Codeine 300-30 mg, one tablet three times a day on dialysis days (Monday, Wednesday, Friday) as ordered. During an interview on 6/6/25 at 9:21 A.M., NC #1 said the admission MRRs had not been addressed until today, 6/6/25, but should have been addressed promptly after the MRR was completed by the Consultant Pharmacist. NC #1 further said that admission MRRs had been sent to the email of a Supervisor who had been out on FMLA and the MRRs had not been seen by the facility until today, 6/6/25.

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	06/10/2025

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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to assist one Resident (#89), out of a total sample of 24 residents, in obtaining routine dental services. Specifically, the facility failed to schedule dental appointments when consent was given, to ensure that Resident #89 received routine dental services as requested. Findings include: Resident #89 was admitted to the facility in April 2023 with diagnoses including Alzheimer's Disease. Review of the Request for Service Form, dated and signed 5/15/23, by the Resident Representative requested Dental Services. Review of a Physician's order dated 7/26/24, indicated: -May have Vision, Auditory, Dental, Podiatry, Wound Consult. Review of Resident #89's Dental Care Plan initiated 10/17/24, indicated: -the Resident has broken natural teeth and cavities noted on admission to the facility. -coordinate arrangements for dental care. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #89: -was severely cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 0 out of 15. -was dependent on staff for completion of oral hygiene. -has obvious or likely cavity or broken natural teeth. During an interview on 6/5/25 at 1:09 P.M., the Medical Records (MR) staff member said she oversees managing dental services and makes the referral request after the family signs the permission form. The MR staff member said when Resident #89 was admitted in April 2023, the request for services was signed by the Resident Representative but the Resident did not receive Dental Services due to an insurance issue. The MR staff said that Resident #89's insurance issue was resolved about six months later and he/she should have started dental services at that time but the services did not start. During an interview on 6/10/25 at 8:58 A.M., the Administrator said that Resident #89 should have been seen by Dental Services but was not. The Administrator said he was not aware that the Resident had not been seen by Dental Services and had they known, they could have made other arrangements to have Resident #89 seen by a different Dentist.

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	06/10/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to ensure proper sanitation and food handling practices in the facility main kitchen and cleaning in three (Floor One, Two and Three) out of the three kitchenettes on the resident care units. Specifically, the facility failed to: 1. ensure that dietary staff maintained and performed appropriate hand hygiene practices while preparing and serving meals for residents in the facility main kitchen. 2. ensure that cooking utensils, dishes, and countertops were properly cleaned and sanitized in the facility main kitchen. 3. ensure that the kitchenettes on Floors One, Two and Three were properly cleaned, and that utensils were stored in accordance with food service standards, putting the residents at risk for foodborne illness, cross-contamination, and food contamination. Findings include: Review of the facility policy titled Manual Ware Washing and Testing Sanitizer Concentration, effective October 2022, indicated but was not limited to the following: -Foods can become contaminated by coming into contact with surfaces that are not clean and sanitized. -Manual ware washing is used in most every unit daily, and the proper process must be followed every time wares are washed. -Manual ware washing steps must be followed in order as outlined below: 1. Sink set-up 2. Pre-clean 3. Wash: Agitate and scrub equipment and utensils in the wash compartment to remove visible grease and soils from the surface. 4. Rinse: Move equipment or utensil to the rinse compartment to remove any visible soils and soap . 5. Sanitize: Submerge equipment or utensil into the third sink for 60 seconds . 6. Air dry: Place equipment or utensils onto a clean surface to air dry. Do not dry with a towel or other method. 7. Return to storage (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	06/10/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Must train associates on the proper ware washing procedure, including proper water temperatures, sanitizer concentration, the 60 second submersion time in sanitizer, and sanitizer testing. -Must monitor associates who are manually ware washing to ensure they are following the proper process. Review of the U.S. FDA's 2022 Food Code, February 2023, indicated but was not limited to the following: -Equipment food-contact surfaces and utensils shall be cleaned .at any time during the operation when contamination may have occurred. -Equipment food-contact surfaces and utensils shall be sanitized. - .Cleaned equipment and utensils .shall be stored in a clean, dry location; Where they are not exposed to splash, dust, dust or other contamination . Review of the facility policy titled Hand Hygiene, revised January 2025, indicated but was not limited to the following: >In the Food and Nutrition Services Department: All associates associated with the handling of food shall wash hands. >Hands are washed with soap and water at the following times, including but not limited to: -Before putting on gloves -After touching hair, skin, beard or clothing -After using tobacco products, eating or drinking -After handling soiled silverware/utensils -After removing gloves -After any other activity that may contaminate the hands Review of the facility policy titled Common Area Cleaning, effective May 2025, indicated but was not limited to the following: -Common areas will be cleaned per an established schedule . 1. On 6/5/25, the surveyor observed the following in the facility main kitchen: -At 11:48 A.M., the [NAME] took a sip of a beverage using gloved hands, then removed her gloves, wiped her face with her hands, and then applied new gloves. The surveyor intervened at this time to discuss hand hygiene practice concerns with the Cook. (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	06/10/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:52 A.M., Dietary Aide #2 adjusted his beard guard with his gloved hands, and continued to assist in the tray service line, touching residents' clean meal trays. -At 12:03 P.M., Dietary Aide #2 adjusted his beard guard with his gloved hands, and continued to assist in the tray service line, touching residents' clean meal trays. -At 12:04 P.M., Dietary Aide #2 adjusted his beard guard with his gloved hands, and then continued to assist in the tray service line, touching residents' clean meal trays. -At 12:10 P.M., Dietary Aide #3 adjusted his surgical mask to cover his mouth and nose using his gloved hands, then continued to open the refrigerator door and touch multiple covered food items. Dietary Aide #3 then rubbed his left eye with gloved hands and proceeded to open a package of rice. During an interview on 6/5/25 at 11:48 A.M., the [NAME] said when she touched her face with her hands, she should have washed her hands with soap and water prior to donning (putting on) new gloves, but she did not wash her hands with soap and water. During an interview on 6/5/25 at 1:15 P.M., Dietary Aide #3 said he should perform hand hygiene if he touched his surgical mask or his eye. Dietary Aide #3 said he typically used the back of his gloved hand to touch his surgical mask, and that this method was an acceptable practice. Dietary Aide #3 said the importance of proper hand hygiene practices was to keep residents safe. During an interview on 6/5/25 at 2:50 P.M., Dietary Aide #2 said he should remove contaminated gloves after touching his beard guard. Dietary Aide #2 said he should then perform hand hygiene, and apply new gloves. Dietary Aide #2 said the concern with not performing proper hand hygiene practices was that residents could get sick. During an interview on 6/5/25 at 4:34 P.M., the Food Service Director (FSD) said that he expected food service staff working in the main kitchen to remove contaminated gloves, wash hands with soap and water, and don clean gloves at the time the gloves were contaminated. The FSD said the concern with not performing proper hand hygiene practices was food contamination. 2. On 6/5/25 the surveyor observed the following in the facility main kitchen: >At 11:57 A.M., Dietary Aide #4 utilized the three-compartment sink for manual ware washing and performed the following steps: -Rinsed the spatula over the garbage disposal. -Washed the spatula in the wash sink. -Rinsed the spatula in the rinse sink. -Dipped the spatula in the sanitizer sink. -Rinsed the spatula over the garbage disposal. -Wiped the spatula off with a paper towel. (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	06/10/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietary Aide #4 was observed using the spatula to make peanut butter and jelly sandwiches, and dipping the spatula in a container of jelly. >At 12:10 P.M., Dietary Aide #3 scooped water into a bucket from the wash sink of the three-compartment sink for manual ware washing. The water in the wash sink was observed to contain dishes and food debris. The water scooped into the bucket was then used to wash the contaminated countertop. The countertop was then observed to be utilized to plate mashed potatoes. >At 12:16 P.M., Dietary Aide #4 utilized the three-compartment sink for manual ware washing and performed the following: -Rinsed the spatula over the garbage disposal. -Dipped the spatula in the wash sink. -Dipped the spatula in the sanitizer sink. -Rinsed the spatula over the garbage disposal. -Wiped the spatula off with a paper towel. Dietary Aide #4 was observed using the spatula to make sandwiches, and buttering bread with the spatula. >At 12:27 P.M., Dietary Aide #4 utilized the three-compartment sink for manual ware washing and performed the following: -Rinsed the spatula over the garbage disposal. -Washed the spatula in the wash sink. -Rinsed the spatula in the rinse sink. -Dipped the spatula in the sanitizer sink. -Dipped the spatula in the rinse sink. -Placed the spatula on the counter to dry. >At 12:28 P.M., Dietary Aide #4 removed a spatula from a drawer, rinsed the spatula over the garbage disposal, and then wiped the spatula with a paper towel. Dietary Aide #4 then used the spatula to make tuna fish sandwiches. During an interview on 6/5/25 at 1:15 P.M., Dietary Aide #3 said he washed contaminated countertops using the soapy water from the hose over the wash sink of the three-compartment sink. Dietary Aide #3 said if he was not going to use the countertop any longer, he obtained sanitizer solution from the hose over the sanitizer sink of the three-compartment sink and sanitized the countertop. (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	06/10/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/25 at 2:45 P.M., Dietary Aide #4 said the steps involved in using the three-compartment manual ware washing sink were as follows: -Rinse food debris into the garbage disposal. -Wash the dish/utensil in the wash sink. -Rinse the dish/utensil in the rinse sink. -Put the dish/utensil in the sanitizer sink. -Rinse the dish/utensil in the rinse sink again if there is soap on the dish/utensil. -Dry off the dish/utensil with a paper towel. Dietary Aide #4 further said the dish/utensil should soak in the sanitizer sink for 30 minutes. Dietary Aide #4 said she never received training on proper use of the three-compartment manual ware washing sink. Dietary Aide #4 said no one had ever told her to wash and sanitize the dishes/utensils in the three-compartment sink any other way. During an interview on 6/5/25 at 4:34 P.M., the FSD said placing a dish/utensil back into the rinse sink of the three-compartment ware washing sink after sanitizing in the sanitizer sink could cause the dish/utensil to accumulate debris and could cause cross-contamination and pose a risk for foodborne illness. The FSD said dishes/utensils that had already been sanitized should not be rinsed off over the garbage disposal. The FSD said the water pressure from that faucet could cause debris from the garbage disposal to splash onto the clean dish/utensil and contaminate the dish/utensil. The FSD said use of a dish/utensil after being rinsed off over the garbage disposal could cause cross-contamination and pose a risk for foodborne illness. The FSD said it was important for dishes/utensils to soak in the sanitizer sink of the three-compartment manual ware washing sink per facility policy so that the dishes/utensils could be sanitized properly. The FSD said it was not sufficient to dip dishes/utensils in the sanitizer sink. The FSD also said that countertops should be cleaned between food preparations, using sanitizer solution. The FSD said using water from the wash sink of the three-compartment sink to wash countertops could contaminate the countertops and cause cross-contamination and pose a risk for foodborne illnesses. 3. On 6/6/25 at 11:36 A.M., the surveyor and the FSD observed the following in the Floor Two kitchenette: -Dried food splatter inside the microwave. -Dried liquid spillage on the bottom of the lower cabinet, with an open Cheerios container and spilled Cheerios in the cabinet. -Liquid spillage inside the resident refrigerator freezer. -Opened ceiling tile with exposed insulation and pipes over the microwave and open-top toaster oven. (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	06/10/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Unpackaged disposable spoons, condiment packages, coffee packages and oatmeal packages were stored on top of the microwave. -Ice chest with a large crack, exposing foam insulation. -Ice scoop sitting on top of the utility cart in a puddle of water, the utility cart was observed with debris. During an interview at the time, the FSD said the open ceiling tile could allow for debris to fall onto the food packages and unpackaged spoons on top of the microwave as well as into the toaster oven. The FSD said the exposed insulation in the ice chest could cause physical contamination of insulation in residents' beverages. The FSD said the ice scoop should be stored in the provided container on the wall and should not be sitting on the utility cart. On 6/6/25 at 11:45 A.M., the surveyor and the FSD observed the following in the Floor Three kitchenette: -Dried food splatter in the microwave. -Inside cover of the ice chest with debris. -Dried spillage covering the majority of the outside (left side) of the resident refrigerator. -Liquid spillage inside the resident refrigerator on the bottom shelf. During an interview at the time, the FSD said the spilled food could grow mold and pose a risk for foodborne illnesses. On 6/6/25 at 11:54 A.M., the surveyor and the FSD observed the following in the Floor One kitchenette: -Dried food splatter in the microwave. -Debris and dried spillage on top of the microwave. -Excessive crumbs in the toaster oven. -Ice scoop sitting on top of the utility cart and the utility cart was observed with debris. -Opened sugar packets, empty soda bottles, bags of pretzels, and liquid spillage on the bottom of the lower cabinet. -Resident freezer with spillage. During an interview at the time, the FSD said the opened packets of sugar and spilled food and beverages could pose a risk for pests. Review of the Kitchenette Cleaning Logs from 6/6/25 through 6/10/25 indicated the following: (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	06/10/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Kitchenette on Floor One: Documentation failed to indicate cleaning of the kitchenette from 6/6/25 through 6/10/25. -Kitchenette on Floor Two: Documentation failed to indicate cleaning of the kitchenette on 6/7/25 and 6/8/25. -Kitchenette on Floor Three: Documentation failed to indicate cleaning of the kitchenette from 6/7/25 through 6/10/25. During an interview on 6/10/25 at 9:15 A.M., Housekeeper #2 said the housekeeping department is responsible for cleaning the kitchenettes, including the refrigerators, toast ovens, and microwaves. Housekeeper #2 said the kitchenettes are cleaned once daily, around 7:30 A.M. Housekeeper #2 said the housekeeping staff completed the cleaning log when the kitchenette was cleaned. On 6/10/25 at 9:40 A.M., the surveyor and the Housekeeping Supervisor observed the following in Floor Three kitchenette: -Dried spillage covering the majority of the outside (left side) of the resident refrigerator. -Two dead bugs on the inside windowsill. -Dried food splatter in the microwave. During an interview at the time, the Housekeeping Supervisor said the housekeeping department is responsible for cleaning the kitchenettes on all three floors. The Housekeeping Supervisor said the cleaning logs posted in the kitchenettes should be completed by housekeeping staff when the kitchenettes were cleaned. The Housekeeping Supervisor said spillage of food/beverage and crumbs anywhere in the kitchenettes was a risk to the residents. On 6/10/25 at 9:55 A.M., the surveyor and the Housekeeping Supervisor observed the following in Floor Two kitchenette: -Dried food splatter in the microwave. -Liquid spillage in the resident freezer. -Ice chest with a large crack, exposing foam insulation. On 6/10/25 at 10:00 A.M., the surveyor and the Housekeeping Supervisor observed the following in Floor One kitchenette: -Dried food splatter in the microwave. -Excessive crumbs in the toaster oven. -Liquid spillage on the bottom shelf and door of the resident refrigerator. -Ice scoop sitting on top of the utility cart. (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	06/10/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview at the time, the Housekeeping Supervisor said the expectation is that the housekeeping staff cleaned the kitchenettes, including but not limited to the refrigerators, cabinets, microwaves, and countertops.

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	06/10/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, and interviews, the facility failed to adhere to infection control standards of practice while serving meals to residents on one Unit (3rd Floor) out of three Units observed. Specifically, the facility failed to ensure that staff distributing food during the lunch meal service on the 3rd Floor Unit performed appropriate hand hygiene to prevent contamination and the spread of foodborne illnesses. Findings include: Review of the facility policy titled Hand Hygiene, last revised 6/19/24, indicated: -Hand hygiene will be performed in accordance with national standards from the Centers for Disease and Prevention and the World Health Organization (WHO). >Hand hygiene should be performed: -When coming on duty. -Before entering a resident's room and upon exiting a resident's room. -Before and after handling peripheral vascular catheters and other invasive devices. -After removing gloves or aprons. -After completing duty. >Alcohol-based hand rub may be used for all other hand hygiene opportunities (for example [e.g.] when soap and water is not indicated). -After caring for a resident including after removing gloves. -After contact with the resident environment. >Procedure for using Alcohol Sanitizer. -The alcohol hand sanitizer may be used routinely for hand hygiene unless hands are visibly soiled, then soap and water handwashing is required. On 6/5/25 at 12:40 P.M., the surveyor observed the following during the lunch tray meal pass observation on the 3rd Floor: -The meal truck was brought to the unit by kitchen staff and four Unit staff approached the meal truck, opened the truck and began removing meal trays from the truck without performing hand hygiene first. (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	06/10/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #1, Nurse #2, and 2 Certified Nurses Aides (CNAs) on the 3rd floor Unit were observed passing out meal trays to residents in their rooms. -Nurse #1, Nurse #2, and the 2 CNA's, were observed entering resident's room, placing meal trays on the bedside tables, moving items off the bedside tables and positioning the bedside tables in front of the residents. -The surveyor observed the 4 staff members exiting resident rooms without performing hand hygiene after touching items in the resident rooms and continued passing meal trays from the meal truck to other residents. -The surveyor observed alcohol-based hand sanitizer available on the walls of the 3rd floor hallway. -The surveyor observed Nurse #2 exit a residents' room with gloves on his bilateral hands, and Nurse #2 removed the gloves while approaching Nurse #1. -Nurse #1 and Nurse #2 entered a resident room together without performing hand hygiene before entering the room. -The surveyor observed Nurse #1 and Nurse #2 assessing and examining the residents' intravenous line (IV). -The surveyor observed Nurse #1 and Nurse #2 exit the residents' room without performing hand hygiene, walk towards the meal truck outside and continued serving meal trays to residents in their rooms without performing hand hygiene. -The surveyor observed the 2 CNA's exiting the resident rooms with dirty meal trays in their hands, place the dirty trays on top of meal truck and continue to enter other resident rooms to distribute meal trays removed from the meal truck without performing hand hygiene between handling the dirty and the clean meal trays. During an interview on 6/5/25 at 1:15 P.M., Nurse #1 said that typically staff use the alcohol-based hand hygiene outside the resident rooms to clean their hands prior to entering resident rooms and then again upon exiting resident rooms to prevent cross contamination and spreading of infection to residents. Nurse #1 further said that he forgot to perform hand hygiene when he entered and exited resident rooms, and he should have been using the alcohol-based hand hygiene available to clean his hands to prevent the spread of infections to residents. During an interview on 6/5/25 at 1:28 P.M., Nurse #2 said that he had come out into the hallway with gloves on his bilateral hands but had washed his hands prior to applying the gloves. Nurse #2 further said that he was assessing a residents' IV, as it was his responsibility to ensure that the IV line was functioning appropriately. (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	06/10/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/25 at 1:55 P.M., the Infection Control Nurse (ICP) said that the expectation for nursing staff on the unit during meal tray pass was that staff use the alcohol-based hand sanitizer that was available on the wall in the hallways to sanitize their hands prior to entering and exiting a resident room to prevent cross contaminations and the spread of infections to residents. The ICP also said that gloves were not to be worn by staff when staff were in the hallway. The ICP further said that staff were to remove gloves from their hands and perform hand hygiene prior to exiting resident rooms.