STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225420	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Extended Care at Amherst	150 University Drive Amherst, MA 01002

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had right sided weakness from a stroke and whose care plan interventions included that he/she required the assistance of two staff members for bed mobility, including turning and repositioning in bed, the Facility failed to ensure that staff consistently implemented and followed interventions from his/her plan of care. When on [DATE] at 1:15 P.M., while attempting to change his/her bed sheets, Certified Nurse Aide (CNA) #1 turned and repositioned Resident #1 on his/her left side in bed, without having another staff member present to assist her, Resident #1 rolled out of the bed and landed on his/her knees on the floor. Resident #1 sustained bilateral (right and left) distal femur (lower part of the thigh bone near the knee joint) fractures and was transferred to the Hospital Emergency Department (ED) where he/she presented with hemorrhagic shock (major blood loss after trauma) and died the next day. Findings include: Review of the Facility Policy titled Care Plans, Comprehensive-Person Centered, dated as revised [DATE], indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of the Report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated [DATE], indicated that Resident #1, whose Plan of Care identified that he/she required the assistance of two staff members with bed mobility (which included turning and repositioning), received care in bed at 1:15 P.M. from Certified Nurse Aide #1. The Report indicated that CNA #1 rolled Resident #1 (onto his/her left side) without assistance from another staff member, and was changing the bed sheet under him/her when he/she rolled out of bed and landed on his/her knees [on the floor]. The Report indicated that CNA #1 quickly went around the bed and lowered Resident #1 the rest of the way to the floor. The Report indicated a Nurse assessed Resident #1 who reported knee pain, and that no other injuries were identified. The Report indicated that Resident #1 was assisted back to bed via mechanical lift and once in bed he/she reported increased bilateral knee pain. Further review of the Report indicated that STAT (immediate) X-rays were obtained at 3:15 P.M. which identified bilateral distal femur fractures. The Report indicated that Resident #1 was transferred to the Hospital ED for evaluation and he/she died on [DATE]. (continued on next page)

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
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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Radiology Report, dated [DATE], indicated he/she had acute femoral fractures, on the left and right. Review of Resident #1's Hospital Discharge Note, dated [DATE], indicated he/she presented to the Hospital ED on [DATE], with bilateral femur fractures related to a fall at his/her nursing facility. The Note further indicated that Resident #1 was in traumatic hemorrhagic shock, transitioned to comfort measures, and passed away at 1:57 A.M. [on [DATE]]. Resident #1 was admitted to the Facility in February 2025, diagnoses included cerebral infarction (stroke), dysphagia (difficulty swallowing), long term/current use of anticoagulants (blood thinners), osteoarthritis, lack of coordination, need for assistance with personal care and weakness. Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], indicated Resident #1 was severely cognitively impaired with a score of 1 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). Further review of the MDS indicated Resident #1 was dependent on staff to roll left and right in bed and that he/she had upper and lower extremity limitations that interfered with daily functions or placed him/her at risk of injury. Review of Resident #1's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with Quarterly MDS completed [DATE], indicated he/she required assistance of two staff members for bed mobility, which included turning and repositioning during care, and required a mechanical lift with assistance of two staff members for transfers. Review of Resident #1's CNA Care Card (Certified Nurse Aide, reference guide, identifies residents specific care needs, including number of staff required to provide assistance during tasks), dated [DATE], indicated he/she required the assistance of two staff members for bed mobility (which included rolling and repositioning in bed). Review of Certified Nurse Aide #1's Personnel Record, indicated it included a CNA Competency Form, signed and dated by CNA #1 on [DATE], that indicated she had demonstrated competency in following the Fall Prevention Program, utilizing fall preventative measures according to the residents care plan, and reviewing the CNA Care Card. Further review of the Record indicated that on [DATE], CNA #1 completed education on safe patient handling for lifting and positioning. During a telephone interview on [DATE] at 4:36 P.M., Certified Nurse Aide (CNA) #1 said she had been a CNA for 15 years, had worked per diem at the Facility since [DATE], and that she had only provided care to Resident #1 on two other occasions prior to [DATE]. CNA #1 said that she was not familiar with the procedure for reviewing the CNA Care Card or the Care Plan to determine the residents' care needs and relied on asking other staff. However CNA #1's statement was inconsistent and contradicted documentation in her personnel record, that was signed and dated by her, which indicated she had been educated and trained on facility procedure and need to review each residents Care Plan and CNA Care Card, prior to providing care. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA #1 said she did not review Resident #1's Care Plan or CNA Care Card, to determine the level of staff assistance he/she required to provide safe care. CNA #1 said that on [DATE], she was changing Resident #1's bed sheets at 1:15 P.M., while he/she was in bed. CNA #1 said that she rolled Resident #1 onto his/her left side, and he/she held on to the left bedrail while she (CNA #1) went around to the right side of the bed and secured the fitted sheet to the mattress. CNA #1 said the sheet was too small for the mattress, and the mattress curled up on the right side of the bed which then caused Resident #1 to roll out of the left side of the bed. CNA #1 said Resident #1 landed on his/her knees on the floor, with the upper portion of his/her body still on the bed. CNA #1 said that while Resident #1 clung to the bedrail, she reached over the bed, grabbed him/her by the shirt, climbed across the bed, and slowly lowered his/her upper body to the ground. CNA #1 said she supported Resident #1's upper body against her legs while she rang the call light and yelled for help. During a telephone interview on [DATE] at 9:01 A.M., Certified Nurse Aide (CNA) #2 (which also included a review of her written witness statement dated [DATE]) said she reviewed CNA #1's assignment with her at the start of the shift on [DATE] and said she told CNA #1 that Resident #1 required the assistance of two staff members for bed mobility and transfers. CNA #2 said that she offered to assist CNA #1 with Resident #1's care, about 30 minutes before her break, and again at 1:00 P.M., when she was leaving for break. CNA #2 further said that she informed CNA #1 she would be taking her break on the porch nearby and was available to help with Resident #1's care when needed. CNA #2 said CNA #1 never came to get her while she was on break and when she returned to the unit she learned that Resident #1 had fallen out of bed. During an interview on [DATE] at 11:00 A.M., Physical Therapist Assistant (PTA) #1 said that during the day shift on [DATE], she was in the hallway on [NAME] 2 when she heard someone in Resident #1's room yelling for help. PTA #1 said that when she entered the room, Resident #1 was sitting on the floor on the left side of the bed, with both knees bent to one side and his/her upper body resting against CNA #1's legs. PTA #1 said no other staff members were present when she arrived, so she immediately went to find Nurse #1. During a telephone interview on [DATE] at 3:07 P.M., Nurse #1 (which also included a review of her written witness statement dated [DATE]) said at 1:15 P.M. she responded to a call for help and found Resident #1 sitting on the floor on the left side of his/her bed. Nurse #1 said that Resident #1's knees were slightly tucked underneath him/her like someone in a skirt might sit and his/her back was supported by CNA #1's legs. Nurse #1 said there were no other staff members in the room and that CNA #1 admitted that she moved [turned and repositioned] Resident #1 on her own. During an interview on [DATE] at 3:39 P.M., Unit Manager #1 (which also included a review of her written witness statement dated [DATE]) said that she was called at 1:17 P.M. to come to Resident #1's room because he/she had fallen. Unit Manager #1 said that when she entered Resident #1's room, Nurse #1 and CNA #1 were already there, and Resident #1 was lying on the floor, parallel to the bed, on his/her right side with a pillow under his/her head. Unit Manager #1 said that when she asked Resident #1 what happened, he/she pointed at CNA #1 and said, it's her fault. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unit Manager #1 said that CNA #1 told her that she rolled Resident #1 onto his/her left side, without another staff member present to assist her, and to change the fitted sheet on his/her bed. Unit Manager #1 said CNA #1 reported that the sheet was too small, caused the mattress to buckle, and Resident #1 rolled out of bed and landed on his/her knees on the floor. Unit Manager #1 said that CNA #1 told her that she was on the opposite side of the bed from Resident #1 when this happened and that she had to go around the bed to lower Resident #1's upper body to the floor. Unit Manager #1 further said that when she asked CNA #1 if she was aware that Resident #1 required assistance from two staff members with care, which included bed mobility and repositioning, that CNA #1 remained silent, would not answer the question. Unit Manager #1 said that Resident #1 was transferred back to bed with the help of a mechanical lift and assistance from three staff members. Unit Manager #1 said that Resident #1 was alert and communicated that he/she was experiencing pain in both knees. Unit Manager #1 said Resident #1 was administered medication for pain and a STAT X-ray was ordered by the Physician. During an interview on [DATE] at 4:00 P.M., the Director of Nurses (DON) said that Resident #1's X-rays were completed at 3:15 P.M., revealing fractures in both the left and right distal femurs. The DON said Resident #1 was transferred to the Hospital ED and comfort measures were initiated, as he/she was not a surgical candidate. The DON said the Facility was later informed that he/she had died in the early hours of [DATE]. The DON said that although CNA #1 was not typically assigned to the [NAME] 2 unit, she had worked several shifts per week at the Facility for nearly a year. The DON said that during CNA #1's orientation, she received training on how to access the CNA Care Card and Care Plan, prior to caring for a resident, to reference and determine the level of staff assistance each resident needed to be safely cared for. The DON further said the Resident Care Plans were regularly updated in the Electronic Health Record (EHR) and the interventions were automatically reflected on the CNA Care Card to ensure it accurately represented each resident's current care needs. The DON said the expectation was for staff to reference the Care Card before providing care. The DON said that Resident #1 required the assistance of two staff members for turning and repositioning in bed. The DON said that on [DATE], CNA #1 had not checked Resident #1's Care Plan or Care Card prior to moving Resident #1 in bed, without assistance from another staff member. On [DATE], the Facility presented the Surveyor with a plan of correction that addressed the areas of concern identified in this survey, the Plan of Correction provided is as follows: A. [DATE], Nursing immediately assessed Resident #1 for injuries, STAT X-rays were ordered, and he/she was transferred to the Hospital Emergency Department for evaluation. B. [DATE], CNA #1 was suspended pending investigation and no longer works at the Facility. C. [DATE] through [DATE], the Director of Nurses (DON) and the Staff Development Coordinator (SDC) provided re-education and re-trained all nursing staff that provide direct resident care, regarding the requirement to follow the resident's plan of care with every encounter. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	D. [DATE], a Root Cause Analysis was completed by the Quality Assurance Performance Improvement (QAPI) Committee and an Improvement plan was developed. E. [DATE], the DON and the SDC completed additional staff training with a post education quiz, on providing assistance of two as care planned, with bed mobility and transfers. The training included instructions to get a nurse or therapist if another CNA is not available. F. [DATE], the Facility recognized that all residents have the potential to be affected by the same deficient practice, and the DON completed a facility-wide audit for all residents requiring assistance from two staff members for bed mobility and transfers, which included a review of their Comprehensive Care Plans and CNA Care Cards. G. Effective [DATE] through [DATE], daily visual observation audits by the Nursing Administration were conducted on all three shifts to ensure the resident's care plan interventions were being implemented and followed. H. The areas of concern and data collected, will continue to be presented at the Facility's Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly, and the Committee will continue to monitor for 60 to 90 days, to ensure substantial compliance. I. The Administrator, the Director of Nursing and/or their designees are responsible for overall compliance.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 records reviewed and interviews, for one of three sampled residents (Resident #1), who had right sided weakness from a stroke and required the assistance of two staff members for turning and repositioning in bed, the Facility failed to ensure he/she was provided with the necessary level of staff assistance to maintain his/her safety and prevent an incident/accident resulting serious injury and death. On [DATE] at 1:15 P.M., while attempting to change his/her bed sheets, Certified Nurse Aide (CNA) #1, without another staff member to assist her, positioned Resident #1 on his/her left side away from her, and Resident #1 rolled out of the bed, landing on his/her knees on the floor. Resident #1 sustained bilateral (right and left) distal femur (lower part of the thigh bone near the knee joint) fractures and was transferred to the Hospital Emergency Department (ED) where he/she presented with hemorrhagic shock (major blood loss after trauma) and died the next day. Findings include: Review of the Facility Policy titled Falls and Fall Risk, Managing, dated as revised [DATE], indicated that a fall is defined as unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g. a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen if not for another person or if he or she had not caught himself/herself, is considered a fall. Review of the Report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated [DATE], indicated that Resident #1, whose Plan of Care identified that he/she required assistance from two staff members with bed mobility [which included turning and repositioning] received care in bed, at 1:15 P.M. from Certified Nurse Aide #1. The Report indicated that CNA #1 rolled Resident #1, without assistance from another staff member, and was changing the sheet under him/her when he/she rolled out of bed and landed on his/her knees. The Report indicated that CNA #1 quickly went around the bed and lowered Resident #1 the rest of the way to the floor. The Report indicated the Nurse assessed Resident #1 who reported knee pain, that no other injuries were identified, Resident #1 was assisted back to bed via mechanical lift and once in bed he/she reported increased bilateral knee pain. Further review of the Report indicated that STAT (immediate) X-rays were obtained at 3:15 P.M. which identified bilateral distal femur fractures. The Report indicated that Resident #1 was transferred to the ED for evaluation and he/she died on [DATE]. Review of Resident #1's Radiology Report, dated [DATE], indicated he/she had acute femoral fractures, on the left and right. Review of Resident #1's Hospital Discharge Note, dated [DATE], indicated he/she presented to the Hospital ED on [DATE], with bilateral femur fractures related to a fall at his/her nursing facility. The Note further indicated that Resident #1 was in traumatic hemorrhagic shock, transitioned to comfort measures, and passed away at 1:57 A.M. ([DATE]). (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 was admitted to the Facility in February 2025, diagnoses included cerebral infarction (stroke), dysphagia (difficulty swallowing), long term/current use of anticoagulants (blood thinners), osteoarthritis, lack of coordination, need for assistance with personal care and weakness. Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], indicated Resident #1 was severely cognitively impaired with a score of 1 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). Further review of the MDS indicated Resident #1 was dependent on staff to roll left and right in bed, and that he/she had upper and lower extremity limitations that interfered with daily functions or placed him/her at risk of injury. Review of Resident #1's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with Quarterly MDS completed [DATE], indicated he/she required assistance of two staff members for bed mobility, which included turning and repositioning, and required a mechanical lift with assistance of two staff members for transfers. Review of Resident #1's CNA Care Card (Certified Nurse Aide, reference guide, identifies residents specific care needs, including number of staff required to provide assistance during tasks), dated [DATE], indicated he/she required the assistance of two staff members for bed mobility (rolling and repositioning in bed). Review of Certified Nurse Aide #1's Personnel Record, indicated there was a CNA Competency Form, signed and dated by CNA #1 on [DATE], that indicated she had demonstrated competency in following, the Fall Prevention Program, utilizing fall preventative measures according to the care plan, and reviewing the CNA Care Card. Further review of the Record indicated that on [DATE] CNA #1 completed additional education on safe patient handling for lifting and positioning. During a telephone interview on [DATE] at 4:36 P.M., Certified Nurse Aide (CNA) #1 said she had been a CNA for 15 years, had worked per diem at the Facility since [DATE], and that she had only provided care to Resident #1 on two occasions, prior to [DATE]. Although CNA #1's personnel record contained documenation specific to education and training she received while at the facility, which she dated and signed, CNA #1 said that she was not familiar with the facility procedure for reviewing the CNA Care Card or the Care Plans to determine the residents' care needs and relied on asking the staff. CNA #1 said she did not review Resident #1's Care Plan or CNA Care Card, to determine the level of assistance needed to provide safe care. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA #1 said on [DATE] she changed Resident #1's bed sheets at 1:15 P.M., while he/she was in bed. CNA #1 said that she rolled Resident #1 onto his/her left side, and he/she held on to the left bedrail while she (CNA #1) went around to the right side of the bed and secured the fitted sheet to the mattress. CNA #1 said the sheet was too small for the mattress, the mattress started curling up on the right side of the bed and caused Resident #1 to roll out of the left side of the bed. CNA #1 said Resident #1 landed on his/her knees on the floor, with the upper portion of his/her body still on the bed. CNA #1 said that while Resident #1 clung to the bedrail, she reached over the bed and grabbed him/her by the shirt, climbed across the bed, and slowly lowered his/her upper body to the ground. CNA #1 said she supported Resident #1's upper body against her legs while she rang the call light and yelled for help. During a telephone interview on [DATE] at 9:01 A.M., Certified Nurse Aide (CNA) #2 (which also included a review of her written witness statement dated [DATE]) said she reviewed CNA #1's assignment with her at the start of the shift and told her that Resident #1 required the assistance of two staff members for bed mobility and transfers. CNA #2 said that she offered to assist CNA #1 with Resident #1's care, about 30 minutes before her break, and again at 1:00 when she was leaving for break. CNA #2 further said that she informed CNA #1 she would be taking her break on the porch nearby and was available to help with Resident #1's care when needed. CNA #2 said CNA #1 never came to get her to assist with Resident #1's care. During an interview on [DATE] at 11:00 A.M., Physical Therapist Assistant (PTA) #1 said that during the day shift on [DATE], she was in the hallway on [NAME] 2 when she heard someone in Resident #1's room yelling for help. PTA #1 said that when she entered the room, Resident #1 was sitting on the floor to the left side of the bed, with both knees bent to one side and his/her upper body resting against CNA #1's legs. PTA #1 said no other staff members were present when she arrived, so she immediately went to find Nurse #1. During a telephone interview on [DATE] at 3:07 P.M., Nurse #1 (which also included a review of her written witness statement dated [DATE]) said at 1:15 P.M. she responded to a call for help and found Resident #1 sitting on the floor on the left side of his/her bed. Nurse #1 said that Resident #1's knees were slightly tucked underneath him/her like someone in a skirt might sit and his/her back was supported by CNA #1's legs. Nurse #1 said there were no other staff members in the room and that CNA #1 admitted that she moved [turned and repositioned] Resident #1 on her own. Nurse #1 said that Resident #1 required the assistance of two staff members with turning in bed and that CNA #1 did not ask anyone for assistance. Nurse #1 said that CNA #1 told her the fitted sheet she used was too small for Resident #1's mattress and that when she tried to make it fit the mattress buckled. Nurse #1 said she observed that the right side of the mattress was curled up because the fitted sheet was too small for the mattress. During an interview on [DATE] at 3:39 P.M., Unit Manager #1 (which also included a review of her written witness statement dated [DATE]) said that she was called at 1:17 P.M. to come to Resident #1's room because he/she had fallen. Unit Manager #1 said that when she entered Resident #1's room, Nurse #1 and CNA #1 were already there, and Resident #1 was lying on the floor, parallel to the bed, on his/her right side with a pillow under his/her head. Unit Manager #1 said that when she asked Resident #1 what happened, he/she pointed at CNA #1 and said it's her fault. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unit Manager #1 said that CNA #1 told her that she rolled Resident #1 onto his/her left side, without another staff member present to assist her, and changed the fitted sheet on his/her bed. Unit Manager #1 said CNA #1 reported that the sheet was too small, caused the mattress to buckle, and Resident #1 rolled out of bed and landed on his/her knees. Unit Manager #1 said that CNA #1 told her that she was on the opposite side of the bed from Resident #1 when this happened and that she had to go around the bed to lower Resident #1's upper body to the floor. Unit Manager #1 further said that when she asked CNA #1 if she was aware that Resident #1 required assistance from two staff members with care, she remained silent, would not answer the question and later blamed the incident on an ill-fitting sheet. Unit Manager #1 said that after the incident, once Resident #1 was in bed, she observed that there were bariatric sheets (the appropriate size for Resident #1's mattress) readily available in both nearby linen closets. Unit Manager #1 said that Resident #1 was transferred back to bed with the help of a mechanical lift and assistance from three staff members. Unit Manager #1 said that Resident #1 was alert and communicated that he/she was experiencing pain in both knees. Unit Manager #1 said Resident #1 was administered medication for pain and STAT X-rays were ordered by the Physician. During an interview on [DATE] at 4:00 P.M., the Director of Nurses (DON) said that Resident #1's X-rays were completed at 3:15 P.M., revealing fractures in both the left and right distal femurs. The DON said Resident #1 was transferred to the Hospital ED and the Facility was later informed that he/she had died in the early hours of [DATE]. The DON said that although CNA #1 was not typically assigned to the [NAME] 2 unit, she had worked several shifts per week at the Facility for nearly a year. The DON said that during CNA #1's orientation, she received training on how to use the CNA Care Card and Care Plan to reference the level of assistance each resident needed to be safely cared for. The DON further said the CNA Care Card and Care Plans were regularly updated to reflect each resident's current care requirements. The DON said that Resident #1 required the assistance of two staff members for turning and repositioning in bed, and that on [DATE], CNA #1 rolled Resident #1 in bed without assistance from another staff member and did not seek help from anyone else while providing his/her care. The DON said that although the bed sheet that CNA #1 used was too small, Resident #1's fall from bed would have been prevented if a second staff member had been present to assist as required. On [DATE], the Facility presented the Surveyor with a plan of correction that addressed the areas of concern identified in this survey, the Plan of Correction provided is as follows: A. [DATE], Nursing immediately assessed Resident #1 for injuries, STAT X-rays were ordered, and he/she was transferred to the Hospital Emergency Department for evaluation. B. [DATE], CNA #1 was suspended pending investigation and no longer works at the Facility. C. [DATE] through [DATE], the Director of Nurses (DON) and the Staff Development Coordinator (SDC) provided re-education and re-trained all nursing staff that provide direct resident care, regarding the requirement to follow the resident's plan of care with every encounter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225420	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Extended Care at Amherst	150 University Drive Amherst, MA 01002

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	D. [DATE], a Root Cause Analysis was completed by the Quality Assurance Performance Improvement (QAPI) Committee and an Improvement plan was developed. E. [DATE], the DON and the SDC completed additional staff training with a post education quiz, on providing assistance of two as care planned, with bed mobility and transfers. The training included instructions to get a nurse or therapist if another CNA is not available. F. [DATE], the Facility recognized that all residents have the potential to be affected by the same deficient practice, and the DON completed a facility-wide audit for all residents requiring assistance from two staff members for bed mobility and transfers, which included a review of their Comprehensive Care Plans and CNA Care Cards. G. Effective [DATE] through [DATE], daily visual observation audits by the Nursing Administration were conducted on all three shifts to ensure the resident's care plan interventions were being implemented and followed. H. The areas of concern and data collected, will continue to be presented at the Facility's Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly, and the Committee will continue to monitor for 60 to 90 days, to ensure substantial compliance. I. The Administrator, the Director of Nursing and/or their designees are responsible for overall compliance.