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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225535	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Skilled Nursing Facility	97 Bethany Road Framingham, MA 01701

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 - Actual harm 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** 41107 Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose comprehensive plan of care indicated he/she required the use of a Hoyer lift (mechanical mobility aid that supports a person's body weight to allow movement from one surface to another) with assistance of two staff members for all transfers, and that staff should reapproach him/her if he/she became combative with care, the Facility failed to ensure staff implemented and followed interventions in his/her care plan, when on 8/22/24, while waiting to be transferred back to bed, Resident #1 became agitated, and per Certified Nurse Aide (CNA) #1, she lifted Resident #1 up from his/her wheelchair with a Hoyer lift to relieve pressure from Resident #1's buttocks, however CNA #1 did so, without having another staff member present to assist her, and Resident #1 slid out of the Hoyer lift pad and fell forward onto the floor. Resident #1 was transferred to the Hospital Emergency Department (ED) where he/she was diagnosed with a scalp laceration, head injuries, fractures and was admitted . Findings include: Review of the Facility's Policy titled, Resident Care Planning, dated March 2017, indicated that: - the Facility provides individualized, person centered care which is reflected in each resident's care plan. To facilitate the creation of such plans, the Facility performs a comprehensive assessment on all residents, -the care plan will include an assessment of resident's strengths and needs and, -the care plan may be accessed by any person involved in the implementation of the care plan. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/27/24, indicated that on 8/22/24, a staff member (later identified as CNA #1) was preparing the resident for a transfer to bed from his/her wheelchair via mechanical lift (Hoyer). The Report indicated that Resident #1 became agitated and yelled, my butt is hurting, so CNA #1 raised Resident #1 slightly [up off the wheelchair using the Hoyer lift] to relieve pressure on his/her buttocks. The Report indicated that Resident was kicking and flailing, and then slid out of the Hoyer pad landing on the floor. The Report indicated that Resident #1 was transferred to the Hospital Emergency Department (ED) and diagnosed with a right clavicle (collar bone) fracture, question of a right temporal bone (side of skull) fracture, a scalp laceration requiring five staples and subarachnoid/subdural hemorrhages (brain bleeds). The Report indicated that Resident #1 returned to the Facility within 24 hours. Review of the Facility's Fall Investigation, dated 08/22/24, indicated that Resident #1 was being prepared to transfer from his/her wheelchair to bed via mechanical (Hoyer) lift. The Investigation indicated Resident #1 became agitated, was flailing, kicking, and yelling, and then slid to the floor hitting his/her head. The Investigation indicated that the root [cause] of the fall was that Resident #1 became agitated and combative while he/she was prepared for care and slid down the chair (lift pad). Review of Resident #1's Hospital Discharge Report, dated 08/23/24, indicated that Resident #1 was evaluated after a fall from a Hoyer lift, and he/she admitted to the Hospital's Surgical Intensive Care Unit (SICU). The Report indicated that a computerized tomography (CT) scan of Resident #1's head on 08/23/24 at 4:00 A.M., revealed worsening subdural and subarachnoid hemorrhages compared to a prior CT scan done on 08/22/24. The Report indicated that Resident #1's injuries were deemed non-operative given his/her Do Not Resuscitate/Do Not Intubate status. The Report indicated that Resident #1 also had an occipital (back of head) wound that required staples for closure, a right temporal bone (side of skull) fracture, and a right clavicle (collar bone) fracture. The Report indicated that Resident #1 was sent back to the facility on [DATE]. Resident #1 was admitted to the Facility in March 2017, diagnoses included dementia and major depressive disorder. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/05/24, indicated he/she was dependent on staff for care and had severe cognitive impairment. Review of Resident #1's Activities of Daily Living Care Plan, reviewed and renewed with his/her June 2024 Quarterly MDS, indicated that Resident #1 required a Hoyer lift with the assistance of two staff members for transfers. Review of Resident #1's Behavior Care Plan, reviewed and renewed with his/her June 2024 Quarterly MDS, indicated that if Resident #1 resists ADLs, reassure him/her, leave and return five to ten minutes later to try again. (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 - Actual harm Residents Affected - Few	During an interview on 09/26/23 at 3:03 P.M., (which included a review of her Written Witness Statement, dated 08/23/24), CNA #1 said she knew Resident #1 transferred with a mechanical lift and that two staff members were required to do the transfer. CNA #1 said she was in Resident #1's room waiting for CNA #2 to come and assist her. CNA #1 said Resident #1 was seated in his/her wheelchair on a Hoyer lift pad, but it was not attached to the Hoyer lift yet. CNA #1 said Resident #1 started yelling, my butt hurts, so she (CNA #1) attached the Hoyer lift pad straps to the Hoyer lift, pressed the lift button on the Hoyer lift, and lifted him/her (Resident #1) up a little. CNA #1 said when she lifted Resident #1 up with the Hoyer lift, his/her combative behavior worsened and Resident #1 fell forward out of the Hoyer pad onto the floor. CNA #1 said she was standing in front of Resident #1 when she lifted him/her up, but was unable to stop him/her (Resident #1) from falling to the floor and hitting his/her head. CNA #1 said that she did not wait for CNA #2 to assist her [with the transfer] because Resident #1 was yelling, but said she should have waited. During a telephone interview on 10/02/24 at 10:31 A.M., (which included a review of a statement taken during a telephone interview conducted by the Director of Nurses, dated, 08/23/24), CNA #2 said she knew Resident #1 well and that two staff members were required to transfer him/her safely. CNA #2 said on 08/22/24, she was providing care to another resident, when she heard CNA #1 yell her name. CNA #2 said she ran to Resident #1's room, and when she entered Resident #1's room, she saw Resident #1 lying on the floor with blood around his/her head. During an interview on 09/26/24 at 11:21 P.M., (which included a review of her Written Witness Statement, dated 08/22/24), Nurse #1 said she was familiar with Resident #1 and that he/she required a Hoyer lift with two staff members present to assist with his/her transfers. Nurse #1 said CNA #1 and CNA #2 called her to Resident #1's room, and when she entered Resident #1's room, she saw Resident #1 lying on the floor on his/her back between the bed and the Hoyer lift, and he/she had blood coming from his/her head. Review of a Nurse Progress Note, written by Nursing Supervisor #1, dated 08/22/24 at 7:35 P.M., indicated that Resident #1 was being transferred via Hoyer Lift, became anxious and agitated, was flailing and kicking, and then slid out of the Hoyer pad onto the floor hitting his/her head on the floor. The Note indicated Resident #1 was visibly bleeding from a laceration on the back of his/her head. The Note indicated that Resident #1's mobility order was Hoyer lift with assistance of two staff members. During an interview on 09/2624 at 1:18 P.M., Nursing Supervisor #1 said CNA #1 told her that Resident #1 had been yelling, kicking, and flailing in his/her wheelchair, and screaming that his/her butt hurt. Nursing Supervisor #1 said CNA #1 told her that she (CNA #1) had tried to relieve pressure on Resident #1's buttocks by lifting him/her up [with the Hoyer lift], while she waited for CNA #2 to come to Resident #1's room to assist her. Review of an Employee Warning Form, dated 08/23/24, completed by the Staff Development Coordinator (SDC) indicated that CNA #1 was issued a written warning related to Resident #1's fall from the Hoyer lift. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 10/03/24 at 12:08 P.M., the Staff Development Coordinator (SDC) said she completed the Employee Warning Form on 08/23/24 for CNA #1 because she (CNA #1) lifted Resident #1 up in the Hoyer lift without another staff member present to assist her, which caused Resident #1 to fall. The SDC said that per Facility Policy, two staff members are required to be present for all Hoyer lift transfers. The SDC said that a transfer begins as soon as a staff member uses a Hoyer lift to begin lifting the resident from the surface he or she is seated on. During an interview on 09/26/24 at 11:40 P.M., Unit Manager #1 said that Resident #1 is dependent on staff for all care, and said he/she can be combative during care. Unit Manager #1 said if Resident #1 becomes combative during care, then the CNAs should tell the nurse, and reapproach the resident later. The Unit Manager said two staff members are always required for Hoyer lift transfers. During an interview on 09/26/24 at 1:37 P.M., the Director of Nurses (DON) said that two staff members are required to provide assistance to any resident when using a Hoyer lift for a transfer. The DON said CNA #1 told her that the Hoyer pad was connected to the Hoyer lift and that she slightly lifted Resident #1 with the Hoyer without the assistance from another staff member. The DON said that CNA #1 also told her that when she (CNA #1) began attaching the Hoyer straps to the Hoyer lift, that Resident #1 became more agitated and combative. The DON said that after this incident, for any resident requiring a Hoyer lift for transfers, two staff members must enter the resident's room simultaneously. On 09/26/24, 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. 8/22/24, Nursing immediately assessed Resident #1 for injuries, 911 was initiated and he/she was transferred to the Hospital Emergency Department, he/she returned within 24 hours. B. 8/23/24, The Staff Development Coordinator (SDC) initiated staff education on the use of mechanical lifts and all nursing staff were required to complete an additional Mechanical Lift competency that included return demonstration. C. Effective 08/23/24, daily visual observation audits by Nursing administration on the day and evening shifts were initiated to ensure two staff members were present for Hoyer lift transfers. Observation Audits will continue for 60-90 days D. 8/24/24, Resident #1 returned to the facility and his/her Comprehensive Care Plan was reviewed and revised. E. 8/26/24, 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 Hoyer lifts which included a review of their Comprehensive Care Plans. F. 09/03/24, the Director of Rehabilitation (DOR) completed facility-wide audit of all residents requiring a Hoyer lift, to ensure the correct Hoyer pads were being used on all residents according to manufacturer's guidelines. G. 09/10/24, the area of concern and data collected, was presented at the Facility's Quality Assurance Performance Improvement (QAPI) Committee Meeting, and a QI project was developed. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	H. The Administrator, the Director of Nursing and/or their designees will be responsible for overall compliance.

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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 - 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 41107

Based on records reviewed and interviews for one of three sampled residents (Resident #1), who required the use of a Hoyer lift (mechanical mobility aid that supports a person's body weight to allow movement from one surface to another) with assistance of two staff members for all transfers, 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 in multiple injuries, when on 08/22/24, Certified Nurse Aide (CNA) #1 initiated a Hoyer lift transfer with Resident #1 from his/her wheelchair, without another staff member present to assist her, and Resident #1 slid forward in the Hoyer lift pad and fell forward onto the floor. Resident #1 was transferred to Hospital Emergency Department where he/she diagnosed with a scalp laceration, head injuries, fractures and was admitted .

Findings include:

Review of the Facility's Policy, titled Mechanical Lifts, dated as reviewed January 2024, indicated the following:

- Two staff members must be present during the transfer, and

- One staff (member) will monitor the clip/loop placement and steady the resident, while the second staff member will use the control to lower the resident into position.

Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/27/24, indicated that on 8/22/24, a staff member (later identified as CNA #1) was preparing the resident for a transfer to bed from his/her wheelchair via mechanical lift (Hoyer). The Report indicated that Resident #1 became agitated and yelled, my butt is hurting, so CNA #1 raised Resident #1 slightly up off the wheelchair to relieve pressure on his/her buttocks. The Report indicated that Resident was kicking and flailing, and then slid out of the Hoyer pad landing on the floor. The Report indicated that Resident #1 was transferred to the Hospital Emergency Department (ED) and diagnosed with a right clavicle (collar bone) fracture, question of a right temporal bone (side of skull) fracture, a scalp laceration requiring five staples and a subarachnoid/subdural hemorrhage (brain bleeds). The Report indicated that Resident #1 returned to the Facility within 24 hours.

Review of the Facility's Fall Investigation, dated 08/22/24, indicated that Resident #1 was being prepared to transfer from his/her wheelchair to bed via mechanical lift. The Investigation indicated Resident #1 became agitated, flailing, kicking, and yelling, and then he/she slid to the floor hitting his/her head. The Investigation indicated that the root [cause] of the fall was that Resident #1 became agitated and combative while he/she was prepared for care and slid down the chair.

However, the Investigation findings did not include that CNA #1 was alone at the time of Resident #1's fall and did not have another staff member with her when she lifted him/her up off the wheelchair, with the Hoyer lift.

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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 - Actual harm Residents Affected - Few	Review of Resident #1's Hospital Discharge Report, dated 08/23/24, indicated that Resident #1 was evaluated in the Hospital's Emergency Department after a fall from a Hoyer lift, and then admitted to the Hospital's Surgical Intensive Care Unit (SICU). The Report indicated that a computerized tomography (CT) scan of Resident #1's head on 08/23/24 at 4:00 A.M., revealed worsening subdural and subarachnoid hemorrhages (brain bleeds) compared to a prior CT scan done on 08/22/24. The Report indicated that Resident #1's injuries were deemed non-operative given his/her Do Not Resuscitate/Do Not Intubate status. The Report indicated that Resident #1 also had an occipital (back of head) wound that required staples for closure, a right temporal bone (side of skull) fracture, and a right clavicle (collar bone) fracture. The Report indicated that Resident #1 was sent back to the facility on [DATE]. Resident #1 was admitted to the Facility in March 2017, diagnoses included dementia, and major depressive disorder. Review of Resident #1's Activities of Daily Living Care Plan, reviewed and renewed with his/her June 2024 Quarterly MDS, indicated that Resident #1 required a Hoyer lift with the assistance of two staff members for transfers. Review of Resident #1's Behavior Care Plan, reviewed and renewed with his/her June 2024 Quarterly MDS, indicated that if Resident #1 resists ADLs, reassure him/her, leave and return five to ten minutes later to try again. During an interview on 09/26/23 at 3:03 P.M., (which included a review of her Written Witness Statement dated, 08/23/24), CNA #1 said she was in Resident #1's room waiting for CNA #2 to come and assist her with Resident #1's transfer. CNA #1 said Resident #1 was seated in his/her wheelchair on a Hoyer pad when he/she started yelling, my butt hurts. CNA #1 said she attached the Hoyer pad straps to the Hoyer lift, pressed the lift button on the Hoyer lift, and lifted him/her (Resident #1) up a little. CNA #1 said when she lifted Resident #1 up with the Hoyer lift, his/her combative behavior worsened and Resident #1 fell forward out of the Hoyer pad onto the floor. CNA #1 said she was standing in front of Resident #1 when she lifted him/her up in the Hoyer lift, but she was unable to stop him/her from falling to the floor and hitting his/her head. CNA #1 said she was aware that tow staff members needed to be present when doing Hoyer lift transfer, but that she did not wait for CNA #2 to come to assist her [with the transfer] because Resident #1 was yelling. During the interview with the surveyor, CNA #1 physically demonstrated how she lifted Resident #1 up alone in the Hoyer lift, and how he/she fell forward out of the Hoyer lift onto the floor. When CNA #1 reenacted the incident, she had the surveyor play her role as the only CNA present in Resident #1's room, and she (CNA #1) played the role of Resident #1. CNA #1 had the surveyor stand in front of her while she was seated in a chair. CNA #1 then demonstrated how Resident #1 fell from the raised Hoyer lift pad, by leaning her upper body far forward in her seat and then moving her entire body head-first toward the floor. During a telephone interview on 10/02/24 at 10:31 A.M., (which included a review of a statement obtained during a telephone interview conducted by the Director of Nurses, dated 08/23/24), CNA #2 said on 08/22/24, she was providing care to another resident in another room, when she heard CNA #1 yell her name. CNA #2 said when she arrived at Resident #1's room, she saw Resident #1 lying on the floor and blood was coming from his/her head. (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 - Actual harm Residents Affected - Few	During an interview on 09/26/24 at 11:21 P.M., (which included a review of her Written Witness Statement dated 08/22/24), Nurse #1 said she was familiar with Resident #1 and said he/she required a Hoyer lift with two staff members present to assist for transfers. Nurse #1 said CNA #1 and CNA #2 called her to Resident #1's room, and when she entered his/her room, she saw Resident #1 lying on the floor on his/her back between the bed and the Hoyer lift, and he/she had blood coming from his/her head. During a telephone interview on 10/03/24 at 1:40 P.M., Nurse #2 said she heard CNA #1 and Nurse #1 yell to her to call 911. Nurse #2 said that after she called 911 and notified Nursing Supervisor #1, she entered Resident #1's room and saw Resident #1 lying on the floor on his/her back with blood near his/her head. Review of a Progress Note, written by Nursing Supervisor #1, dated 08/22/24 at 7:35 P.M., indicated that Resident #1 was being transferred via Hoyer Lift, became anxious and agitated, flailing and kicking, and then slid out of the Hoyer pad onto the floor in the supine (lying on back) position, hitting his/her head on the floor. The Note indicated Resident #1 was visibly bleeding from his/her head and that he/she had a laceration on the back of his/her head. The Note indicated that Resident #1's mobility order was Hoyer lift with an assist of two staff members. During an interview on 09/2624 at 1:18 P.M., Nursing Supervisor #1 said Nurse #2 called her to come emergently to Resident #1's room, and when she arrived, she saw Resident #1 lying on the floor with blood coming from the back of his/her head. Nursing Supervisor #1 said CNA #1 told her that Resident #1 had been yelling, kicking, and flailing in his/her wheelchair, and screaming that his/her butt hurt, so she tried to relieve pressure on Resident #1's buttocks while she waited for CNA #2 to assist her, by lifting him/her up off the wheelchair [with the Hoyer lift]. Review of an Employee Warning Form, dated 08/23/24, completed by the Staff Development Coordinator (SDC) indicated that CNA #1 was issued a written warning because of the incident with Resident #1. During a telephone interview on 10/03/24 at 12:08 P.M., the Staff Development Coordinator (SDC) said she completed the Employee Warning Form on 08/23/24 for CNA #1 because she (CNA #1) lifted Resident #1 up in the Hoyer lift without having another staff member present to assist her, which caused Resident #1 to fall. The SDC said that per Facility Policy, two staff members are required to be present for all Hoyer lift transfers. The SDC said that a transfer begins as soon as staff members use a Hoyer lift to start lifting the resident from the surface, he/she is seated on. During an interview on 09/26/24 at 1:37 P.M., the Director of Nurses (DON) said that when she interviewed CNA #1, CNA #1 told her that the Hoyer pad was connected to the Hoyer lift and that she slightly lifted Resident #1 up with the Hoyer lift without the assistance from another staff member. The DON said when CNA #1 went into Resident #1's room, Resident #1 became agitated and combative as soon as CNA #1 started hooking up the Hoyer pad to the machine. The DON said that following this incident, the Facility had determined that going forward, for any resident requiring a Hoyer lift for transfers, two staff members must enter the resident's room simultaneously. On 09/26/24, 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: (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 - Actual harm Residents Affected - Few	A. 8/22/24, Nursing immediately assessed Resident #1 for injuries, 911 was initiated and he/she was transferred to the Hospital Emergency Department, he/she returned within 24 hours. B. 8/23/24, The Staff Development Coordinator (SDC) initiated staff education on the use of mechanical lifts and all nursing staff were required to complete an additional Mechanical Lift competency that included return demonstration. C. Effective 08/23/24, daily visual observation audits by Nursing administration on the day and evening shifts were initiated to ensure two staff members were present for Hoyer lift transfers. Observation Audits will continue for 60-90 days D. 8/24/24, Resident #1 returned to the facility and his/her Comprehensive Care Plan was reviewed and revised. E. 8/26/24, 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 Hoyer lifts which included a review of their Comprehensive Care Plans. F. 09/03/24, the Director of Rehabilitation (DOR) completed facility-wide audit of all residents requiring a Hoyer lift, to ensure the correct Hoyer pads were being used on all residents according to manufacturer's guidelines. G. 09/10/24, the area of concern and data collected, was presented at the Facility's Quality Assurance Performance Improvement (QAPI) Committee Meeting, and a QI project was developed. H. The Administrator, the Director of Nursing and/or their designees will be responsible for overall compliance.