

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Carlyle House		STREET ADDRESS, CITY, STATE, ZIP CODE 342 Winter Street 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>15203</p> <p>Based on records reviewed and interviews, for two of six sampled residents (Resident #1 and Resident #5), who both had bed rails on their beds, the Facility failed to ensure they developed and implemented individualized comprehensive plans of cares that included interventions, treatment goals and measurable outcomes, when Resident #1 and Resident #5, Plans of Care did not include or address the installation and use of bed rails.</p> <p>Findings include:</p> <p>Review of the Facility's Policy titled Resident Assessment and Care Plan, dated as revised 10/01/17, indicated the Facility would develop and maintain an individualized interdisciplinary plan of care, treatment and services with appropriate education and training about each resident's care needs. The Policy indicated the care plan identifies the plan for the resident's care, treatment and services and how services will be provided. Review of the Facility's Policy titled Bed Rails, dated as released 11/28/17, indicated the facility will ensure the care plan reflects bed rail usage, including purpose of the bed rails.</p> <p>1) Resident #1 was admitted to the Facility during December 2024 following a hospitalization with diagnoses that included right patella (kneecap) fracture and Parkinson's Disease.</p> <p>Review of Resident #1's Baseline Care Plan, dated 1/01/25, indicated side rails per resident request for turning and positioning.</p> <p>During an interview on 2/20/25 at 12:00 P.M., the Maintenance Director said that, on 1/02/25, at the request of nursing staff, he installed two half bed rails on Resident #1's bed.</p> <p>Resident #1's Admission Minimum Data Set Assessment, dated as completed 1/07/25, indicated his/her cognitive patterns were intact, he/she required partial or moderate assistance for bed mobility, substantial to maximum assistance to move from lying to sitting on the edge of the bed and vice versa and was dependent for transferring between surfaces.</p> <p>Review of Resident #1's Comprehensive Care Plan indicated there was no documentation to support the Facility developed and implemented a care plan to address Resident #1's bed rail use.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 2/26/25 at 2:30 P.M. the MDS Nurse said that it was an oversight that the use of bed rails were not included and developed as care planned area, and said that there were no interventions, goals or outcomes identified in Resident #1's care plan.</p> <p>2) Resident #5 was admitted to the Facility during July 2024, with diagnoses that included low back pain and coronary artery disease.</p> <p>Resident #1's most recent Quarterly Minimum Data Set Assessment, completed 1/22/25, indicated his/her cognitive patterns were intact, he/she was independent for rolling side to side in bed and required supervision or physical assistance to move from lying to sitting on the edge of the bed and vice versa and for transferring between surfaces.</p> <p>Review of Resident #5's physician orders indicated there was a physician order in place, dated 7/16/24, for two half rails.</p> <p>The Bed System Measurement Device Test Results Worksheet, dated 7/16/24, indicated the Maintenance Director applied a half rail to the right side of Resident #5's bed.</p> <p>Review of Resident #5's Comprehensive Care Plan indicated there was no documentation to support the Facility developed and implemented a care plan to address Resident #1's side rail use, until 2/11/25.</p> <p>During an interview on 3/03/25 at 2:40 P.M. the MDS Nurse said that it was an oversight that the bed rails were not included as an intervention on Resident #5's care plan between July 2024 and 2/11/25.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15203</p> <p>Based on observation, records reviewed and interviews, for one of six sampled residents (Resident #1), who had limited mobility due to a cylinder (plaster type) cast on his/her right leg from his/her mid thigh down to his/her ankle, required physical assistance from staff with rolling and moving in bed, and had requested the use of bed rails for bed mobility, the Facility failed to ensure he/she was adequately supervised for safety and potential hazards related to the use of bed rails as an assistive device, in order to prevent an incident and/or accident resulting in serious injury or death. On [DATE] around 6:00 A.M., Resident #1 was found unresponsive, without a pulse, his/her lower body was hanging off the mattress with his/her feet touching the floor, and his/her head/neck area was hyperextended and caught between the mattress and the bed rail. Resident #1 was pronounced dead at the facility.</p> <p>Findings include:</p> <p>Review of the Facility's Policy titled Bed Rails, dated as released [DATE], indicated the facility will ensure the resident receives assistance as needed for bathroom utilization, transferring in and out of bed, bed mobility and other care needs.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated [DATE], indicated that around 6:00 A.M. on [DATE], staff members observed Resident #1 in bed with his/her head between the mattress and the bed rail and his/her right leg and leg cast off of the mattress with his/her foot touching the floor.</p> <p>The Report indicated that Resident #1 did not have a pulse, CPR was initiated and 911 was called, however, Resident #1 was pronounced dead at the Facility.</p> <p>Resident #1 was admitted to the Facility in [DATE], with diagnoses that included right patella (kneecap) fracture and Parkinson's Disease.</p> <p>Review of Resident #1's Baseline Care Plan, dated [DATE], indicated bed rails per resident request for turning and positioning.</p> <p>During a telephone interview on [DATE] at 2:30 P.M. the MDS Nurse said that she wrote the notation on Resident #1's Baseline Care Plan that bed rails were requested by Resident #1 for turning and positioning after a conversation with Resident #1 during which he/she asked for the bed rails to be put on the bed.</p> <p>Review of Resident #1 medical record indicated there was no documentation to support nursing obtained a physician's order for use of bed rails.</p> <p>During an interview on [DATE] at 12:00 P.M., the Maintenance Director said that, on [DATE], at the request of nursing staff, he installed two half bed rails on Resident #1's bed. The Maintenance Director said he completed an entrapment assessment at that time.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1's Admission Minimum Data Set Assessment, dated as completed [DATE], indicated the following:</p> <ul style="list-style-type: none"> -his/her cognitive patterns were intact, -he/she was 5'3 tall and weighed 131 pounds, -was always incontinent of bowel and bladder, -had impaired functional mobility in lower extremity on one side, -required partial to moderate assistance for bed mobility, -required substantial to maximum assistance to move from lying to sitting on the edge of the bed and vice versa, (staff provided more than half the effort to complete activity). -he/she was dependent for transferring between surfaces (staff member does all the effort to complete the activity). <p>Further review of Resident #1's medical record indicated there was no documentation to support that nursing assessed him/her for the use of bed rails upon admission, if the bed rails potentially posed a safety hazard or that any alternative measures were attempted.</p> <p>During an interview on [DATE] at 1:25 P.M., the Director of Nursing said that it was the Facility practice for all newly admitted residents to be assessed for bed rails on admission. The Director of Nursing said that the nurse who completed Resident #1's admission worked for an Agency and had not completed his/her bed rail assessment, but should have.</p> <p>The Surveyor was unable to interview the Agency Nurse that completed Resident #1's admission as she did not respond to the Department of Publics requests for an interview.</p> <p>During a follow-up interview on [DATE] at 1:13 P.M., the Director of Nursing said that at the time of Resident #1's admission, the Facility did not have a procedure in place for auditing to ensure bed rail assessments for newly admitted residents had been completed within twenty-four hours of admission.</p> <p>Review of Resident #1's physician orders and Treatment Administration Record (TAR), dated [DATE] through [DATE], indicated he/she had a hinge brace on his/her right leg (from mid thigh area down to just above the ankle).</p> <p>However, there was no documentation to support the Facility developed a care plan which addressed Resident #1's bed rail use.</p> <p>Review of Resident #1's physician orders and Treatment Administration Record (TAR), dated [DATE] through [DATE], indicated he/she had a cylinder cast on his/her right leg (from mid thigh area down to just above the ankle).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Further review of Resident #1's medical record indicated there was no documentation to support that after Resident #1 had the hinged brace removed and a cylinder cast was placed on his/her right leg (from the upper thigh to ankle) on [DATE], which also limited his/her mobility with an increased need for staff assistance to lift and move his/her right leg, that nursing re-assessed him/her for an appropriate alternative to bed rails, or re-assessed him/her for safety or potential for hazards related to continued use of bed rails.</p> <p>Review of Resident #1's Comprehensive Care Plan related to Focus Area of Activities of Daily Living (ADL) self-care performance deficit due to Parkinson's Disease and patella fracture and incontinence care needs, dated [DATE], indicated interventions included the following:</p> <ul style="list-style-type: none"> - the resident is totally dependent on two staff for repositioning and turning in bed every 2 hours and as necessary, - the resident requires assistance by one to two staff to move between surfaces, - check every two hours and as required for incontinence <p>During an in-person interview on [DATE] at 12:55 P.M. with the Rehab Manager (RM) and a telephone interview on [DATE] at 1:15 P.M. with the Physical Therapy Assistant (PTA), they said the following: Resident #1 was admitted to the Facility with a right patella fracture following a motor vehicle accident. Resident #1 was admitted to the Facility with a hinge brace on his/her right leg which kept his/her right leg in a fully extended position. That on [DATE], Resident #1 had a surgical procedure (an open reduction and internal fixation of the right patella and soft tissue repair) and returned to the Facility with a cylinder (long leg) cast.</p> <p>The Rehab Manager said the cast extended from Resident #1's mid-thigh to ankle, ended with a large plaster lump in the area of his/her ankle and made the cast heavier. The RM and PTA said that on [DATE], Resident #1 went for a surgical follow up and returned with a different cylinder cast which also extended from his/her mid thigh to ankle, that there was no longer a large lump at the ankle, but that is was still difficult for Resident #1 to move his/her right without assistance due to the weight of the cast.</p> <p>The RM and PTA said Resident #1 was able to stand and bear weight, was non-ambulatory, and required maximum assistance to transfer between surfaces. The RM and PTA said Resident #1 required physical assistance with bed mobility, that he/she had trouble moving his/her right leg on his/her own because of the weight of the cast. The RM and PTA said staff had to pick up and help move Resident #1's right leg (in the cylinder cast) when he/she moved from sitting to lying down and vice versa, as well as during transfers between surfaces.</p> <p>During an interview on [DATE] at 7:07 A.M., CNA #3 said that she was assigned to care for Resident #1 during the overnight shift that started on [DATE] and ended on [DATE]. CNA #3 said that she did not know Resident #1 well and staff members on the 3:00 P.M. to 11:00 P.M. shift told her that Resident #1 would ring his/her call bell for assistance if he/she needed anything. CNA #3 said that she checked on Resident #1 at 11:00 P.M. and 3:00 A.M., and said Resident #1 appeared to be asleep, the head of his/her bed was raised and the bed was in a low position. CNA #1 said she did not check Resident #1 for incontinence, did not provide any personal care and did not reposition him/her during the 11:00 P.M. to 7:00 A.M. shift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>CNA #3 said sometime around 5:30 A.M. or 6:00 A.M. (exact time unknown). when she went to check on him/her, she found Resident #1 half off the bed and called for help from the nurse.</p> <p>During an interview on [DATE] at 1:06 P.M., Nurse #1 said that she was the nurse assigned to Resident #1's unit during the 7:00 P.M. to 7:00 A.M. shift starting on [DATE] and ending on [DATE]. Nurse #1 said that had cared for Resident #1 one or two times prior to the shift. Nurse #1 said Resident #1 received medications around 8:00 P.M. or 9:00 P.M. and usually slept through the night.</p> <p>Nurse #1 said that between 5:30 A.M. and 6:00 A.M., she was in and out of Resident #1's room several times because Resident #1's roommate had a problem with his/her blood sugar. Nurse #1 said that she could see Resident #1 in his/her bed asleep while she attended to the roommate.</p> <p>Nurse #1 said that around 6:00 A.M., when she was at his/her medication cart in the hallway, one of the CNAs came running and reported that something was wrong in Resident #1's room.</p> <p>Nurse #1 said when she arrived at Resident #1's room, she saw that Resident #1's legs were dangling off the mattress and hanging over the safety mat that was on the floor beside the bed. Nurse #1 said that it looked like Resident #1 had rolled out of bed. Nurse #1 said that Resident #1's buttock area was neither on the mattress or the floor, was hanging in the air. Nurse #1 said that Resident #1's right (casted) leg was crossed over his/her left leg. Nurse #1 said that the only part of Resident #1's body that was on the floor were his/her feet.</p> <p>Nurse #1 said that Resident #1's head was on the bed rail, with the bed rail under Resident #1's chin, his/her face was pointed up toward the ceiling and the back of his/her head was on the corner edge of the mattress. Nurse #1 said that Resident #1's head was stuck between the bottom corner of the bed rail and the mattress.</p> <p>Nurse #1 said that the head of Resident #1's bed was raised to 45 degrees, that the bed rail was down, and that the lower corner of the bed rail was higher than the mattress.</p> <p>Nurse #1 said that Resident #1 was not alert, was pale, had no pulse and did not appear to be breathing. Nurse #1 said they called a Code Blue, called 911, Nurse #2 came to assist her, the CNAs assisted Nurse #2 with transferring Resident #1 back to bed, and CPR was initiated.</p> <p>During an interview on [DATE] at 6:15 A.M., Nurse #2 said that on [DATE] around 6:00 A.M. she was called to Resident #1's unit to assist with a Code Blue. Nurse #2 said that when she arrived at Resident #1's room, Resident #1 was on the side of the bed with the side rail in front of him/her keeping him/her from falling out of bed. Nurse #2 said that Resident #1's legs were off the mattress and angled toward the floor and his/her chin was resting on top of the bed rail. Nurse #2 said Resident #1's head was hyperextended and his/her face was pointed upward toward the ceiling.</p> <p>Nurse #2 said she released the side rail and Resident #1 fell forward into the arms of CNA #1 and CNA #7 and they lifted him/her into bed. Nurse #2 said Resident #1's body was warm, he/she was not breathing, his/her face color was ashen and his/her left leg was discolored and almost mottled.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an in-person interview on [DATE] at 4:11 P.M. with Certified Nurse Aide (CNA) #1 and a telephone interview on [DATE] at 11:00 A.M. with CNA #7, they said on [DATE], they assisted with putting Resident #1 back to bed around 6:30 A.M. They said that Resident #1's head was stuck between the mattress and the bed rail, his/her chin was caught on the bed rail, his/her lower body was off the bed and his/her legs were extended out in front of him/her. CNA #7 said that when Resident #1 was freed from the bed rail, he saw that the area underneath Resident #1's neck was red and his/her head remained in the same position, with his/her neck extended and face looking upward.</p> <p>Nurse #1 said that while administering CPR she noted bruising under Resident #1's chin. Nurse #1 said Emergency Medical Services (EMS) arrived and pronounced Resident #1 dead.</p> <p>The Police Report, dated [DATE], indicated the police arrived at the Facility at 6:23 A.M. having been dispatched for an unresponsive resident. The Police Report indicated Resident #1 was found by Nurse #1 with his/her body laying half off the bed with his/her body on the ground and his/her head pinned between the mattress and the guardrails [bed rails].</p> <p>The EMS Patient Care Report for the ambulance service dated [DATE] at 6:30 A.M. indicated EMS arrived at the Facility for an unresponsive patient. The Report indicated staff were unable to provide a certain time Resident #1 was last known to be well. The Report indicated staff reported that they found no pulse or breathing and began CPR.</p> <p>The Report indicated that on exam, Resident #1 was unresponsive to painful stimuli and the paramedic was unable to manipulate his/her neck, jaw, shoulders, hips and knees due to rigor (rigor mortis, stiffening of the joints and muscles of the body a few hours after death). The Report indicated that resuscitative efforts for Resident #1 were ceased due to bodily condition clearly indicating biological death.</p> <p>During an interview on [DATE] at 1:40 P.M., the Administrator said that he was informed of Resident #1's accident/incident at the Facility on [DATE] and responded to the Facility to initiate an investigation and assist the police who were on site and also conducting an investigation.</p>		

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15203</p> <p>Based on observation, records reviewed and interviews for one of six sampled residents (Resident #1) who had limited mobility in his/her right leg related the need for a hinge brace which was changed to a long leg cylinder cast (both of which kept his/her right leg fully extended) for treatment of a fractured patella (knee cap), and had requested bed rails to aide in bed mobility, the Facility failed to ensure nursing completed bed rail assessment on Resident #1, attempted the use of an appropriate alternative to bed rails and obtained informed consent prior to installing two quarter bed rails on his/her bed. On [DATE], around 6:00 A.M., Resident #1 was found by staff unresponsive, without a pulse, his/her legs were off the bed, extended over the floor mat next to the bed, his/her head/neck was caught on and hyperextended up over the bed rail, and the back of his/head was against the mattress. Resident #1 was pronounced dead at the facility.</p> <p>Findings include:</p> <p>Review of the Facility's Policy titled Bed Rails, dated as released [DATE], indicated the facility will:</p> <ul style="list-style-type: none"> - attempt to use appropriate alternatives prior to installing a bed rail, - assess the resident risk for entrapment using established systems, - obtain informed consent, - ensure the care plan reflects bed rail usage, including purpose of the bed rails, - will periodically reassess the resident's needs and bed rail usage to determine ongoing appropriateness, and, - ensure the resident receives assistance as needed for bathroom utilization, transferring in and out of bed, bed mobility and other care needs. <p>Federal regulations related to Bed Rails, include guidance facilities' need to consider when determining whether to use bed rails to meet the needs of a resident, the following components of the resident assessment should be considered including, but not limited to:</p> <ul style="list-style-type: none"> -Medical diagnosis, conditions, symptoms, and/or behavioral symptoms; -Size and weight; -Sleep habits; -Medication(s); <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> -Acute medical or surgical interventions; -Underlying medical conditions; -Existence of delirium; -Ability to toilet self safely; -Cognition; -Communication; -Mobility (in and out of bed); and -Risk of falling <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated [DATE], indicated that around 6:00 A.M. on [DATE], staff members observed Resident #1 in bed with his/her head between the mattress and the side rail and his/her right leg and leg cast off the mattress with his/her foot touching the floor. The Report indicated that Resident #1 did not have a pulse, CPR was initiated, 911 was called, and was pronounced dead at the Facility.</p> <p>Resident #1 was admitted to the Facility during [DATE] following a hospitalization with diagnoses that included right patella (knee cap) fracture and Parkinson's Disease.</p> <p>During a telephone interview on [DATE] at 2:30 P.M. the MDS Nurse said she had a conversation with Resident #1 right after his/her admission and that he/she requested bed rails be put on his/her to help with turning and positioning.</p> <p>The MDS Nurse said she did not discuss alternatives to bed rails with Resident #1 or discuss the risks and benefits of bed rails with Resident #1 during their conversation.</p> <p>During an interview on [DATE] at 12:00 P.M., the Maintenance Director said that, on [DATE], at the request of nursing staff, he assessed Resident #1's bed for entrapment risk and installed two half bed rails.</p> <p>Review of the Bed System Measurement Device Test Results Worksheet, dated [DATE] and signed by the Maintenance Director, indicated two half rails were installed on Resident #1's bed.</p> <p>Resident #1's Admission Minimum Data Set Assessment, dated as completed [DATE], indicated the following:</p> <ul style="list-style-type: none"> -his/her cognitive patterns were intact, -he/she was 5'3 tall and weighed 131 pounds, -was always incontinent of bowel and bladder, <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-had impaired functional mobility in lower extremity on one side,</p> <p>-required partial to moderate assistance for bed mobility,</p> <p>-required substantial to maximum assistance to move from lying to sitting on the edge of the bed and vice versa, (staff provided more than half the effort to complete activity).</p> <p>-he/she was dependent for transferring between surfaces (staff member does all the effort to complete the activity).</p> <p>Further review of Resident #1's medical record indicated there was no documentation to support that nursing assessed him/her for the use of bed rails upon admission, if the bed rails potentially posed a safety hazard or that any alternative measures were attempted.</p> <p>During an interview on [DATE] at 1:25 P.M., the Director of Nursing said that every Facility resident has a bed rail assessment completed by nursing as part of their admission assessment, but said however, that Resident #1's bed rail assessment had not been completed.</p> <p>Further review of Resident #1's medical record indicated there was no documentation to support nursing reviewed and documented the risks and benefits of bed rail use with Resident #1 or that they obtained informed consent from Resident #1 prior to installing the two half bed rails on his/her bed.</p> <p>The Surveyor asked the Director of Nursing if the facility had any documentation related to the review of the risks and benefits of the use of bed rails with Resident #1 or of his/her informed consent for the bed rails, prior to the Facility having installed his/her bed rails.</p> <p>The Director of Nursing provided the Surveyor with a blank Side (bed) Rail Consent Form and said the Facility used the Form to document informed consent for bed rails with residents, including documentation of discussions of the risks and benefits of bed rails. The Director of Nursing said that staff had not completed a Side (bed) Rail Consent Form with Resident #1.</p> <p>Review of Resident #1's physician orders and Treatment Administration Record (TAR), dated [DATE] through [DATE], indicated he/she had a hinge brace on his/her right leg (from mid thigh area down to just above the ankle).</p> <p>Review of Resident #1's Comprehensive Care Plan indicated the Facility initiated care plans for the following Focus Areas between [DATE] and [DATE]:</p> <ul style="list-style-type: none"> - Activities, - ADL self-care performance deficit due to Parkinson's Disease and patella fracture, - Wish to return home when medically cleared for discharge, - Risk for falls due to unaware of safety needs, - Adjustment disorder with mixed anxiety and depressed mood, <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Carlyle House		STREET ADDRESS, CITY, STATE, ZIP CODE 342 Winter Street 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)		
<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Potential Nutritional problem due to self-imposed diet restrictions, - Parkinson's Disease without dyskinesia - Risk for pain due to patella fracture - Potential for pressure ulcer development due to immobility - Bladder and bowel incontinence, and, - Impaired visual function. <p>Although, Resident #1's Baseline Care Plan indicated he/she had requested bed rails, there was no documentation to support the Facility developed an individualized comprehensive care plan which addressed his/her use of bed rails.</p> <p>Review of Resident #1's physician orders and Treatment Administration Record (TAR), dated [DATE] through [DATE], indicated he/she had a cylinder cast on his/her right leg (from mid thigh area down to just above the ankle).</p> <p>Further review of Resident #1's care plan indicated there was no documentation to support that after Resident #1 had the hinged brace removed and a cylinder cast was placed on his/her right leg (from the upper thigh to ankle) on [DATE], which also limited his/her mobility with an increased need for staff assistance to lift and move his/her right leg, that nursing re-assessed him/her for an appropriate alternative to bed rails, or re-assessed him/her for safety related to continued use of bed rails.</p> <p>During an in person interview on [DATE] at 12:55 P.M. with the Rehab Manager (RM) and a telephone interview on [DATE] at 1:15 P.M. with the Physical Therapy Assistant (PTA) they said the following: Resident #1 was admitted to the Facility with a right patella fracture following a motor vehicle accident. Resident #1 was admitted to the Facility with a hinge brace on his/her right leg which kept his/her right leg fully extended. That on [DATE], Resident #1 had a surgical procedure (an open reduction and internal fixation of the right patella and soft tissue repair) and returned to the Facility in a long leg cylinder cast.</p> <p>The Rehab Manager said the cast extended from Resident #1's mid-thigh to ankle, ended with a large plaster lump in the area of his/her ankle, which made the cast heavier. The RM and PTA said that on [DATE], Resident #1 went for a surgical follow up and returned with a different cylinder cast which also extended from his/her mid thigh to ankle, that there was no longer a large lump at the ankle, but that is was still difficult for Resident #1 to move his/her right without assistance.</p> <p>The Rehab Manager and PTA said that during his/her stay at the Facility, Resident #1 was able to stand and bear weight, however, was non-ambulatory and that required maximum assistance to transfer between surfaces. They said Resident #1 required physical assistance with bed mobility, had trouble moving his/her right leg on his/her own because of the weight of the cast, and used the bed rails to shift his/her weight. They said that staff members had to pick up, support and move Resident #1's right leg when he/she moved from sitting to lying down and vice versa and during transfers between surfaces.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on [DATE] at 2:18 P.M., Certified Nurse Aide (CNA) #5 said Resident #1 did not always understand how to use his/her call light and sometimes called out for assistance when staff entered his/her room during rounds. CNA #5 said Resident #1 used the bed rails to help him/herself roll.</p> <p>CNA #5 said that on more than one occasion, when she entered Resident #1's room after having previously left him/her positioned properly in the bed, she observed Resident #1 with his/her legs off the mattress hanging toward the floor. CNA #5 said she had not reported what she had seen to nursing or rehab staff. CNA #5 said that Resident #1 could move his/her legs off the mattress when he/she wanted to get out of bed.</p> <p>During an interview on [DATE] at 7:07 A.M., CNA #3 said that on [DATE] sometime around 5:30 A.M. or 6:00 A.M. (exact time unknown), she found Resident #1 half off the mattress and called for help from the nurse.</p> <p>During an interview on [DATE] at 1:06 P.M., Nurse #1 said that between 5:30 A.M. and 6:00 A.M., she was in and out of Resident #1's room several times because Resident #1's roommate had a problem with his/her blood sugar.</p> <p>Nurse #1 said that around 6:00 A.M., one of the CNAs came running and reported that something was wrong in Resident #1's room.</p> <p>Nurse #1 said when she arrived to Resident #1's room she saw that Resident #1's legs were dangling off of the mattress over the fall mat on the floor beside the bed. Nurse #1 said that it looked like Resident #1 had rolled out of bed. Nurse #1 said that Resident #1's buttocks were neither on the mattress or the floor and were hanging in the air. Nurse #1 said that Resident #1's right (casted) leg was crossed over his/her left leg. Nurse #1 said that the only part of Resident #1's body on the floor were his/her feet.</p> <p>Nurse #1 said that Resident #1's head was on the bed rail with the bed rail under Resident #1's chin, his/her face was pointed up toward the ceiling and the back of his/her head was on the corner edge of the mattress. Nurse #1 said that Resident #1's head was stuck between the bottom corner of the bed rail and the mattress.</p> <p>Nurse #1 said that the head of Resident #1's bed was raised to 45 degrees and although the bed rail was down, said the corner of the bed rail was higher than the mattress.</p> <p>Nurse #1 said that Resident #1 was not alert, was pale, had no pulse and did not appear to be breathing.</p> <p>During an interview on [DATE] at 6:15 A.M., Nurse #2 said that on [DATE] around 6:00 A.M. she was called to Resident #1's unit from another unit to assist. Nurse #2 said that when she arrived to Resident #1's room, Resident #1 was on the side of the bed with the bed rail in front of him/her keeping him/her from falling out of bed. Nurse #2 said that Resident #1's legs were angled down toward the floor and his/her chin was resting on top of the bed rail. Nurse #2 said Resident #1's head was hyperextended and his/her face was pointed up toward the ceiling.</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Nurse #1 said she and Nurse #2 initiated CPR and 911 was called. Nurse #1 said that while administering CPR she noted bruising under Resident #1's chin. Nurse #1 said Emergency Medical Services (EMS) arrived and pronounced Resident #1 dead.</p> <p>The Police Report, dated [DATE], indicated the police arrived at the Facility at 6:23 A.M. having been dispatched for an unresponsive resident. The Police Report indicated Resident #1 was found by Nurse #1 with his/her body laying half off of her/her bed with his/her body in the ground and his/her head pinned between the mattress and the guardrail [bed rail].</p> <p>The EMS Patient Care Report for the ambulance service, dated [DATE] at 6:30 A.M., indicated EMS arrived at the Facility for an unresponsive patient. The Report indicated staff were unable to provide a certain time Resident #1 was last known to be well. The Report indicated staff reported that they found no pulse or breathing and began CPR.</p> <p>The Report indicated that on exam, Resident #1 was unresponsive to painful stimuli and the paramedic was unable to manipulate his/her neck, jaw, shoulders, hips and knees due to rigor (rigor mortis, stiffening of the joints and muscles of the body a few hours after death). The Report indicated that resuscitative efforts for Resident #1 were ceased due to bodily condition clearly indicating biological death.</p> <p>During an interview on [DATE] at 1:40 P.M., the Administrator said that he was informed of Resident #1's accident/incident at the Facility on [DATE] and responded to the Facility to initiate an investigation and assist the police who were on site and conducting an investigation.</p>		