

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 01/27/2026
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)		
F 0656 Level of Harm - Actual harm Residents Affected - Few	<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>Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), whose comprehensive plan of care indicated he/she required two staff member assistance with use of the Hoyer (mechanical) lift for all transfers, the Facility failed to ensure staff consistently implemented and followed his/her care plan interventions, when on 12/30/25 Certified Nurse Aide (CNA) #1 transferred him/her without the assistance of another staff member, and Resident #1 sustained injuries including a right head laceration, and multiple fractures during the transfer. Findings include: The Facility Policy, titled Resident Assessment, dated 09/01/20, indicated an individualized interdisciplinary plan of care, treatment and services would be developed by the interdisciplinary team that identified the plan for care treatment, and services to be provided. The Facility Policy, titled Mechanical Lifts dated 02/26/09, indicated at least two nursing assistants were needed to safely move a resident with a mechanical lift. A Hoyer (mechanical) Lift is a device that allows caregivers to safely transfer an individual between a bed, wheelchair, shower chair, or another surface. A sling lift is comprised of a base on casters, a boom, and a cradle that supports the sling. Resident #1 was admitted to the Facility in October 2019, diagnoses included osteoporosis, dementia, and adult failure to thrive. Review of Resident #1's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with his/her quarterly Minimum Data Set (MDS) Assessment, dated 12/10/25, indicated he/she required full mechanical lift transfers with a two person assist (date initiated 01/04/23). Review of Resident #1's electronic resident care Kardex (reference document used by staff detailing key resident information, including transfer status), indicated he/she required two staff member assistance using the Hoyer Lift for all transfers. Review of the Nurse Progress Note, dated 12/30/25, indicated that at 06:00 P.M., Resident #1 was bleeding from his/her right temple area as a result of the Hoyer lift having struck his/her head during a transfer, and Resident #1 was transferred to the Hospital Emergency Department. Review of the Facility's Unusual Event Report, dated 12/31/25, indicated that on 12/30/25 at 06:00 P.M., Resident #1 sustained a laceration to the right side of his/her head as the result of an improper Hoyer Lift transfer, and was transferred to the Hospital Emergency Department as a result. Review of the Hospital Emergency Department admission History and Physical, dated 12/31/25, indicated Resident #1 was diagnosed with the following: -A hematoma (a localized collection of blood outside of blood vessels, usually caused by injury to the vessel wall, resulting in blood pooling within tissues) and ulceration on his/her right lateral temple area, which was wide and unable to be approximated and sutured. -Minimally displaced proximal and distal left clavicular (slender S-shaped long bone that connects the arm to the body's axial skeleton) fractures. -Acute fracture of the left superior and inferior pubic ramus (part of the pelvis). During a telephone interview on 01/28/26 at 2:02 P.M., Certified Nurse Aide (CNA) #1 said that on 12/30/25 at 6:00 P.M., she transferred Resident #1 using the Hoyer Lift without assistance from another staff member. CNA #1 said she lowered Resident #1 onto the bed, but his/her shoulders were not entirely lowered onto</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 225541	If continuation sheet Page 1 of 4

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F 0656 Level of Harm - Actual harm Residents Affected - Few	<p>the mattress but instead were still suspended in the lift sling three to four inches from the mattress. CNA #1 said she disconnected the right upper sling strap from the Hoyer Lift, which caused Resident #1's upper body to quickly land on the bed, and the sling bar to swing onto the right side of Resident #1's head. CNA #1 said Resident #1's right temple area started bleeding immediately, and said she called out to CNA #2 and CNA #3 for help. CNA #1 said she knew how to access the Kardex and that she knew Resident #1's plan of care was that all transfers required two staff members, however she said she had attempted to transfer him/her without assistance. During an interview on 01/21/26 at 2:00 P.M., Nurse #1 said that on 12/30/25 around 6:00 P.M., CNA #1 told her she needed help with Resident #1. Nurse #1 said when she got to Resident #1's room, CNA #1, CNA #2, and CNA #3 were in the room, Resident #1 was on his/her bed lying on his/her left side, and CNA #1 was holding a towel to the right side of his/her head near the temple area. Nurse #1 said she removed the towel to assess Resident #1's head and saw blood was flowing from a deep open wound and there was blood on Resident #1's face and in his/her hair. Nurse #1 said she instructed CNA #1 to maintain pressure on the wound with the towel while she got bandage supplies, and by the time she returned two minutes later, the towel was saturated with blood. Nurse #1 said, after meeting Resident #1 emergent care needs, she asked CNA #1 what happened, that she asked CNA #1 if she had transferred Resident #1 by herself, and that CNA #1 responded yes. During an interview on 01/21/26 at 3:09 P.M., the Director of Nurses (DON) said CNA #1 should have followed Resident #1's plan of care and had another staff member assist her to transfer Resident #1, but did not, and as a result, Resident #1 sustained injuries and required transfer to the Hospital Emergency Department.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</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** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who required two staff member assistance with the use of a Hoyer (mechanical) lift for all transfers, the Facility failed to ensure he/she was provided with the necessary level of staff assistance, in accordance with facility policies and assessed level of care needs, to maintain his/her safety to prevent an incident/accident resulting in significant injuries. On 12/30/25, Certified Nurse Aide (CNA) #1 attempted to transfer Resident #1 without another staff member present to assist her, which resulted in an unsafe transfer. Resident #1 sustained a laceration to the right side of his/her head, was transferred to the Hospital Emergency Department (ED) for an evaluation, where he/she was also diagnosed with multiple fractures. Findings include: The Facility Policy, titled Mechanical Lifts dated 02/26/09, indicated at least two nursing assistants were needed to safely move a resident with a mechanical lift. A Hoyer Lift is a device that allows caregivers to safely transfer an individual between a bed, wheelchair, shower chair, or another surface. A sling lift is comprised of a base on casters, a boom, and a cradle that supports the sling. Resident #1 was admitted to the Facility in October 2019, diagnoses included osteoporosis, dementia, and adult failure to thrive. Review of Resident #1's Activities of Daily Living (ADL) Care Plan, reviewed and renewed with his/her quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated he/she required full mechanical lift transfers with a two person assist (date initiated 01/04/23). Review of Resident #1's electronic resident Kardex (reference document used by staff, with key resident information related to care needs, including transfer status), indicated he/she required two staff member assistance using the Hoyer Lift for all transfers. Review of the Nurse Progress Note, dated 12/30/25, indicated that at 6:00 P.M., Resident #1 was bleeding from his/her right temple area as a result of the Hoyer lift having struck his/her head during a transfer, and Resident #1 was transferred to the Hospital Emergency Department. Review of the Hospital Emergency Department admission History and Physical, dated 12/31/25, indicated Resident #1 was diagnosed with the following: -A hematoma (a localized collection of blood outside of blood vessels, usually caused by injury to the vessel wall, resulting in blood pooling within tissues) and ulceration on his/her right lateral temple area, which was wide and unable to be approximated and sutured. -Minimally displaced proximal and distal left clavicular (slender S-shaped long bone that connects the arm to the body's axial skeleton) fractures. -Acute fracture of the left superior and inferior pubic ramus (part of the pelvis). Review of CNA #1's annual skills competency education record indicated that CNA #1 had been educated and completed facility required competency related to performing mechanical lift transfers. During a telephone interview on 01/28/26 at 2:02 P.M., Certified Nurse Aide (CNA) #1 said she had transferred Resident #1 many times, and said she knew it was Facility policy for at least two staff members to operate the Hoyer lift when completing transfers with a resident. CNA #1 said she knew how to access the care Kardex and knew that Resident #1 required two staff members for all transfers, however said she attempted to transfer him/her without assistance, and could not explain why. CNA #1 said that on 12/30/25 around 6:00 P.M., she transferred Resident #1 using the Hoyer Lift without assistance from another staff member. CNA #1 said she lowered Resident #1 onto the bed, but his/her shoulders were not entirely lowered to the mattress but instead were still suspended in the lift sling three to four inches from the mattress. CNA #1 said when she disconnected the right upper sling strap from the Hoyer Lift, that caused Resident #1's upper body to quickly land on the bed, and the sling bar to swing onto the right side of Resident #1's head. CNA #1 said Resident #1's right temple area started bleeding immediately, and said she called out to CNA #2 and CNA #3 for</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	help.During an interview on 01/21/26 at 2:00 P.M., Nurse #1 said that on 12/30/25 at 6:00 P.M., CNA #1 told her she needed help with Resident #1. Nurse #1 said when she got to Resident #1's room, CNA #1, CNA #2, and CNA #3 were in the room, Resident #1 was on his/her bed lying on his/her left side, and CNA #1 was holding a towel to the right side of his/her head. Nurse #1 said she removed the towel to assess Resident #1's head and saw blood was flowing from a deep open wound and there was blood on Resident #1's face and in his/her hair. Nurse #1 said she instructed CNA #1 to maintain pressure on the wound with the towel while she got bandage supplies, and by the time she returned two minutes later, the towel was saturated with blood.Nurse #1 said, after meeting Resident #1 emergent care needs, she asked CNA #1 what happened, that she asked CNA #1 if she had transferred Resident #1 by herself, and that CNA #1 responded yes.During interviews conducted with CNA #2, CNA #3, CNA #4, CNA #5, and Nurse #1, each of them said it was a well-known Facility policy that all Hoyer Lift transfers required two staff members to be present for the safety of the residents and staff. During an interview on 01/21/26 at 3:09 P.M., the Director of Nurses (DON) said it was Facility policy that two staff assist with all Hoyer Lift transfers, and said CNA #1 should have had another staff member assist her to transfer Resident #1, but did not, and as a result, Resident #1 sustained injuries and required transfer to the Hospital Emergency Department.		