STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225355	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Center	44 Keystone Drive Leominster, MA 01453

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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 had severe cognitive impairment and was dependent on staff for care, the Facility failed to ensure he/she was free from physical abuse and mental anguish, when on 06/11/24 during the evening shift (3:00 P.M. to 11:00 P.M), Resident #1 refused to transfer to bed, he/she became combative with staff and in response, Certified Nurse Aide (CNA) #1 physically restrained Resident #1, to which Resident #1 said stop, you're hurting me! CNA #1 yelled at Resident #1 telling him/her he was the captain, and forced Resident #1 to transfer into bed against his/her will. Findings include: Review of the Facility's Policy titled Abuse Prevention Program, dated as revised April 2021, indicated that the Facility's residents have the right to be free from abuse, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat a person's symptoms. Review of the Facility's Policy Titled and Neglect, Clinical Protocol, dated as revised September 2022, indicated that abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Review of the Facility's Policy titled, Use of Restraints, dated as revised April 2017, indicated the following: -physical restraints are defined as any manual method of physical or mechanical device, material or equipments attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body, and -restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or prevention of falls. Review of the Facility's Policy titled Behavioral Assessment, Intervention, and Monitoring, dated as revised March 2019, indicated the following: (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Behavior can be a way for an individual in distress to communicate unmet needs, indicate discomfort, or express thoughts that cannot be articulated, and -the Resident and or resident surrogate will have the right to refuse treatment. Resident #1 was readmitted to the Facility in February 2024, diagnoses included right femur (long leg bone) fracture, Alzheimer's Disease, depression, and paranoid personality disorder. Review of Resident #1's Minimum Set Data (MDS) Quarterly Assessment, dated 04/24/24, indicated he/she had severe cognitive impairment and required maximal assistance from staff for all mobility. Review of the report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated 06/11/24, indicated that CNA #2 and CNA #3 reported to the Nursing Supervisor that during care, it appeared that CNA #1 was kneeling on Resident #1. Review of a Nursing Progress Note, dated 06/11/24, indicated that two Certified Nurse Aides (CNA #2 and CNA #3) heard CNA #1 talking loudly out of frustration due to Resident #1 being combative. The Note indicated that CNA #2 and CNA #3 reported that CNA #1 used excessive force by putting his (CNA#1) knee on Resident #1's lap to prevent him/her (Resident #1) from getting up. The Note also indicated that CNA #1 was observed (by CNA #2 and CNA #3) to be very loud and aggressive toward Resident #1. Review of the Facility's Investigation Summary Report, undated, indicated that the reporting CNAs (identified as CNA #2 and CNA #3) said that on 6/11/24, CNA #1 kneeled on Resident #1 when he/she attempted to stand up. The Report indicated that CNA #2 and CNA #3 also reported that CNA #1 spoke very loudly and told Resident #1 to listen to him because he (CNA #1) was the captain. Review of Resident #1's CNA Care Kardex, dated 06/11/24, indicated the following: -be careful not to invade Resident #1's personal space, -if Resident #1 refuses care, leave him/her and return in five to ten minutes, and -talk with Resident in a low pitch, calm voice to decrease or eliminate undesired behavior. The Report indicated that CNA #1 said that Resident #1 was being combative when he was trying to put him/her to bed, so he (CNA #1) put one of his (CNA #1) legs on top of Resident #1's legs. The Report indicated that CNA #1 was immediately suspended and then terminated. Review of a Police Report, dated 06/11/24, indicated that an Officer was dispatched to the facility on [DATE] at 10:31 P.M. The Report indicated that the Nursing Supervisor told the Officer that one of their employees (identified as CNA #1), had been aggressive with one of their residents (later identified as Resident #1). The Report indicated that CNA #1 had been suspended and had already left the Facility. The Report indicated that the Nursing Supervisor told the Officer that two employees (identified as CNA #2 and CNA #3) had witnessed CNA #1 place his knee on Resident #1's lap/hip area to hold him/her down. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Report indicated that CNA #2 and CNA #3 told the Officer that CNA #1 grabbed Resident #1's right hand, placed it on his/her lap/hip area and then CNA #1 put his left knee on top of Resident #1's lap/hip area while he/she was sitting down. The Report indicated that CNA # 2 and CNA #3 had also said that CNA #1 was yelling at Resident #1 in frustration. The Report indicated that CNA #2 and CNA #3 said Resident #1 became combative while CNA #1 was trying to set Resident #1 up to transfer him/her back to bed, and that they told CNA #1 to leave him/her alone. The Report indicated that the Officer was requesting a show-cause hearing for CNA #1 for a charge of assault and battery on a 60+/disabled person. During a telephone interview on 07/11/24 at 10:28 A.M., which included review of her Written Witness Statement, dated 06/11/24, CNA #2 said Resident #1 was confused and could be combative during care, but said if staff were patient with him/her, Resident #1 could typically be redirected. CNA #2 said if Resident #1 continued to be combative or refuse care, staff should tell the nurse and reapproach him/her later. CNA #2 said that on 06/11/24 at approximately 10:00 P.M., CNA #1 was trying to get Resident #1 to transfer to bed from his/her wheelchair, and Resident #1 said leave me alone. CNA #2 said CNA #1 was angry and yelled at Resident #1. CNA #2 said that Resident #1 was trying to free him/herself from CNA #1 and then CNA #1 grabbed Resident #1's hand, put it on his/her (Resident #1) lap and then CNA #1 put his knee on Resident #1's hand and lap to hold him down. CNA #2 said Resident #1 yelled, get away from me and ouch, you're hurting me! CNA #2 said that even though Resident #1 did not want to go to bed, CNA #1 forced Resident #1 to transfer into bed. CNA #2 said she and CNA #3 told CNA #1 to stop, but he would not. CNA #2 said she immediately went and told the Nursing Supervisor that CNA #1 was brutal and very aggressive, both verbally and physically, with Resident #1. During a telephone interview on 07/09/24 at 1:26 P.M. (which included a review of her Written Witness Statement, dated 06/11/24), CNA #3 said CNA #1 asked her for help with Resident #1, and that CNA #2 also came in to help. CNA #3 said CNA #1 was talking loudly to Resident #1 and she told him to lower his voice, but he refused. CNA #3 said Resident #1 told CNA #1 to get out! and CNA #1 responded to Resident #1 by telling him/her that he (CNA #1) was the captain and he/she (Resident #1) had to go to bed. CNA #3 said that Resident #1 tried to stand, and CNA #1 put his knee on Resident #1's lap to stop him/her. CNA #3 said CNA #1 should have left Resident #1 alone because he/she was being combative and did not want to go to bed. During a telephone interview on 07/11/24 at 12:03 P.M., (which included review of her Written Witness Statement, undated), the Nursing Supervisor said that on 06/11/24 at approximately 10:00 P.M., CNA #2 told her that she (CNA #2) and CNA #3 had been trying to help CNA #1 with Resident #1 and that CNA #1 had been excessively rough with him/her (Resident #1). The Nursing Supervisor said CNA #2 told her that CNA #1 had put his knee on Resident #1's lap and hand (which was on his/her lap) to hold him/her down. The Nursing Supervisor said she also interviewed CNA #3 that night, and said CNA #3 told her that CNA #1 had held Resident #1 down, was talking loudly, and told Resident #1 that he (CNA #1) was the captain. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Nursing Supervisor said she interviewed CNA #1 before she removed him from the Facility, and said he told her that Resident #1 was hitting him (CNA #1), so he put Resident #1's hand on his/her (Resident #1's) lap and then used his (CNA #1) knee to hold Resident #1's arm down. The Nursing Supervisor said she told CNA #1 that what he admitted to was abuse, and said she suspended CNA #1 and called the Police. During a telephone interview on 07/09/24 at 1:42 P.M., (which included a review of his Written Witness Statement, undated), CNA #1 said he was trying to get Resident #1 into bed, but Resident #1 was being combative, so he held both of Resident #1's hands down with his leg when he/she (Resident #1) was sitting in his/her wheelchair. CNA #1 said Resident #1 was yelling at him, hitting and kicking him, and said Resident #1 told him he/she did not want to go to bed. CNA #1 said he held Resident #1's hands and feet so he/she could not move and put Resident #1 to bed even though he/she had refused. During an interview on 07/02/24 at 2:17 P.M., Social Worker (SW) #1 said when she spoke to Resident #1 about the incident on 6/11/24 with CNA #1, that Resident #1 had been unable to answer any questions about the alleged abuse incident because of his/her severe cognitive impairment. SW #1 said Resident #1 is typically only aggressive when staff does not back off when he/she refuses something, and said Resident #1 gets angry when he/she is not heard. Although Resident#1's impaired cognition minimized his/her understanding of the incident, an unimpaired individual would have experienced mental anguish after being treated by a caregiver in this manner. The Surveyor was unable to interview Resident #1 as he/she was on a medical leave of absence at the time of the survey. During an in-person interview on 07/02/24 at 11:34 A.M., and a follow-up telephone interview on 07/11/24 at 1:04 P.M., the Director of Nurses (DON) said that on 06/11/24 during the evening shift, the Nursing Supervisor called her and said she had removed CNA #1 from the building and called the Police because CNA #2 and CNA #3 reported to her that CNA #1 had used his leg to restrain Resident #1. The DON said that if Resident #1 refused care or became combative, then CNA #1 should walked away, let the nurse know, and attempt care again later. The DON said CNA #1 was immediately suspended and then terminated. The DON said the Facility substantiated an allegation of abuse because CNA #1 had restrained Resident #1. During an in-person interview on 07/02/24 at 2:05 P.M., and a follow-up telephone interview on 07/11/24 at 12:41 P.M., the Administrator said the Nursing Supervisor notified her on 06/11/24 that CNA #1 had been rough and inappropriate with Resident #1. The Administrator said she interviewed CNA #1 in person and said that CNA #1 told her that Resident #1 was being aggressive during care, so he (CNA #1) put his/her (Resident #1) hand down and then he (CNA #1) put his leg on top of Resident #1's leg, so he/she would not kick. The Administrator said CNA #2 and CNA #3 told her that CNA #1 was also yelling at Resident #1. The Administrator said that the outcome of the Facility investigation was that CNA #1 restrained Resident #1, that staff are not allowed to restrain residents and that restraining a resident is considered abuse. The Administrator said CNA #1 had been terminated from the Facility.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41107 Based on records reviewed and interviews, for one of one sampled Employee Files, the Facility failed to ensure staff implemented and followed their Abuse Policy when a Criminal Offender Record Inquiry (CORI) was not conducted on Certified Nurse Aide (CNA) #1 prior to his date of employment at the Facility as required, and in accordance with the Facility's Abuse Policy. Findings include: Review of the Facility's Policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, dated as revised April 2021, indicated that as part of resident abuse prevention, the administration will: - develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents, neglect of residents; and/or theft, exploitation or misappropriation of resident property - conduct employee background checks and not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. Review of CNA #1's Employee File indicated his first date of employment at the Facility was 08/11/17. Further review of his Employee File indicated there was no documentation to support that a Criminal Offender Record Information (CORI) check had been conducted prior to his first day of employment, or at any time during his employment at the Facility, until the day after the abuse allegation was made. During an in-person interview on 07/02/24 at 12:33 P.M., and a telephone interview on 07/17/24 at 12:59 P. M., the Director of Human Resources (HR) said the Facility conducted a CORI on all staff prior to hire. The Director of HR said CNA #1 was hired in 2017 and said she could not provide documentation to support that the Facility conducted a CORI on CNA #1 prior to hire. The Director of HR said she conducted a CORI on CNA #1 06/12/24 following the allegation of abuse against him, and said Administration terminated CNA #1 on 06/13/24. During an interview on 07/11/24 at 12:42 P.M., the Administrator said the Facility was unable to provide documentation to support that a CORI had been conducted on CNA #1 prior to 06/13/24 (following the allegation of abuse against him).