

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>41107</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when on 07/31/24, Certified Nurse Aide (CNA) #1 sat next to Resident #1, with her legs outstretched crossed, raised and extended on top of Resident #1's lap, across both armrests of his/her wheelchair, and enticed him/her to play with her legs and hair to keep him/her calm.</p> <p>Findings include:</p> <p>Review of the Facility's Policy, titled Resident Rights, dated as revised February 2021, indicated that Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence and to be treated with respect, kindness, and dignity.</p> <p>Resident #1 was admitted to the Facility in December 2023, diagnoses included Parkinson Disease, dementia, history of falling, schizoaffective disorder, and depression.</p> <p>Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/19/24, indicated Resident #1 had severe cognitive impairment, evidenced by a Brief Interview for Mental Status (BIMS) of 0/15, and he/she required maximal assistance from staff for all mobility.</p> <p>Review of Resident #1's Behavior Care Plan, reviewed and renewed with his/her June 2024 MDS indicated that he/she yells, hits, kicks, uses profanity, and is resistive to staff. The Care Plan indicated that staff should distract him/her with task or activity,</p> <p>Review of a Nurse's Note, dated 07/31/24, indicated Resident #1 had increased restlessness, agitation and that Ativan was given at 9:40 A.M. with little effect. The Note indicated that Resident #1 continually stood up unassisted at times and that he/she was difficult to redirect.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/29/24 at 1:22 P.M., and review of her Written Statement, the Director of Social Services said that on 07/31/24 at approximately 10:30 A.M., she saw CNA #1 sitting with Resident #1 in the hallway and her (CNA #1's) legs were crossed at the ankle and laying across Resident #1's lap. The Director of Social Services said Resident #1 was rubbing and shaking CNA #1's legs from her ankles to her buttocks. The Director of Social Services said she asked CNA #1 why she was sitting like that, and said CNA #1 told her that Resident #1 likes to play with her legs and it keeps him/her (Resident #1) sitting.</p> <p>During a telephone interview on 08/29/24 at 11:54 A.M., and review of her Written Witness Statement, CNA #3 said on 07/31/24, CNA #1 had been trying to distract Resident #1 because he/she had been trying to stand up. CNA #3 said she saw CNA #1 sitting next to Resident #1, who was in his/her wheelchair, and that she saw both of CNA #1's legs stretched straight across Resident #1's lap.</p> <p>During a telephone interview on 08/29/24 at 11:02 A.M., which included review of her Written Witness Statement, dated 07/31/24, CNA #1 said she had a close bond with Resident #1. CNA #1 said that on 07/31/24, she was sitting with Resident #1 and he/she was playing with her hair. CNA #1 said Resident #1 tries to stand on his/her own, and so she was trying to keep him/her busy. CNA #1 said Resident #1 plays with her arms and legs also. CNA #1 said she put her legs across Resident #1 while he/she was seated in his/her wheelchair so he/she could reach her legs. CNA #1 said Resident #1 likes to trace the prints on her scrub top and scrub pants. CNA #1 said that after the Director of Nurses (DON) told her to remove her leg from Resident #1's lap, Resident #1 played with her (CNA #1's) hands instead.</p> <p>During an interview on 08/29/24 at 2:17 P.M., and review of her Written Witness Statement, the Director of Nurses (DON) said that on 07/31/24, the Director of Social Services asked her to come look at something that was happening on Resident #1's unit. The DON said she observed CNA #1 sitting with her legs across Resident #1's wheelchair. The DON said CNA #1's legs were crossed and the back of her right thigh was resting across him/her on his/her lap. The DON said she immediately told CNA #1 to remove her legs. The DON said she told CNA #1 that it looked like she was restraining Resident #1, and that CNA #1 told her (DON) that she was just trying to calm him/her (Resident #1) down. The DON said CNA #1 told her that Resident #1 likes to play with her hair. The DON said if Resident #1 had been rubbing CNA #1's leg that it could be considered as something inappropriate (sexual) and CNA #1 would be in a lot of trouble.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>41107</p> <p>Based on observation, records reviewed, and interviews, for one of three sampled residents (Resident #1) who had severe cognitive impairment, the Facility failed to ensure Resident #1 was free from the use of a physical restraint when Facility staff failed to assess whether or not the use of a concave mattress and bed rails on his/her bed, prevented him/her from getting out of his/her bed.</p> <p>Findings include:</p> <p>Review of the Facility's Policy, titled Use of Restraints, dated as revised April 2017, indicated the following:</p> <p>-physical restraints are defined as any manual method, or physical, or mechanical device, material or equipment attached to adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts access to one's body, and</p> <p>-the definition of a restraint if based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition, and this restricts his/her typical ability change position or place, that device is considered a restraint.</p> <p>Resident #1 was admitted to the Facility in December 2024, diagnoses included Parkinson Disease, dementia, history of falling, schizo affective disorder, and depression.</p> <p>Review of Resident #1's Skin Care Plan, dated as revised 05/29/24, indicated he/she had two quarter side rails in place to assist with mobility and transfers.</p> <p>Review of Resident #1's Medical Record indicated he/she had a Physician's order, dated 05/30/24, for a scoop/perimeter mattress.</p> <p>Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/19/24, indicated Resident #1 had severe cognitive impairment, evidenced by a Brief Interview for Mental Status (BIMS) of 0/15, and he/she required maximal assistance from staff for all mobility.</p> <p>Review of Resident #1's Falls Care Plan, dated as revised 07/15/24, indicated Resident #1 was at risk for falls, and interventions included the use of a scoop/perimeter mattress initiated 08/27/24.</p> <p>Review of Resident #1's ADL Care Plan, dated as revised 08/12/24, indicated interventions included the addition of a concave/perimeter mattress.</p> <p>Review of the Medical Record indicated there was no documentation to support Facility staff had completed a restraint assessment for the bed rails and/or the concave/perimeter mattress to determine if either or both together prevented Resident #1 from getting out of bed on his/her own.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/29/24 at 10:09 A.M., the Surveyor observed Resident #1 lying in bed on a concave/perimeter mattress with both upper bed rails in the upright position.</p> <p>During an interview on 08/29/24 at 1:06 P.M., Nursing Supervisor #1 said Resident #1 likes to get up on his/her own, and said he/she repeatedly stands up unassisted. Nursing Supervisor #1 said Resident #1 has had multiple falls, and the concave/perimeter mattress gave him/her something to try and climb over if he/she tries to get up. Nursing Supervisor #1 said she was unable to find a Restraint Assessment for Resident #1's concave/perimeter mattress, but said one should have been completed to determine whether or not the mattress was a restraint.</p> <p>During an interview on 08/29/24 at 11:05 A.M., Nurse #1 said Resident #1 falls a lot and said he/she is also aggressive and combative.</p> <p>During an interview on 08/29/24 at 12:14 P.M., CNA #2 said Resident #1 stands up frequently and falls. CNA #2 said Resident #1 can be aggressive and when staff try redirect him/her to sit down, he/she gets angry, hits and squeezes us, and yells, fuck you!</p> <p>During a telephone interview on 08/29/24 at 11:54 A.M., CNA #3 said Resident #1 continually tries to stand up unassisted.</p> <p>During a telephone interview on 09/04/24 at 2:10 P.M., CNA #4 said Resident #1 always tries to stand up unassisted, sometimes he/she is calm, and sometimes he/she hits staff when they try to stop him/her from standing.</p> <p>During an interview on 08/29/24 at 2:17 P.M., the Director of Nurses (DON) said Resident #1 had a concave/perimeter mattress to prevent falls, and said it reminded him/her to stay in bed.</p> <p>When asked by the Surveyor if the concave/perimeter mattress and/or bed rails had been assessed to determine whether or not either of the devices restrained Resident #1's ability to get out of bed, the DON said neither was a restraint because he/she can easily get up with them in place.</p> <p>However, The DON said she could not provide documentation to support that a restraint assessment had been completed for Resident #1 related to the use of upper quarter bed rails and/or the concave mattress.</p> <p>During a follow-up telephone interview on 09/11/24 at 12:28 P.M., the DON said the concave mattress was added to Resident #1's care plan on 08/27/24, but said she did not know when the concave mattress was actually added to Resident #1's bed. The DON said she completed the restraint assessment for the concave mattress on 08/27/24. The DON said she could not provide a restraint assessment for Resident #1's bed rails, because it had not been done. The DON said a restraint assessment should have been completed for Resident #1's bed rails, but had not been, and also said she could not provide documentation to support that a restraint assessment had been done for the concave mattress when it was added to Resident #1's bed.</p> <p>The DON was unable to provide a restraint assessment for Resident #1's scoop mattress to the Surveyor during survey, but said she would fax it, more than a week after the date of exit, the Facility had not provided DPH with that assessment</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41107</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who had severe cognitive impairment and had been repeatedly attempting to stand unassisted, the Facility failed to ensure they reported an allegation of abuse by use of a restraint by a staff member, to the Massachusetts Department of Public Health (DPH), when after being notified by the Director of Social Services, the Director of Nurses witnessed Certified Nurse Aide (CNA #1 sitting next to Resident #1 (who was seated in his/her wheelchair) with her legs raised, crossed and extended across his/her lap, with her legs positioned across both of the armrests to Resident #1's wheelchair.</p> <p>Findings include:</p> <p>Review of the Facility's Policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated as revised, September 2022, indicated the following:</p> <ul style="list-style-type: none"> -all reports of resident abuse, including injuries of unknown origin, neglect, exploitation, or theft/misappropriation of resident property, are reported to local, state, and federal agencies, (as required by current regulations), and thoroughly investigated by facility management. Findings of all investigations are documented and reported, -the Administrator or the individual making allegation immediately reports his or her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility, and -within five business days of the incident, the administrator will provide a follow-up investigation report. <p>Review of Reports submitted by the Facility via the Health Care Facility Reporting System (HCFRS), from 07/31/24 through 08/29/24, indicated the Facility had not reported the incident to the DPH, from 07/31/24 in which CNA #1 was witnessed to have her legs crossed and extended across Resident #1, who was sitting in a wheelchair, and by doing so, he/she was unable to stand up at will.</p> <p>Review of CNA #1's Time Card, dated 07/31/24, indicated CNA #1 entered the Facility at 7:42 A.M., and left the Facility at 11:00 A.M.</p> <p>During an interview on 08/29/24 at 1:22 P.M., which included a review of her Written Witness Statement, dated 07/31/24, the Director of Social Services (SS) said that on 07/31/24 at approximately 10:30 A.M., she saw Certified Nurse Aide (CNA) #1 sitting with Resident #1 in the hallway and saw CNA #1's legs crossed at the ankle and laying across Resident #1's lap. The Director of SS said she asked CNA #1 why she was sitting like that said CNA #1 told her, Resident #1 likes to play with her legs, and it keeps him/her (Resident #1) sitting. The Director of SS said that she immediately told the Director of Nurses (DON) who also witnessed CNA #1 sitting with her legs across Resident #1 wheelchair armrests.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/29/24 at 11:02 A.M., which included a review of her Written Witness Statement, dated 07/31/24, CNA #1 said she put her legs across Resident #1 so he/she could reach her legs. CNA #1 said she was trying to keep him/her (Resident #1) busy that morning because he/she stands up frequently.</p> <p>During a telephone interview on 08/29/24 at 11:35 A.M., which included a review of her Written Witness Statement, dated 07/31/24, Nurse #1 said that on 07/31/24 she saw CNA #1 sitting with Resident #1 across from the Nurse's Station, but could not see below chest level since she was sitting and documenting behind the Nurse's Station desk. Nurse #1 said the DON came to the unit and she heard her say to CNA #1, Why are you doing that? That is a restraint!</p> <p>During an interview on 08/29/24 at 11:54 A.M., which included a review of her Written Witness Statement, dated 07/31/24, CNA #3 said the on 07/31/24, she and Nurse #1 were behind the Nurse's Station documenting and said she saw CNA #1 sitting with Resident #1 trying to distract him/her because he/she (Resident #1) kept trying to stand up. CNA #3 said she left the Nurse's Station to go provide care and when she returned to the Nurse's Station area, she saw CNA #1 and the Director of Social Services (SS) talking, and said she saw CNA #1 sitting next to Resident #1 (who was sitting in his/her wheelchair) with both of her legs extended, and fully across Resident #1's lap.</p> <p>During an interview on 08/29/24 at 2:17 P.M., which included a review of her Written Witness Statement, the DON said on 07/31/24, the Director of SS asked her to look at something on Resident #1's unit. The DON said she saw CNA #1 sitting with her legs across Resident #1's lap. The DON said she removed CNA #1 from the unit and told her it looked like she was restraining Resident #1. The DON said CNA #1 told her that Resident #1 likes to play with her hair. The DON said that if Resident #1 had been rubbing her legs that that would have been considered something inappropriate (sexual) and that she (CNA #1) would have been in a lot of trouble. The DON said she sent CNA #1 home. The DON said she did not consider the incident to be an abuse allegation, so they did not report it to DPH.</p> <p>During an in person interview on 08/29/24 at 2:56 P.M, which included a review of her Written Witness Statement, the Administrator said she had not reported the allegation to the DPH because Resident #1 had been in good spirits and because CNA #1's legs were not actually on Resident #1.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>41107</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment and was dependent on staff to meet his/her care needs, the Facility failed to ensure that after being made aware on 07/31/24 of an allegation of a possible restraint, that they obtained and maintained evidence that a thorough investigation was completed.</p> <p>Findings include:</p> <p>Review of the Facility's Policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated as revised, September 2022, indicated the following:</p> <p>-all reports of resident abuse, including injuries of unknown origin, neglect, exploitation, or theft/misappropriation of resident property, are reported to local, state, and federal agencies, (as required by current regulations), and thoroughly investigated by facility management. Findings of all investigations are documented and reported,</p> <p>Resident #1 was admitted to the Facility in December 2024, diagnoses included Parkinson Disease, dementia, history of falling, schizoaffective disorder, and depression.</p> <p>Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/19/24, indicated Resident #1 had severe cognitive impairment, evidenced by a Brief Interview for Mental Status (BIMS) of 0/15, and he/she required maximal assistance from staff for all mobility.</p> <p>Review of the Facility's Investigation File indicated there was no documentation to support that Resident #1 had been interviewed immediately after the incident about what happened. Review of the File indicated there was no documentation to support that other residents on CNA #1's assignment that day had been interviewed to determine if they had concerns about care or treatment provided by CNA #1. Review of the File also indicated that there was no documentation to support that an investigation summary had been completed or an outcome determined.</p> <p>Review of CNA #1's Time Card, dated 07/31/24, indicated CNA #1 entered the Facility at 7:42 A.M., and left the Facility at 11:00 A.M. on 07/31/24.</p> <p>Review of Resident #1's Medical Record indicated that there was no documentation to support that an incident on 7/31/24, had occurred, with no reference to CNA #1 having been found with her outstretched, raised, crossed legs positioned from armrest to armrest, with Resident #1 seated in the wheelchair.</p> <p>During an interview which included a review of her Written Witness Statement, dated 07/31/24, the Director of Social Services (SS) said that on 07/31/24 at approximately 10:30 A.M., she saw CNA #1 sitting with Resident #1 in the hallway and said CNA #1's were legs crossed at the ankle and laying across Resident #1's lap. The Director of SS said she asked CNA #1 why she was sitting like that and said CNA #1 told her Resident #1 likes to play with her legs, and it keeps him/her (Resident #1) sitting. The Director of SS said that she immediately told the Director of Nurses (DON) and that she (DON) also witnessed CNA #1 sitting with her legs across Resident #1.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/29/24 at 11:35 A.M., which included a review of her Written Witness Statement, dated 07/31/24, Nurse #1 said that on 07/31/24 she saw CNA #1 sitting with Resident #1 across from the Nurse's Station, but could not see below chest level since she was sitting and documenting behind the Nurse's Station desk. Nurse #1 said the DON came to the unit and she heard the DON say to CNA #1, Why are you doing that? That is a restraint!</p> <p>During an interview on 08/29/24 at 11:02 A.M., which included a review of her Written Witness Statement, dated 07/31/24, CNA #1 said she put her legs across Resident #1 so he/she could reach her legs. CNA #1 said she was trying to keep him/her (Resident #1) busy that morning because he/she stands up frequently.</p> <p>During an interview on 08/29/24 at 11:54 A.M., which included a review of her Written Witness Statement, dated 07/31/24, CNA #3 said the on 07/31/24, she and Nurse #1 were behind the Nurse's Station documenting and said she saw CNA #1 sitting with Resident #1 trying to distract him/her because he/she (Resident #1) kept trying to stand up. CNA #3 said she saw CNA #1 sitting next to Resident #1 (who was sitting in his/her wheelchair) with both of her legs extended, and fully across Resident #1's lap.</p> <p>During an in person interview on 08/29/24 at 2:17 P.M., which include a review of her Written Witness Statement, the DON said on 07/31/24, the Director of SS asked her to look at something on Resident #1's unit. The DON said she saw CNA #1 sitting with her legs across Resident #1's lap. The DON said she removed CNA #1 from the unit and told her it looked like she was restraining Resident #1. The DON said CNA #1 told her that Resident #1 likes to play with her hair. The DON said that if Resident #1 had been rubbing her legs that that would have been considered as something inappropriate (sexual) and she (CNA #1) would have been in a lot of trouble. The DON said she sent CNA #1 home.</p> <p>The DON said she could only provide a soft investigation file that contained Written Witness Statements, because she and the Administration did not conduct a formal investigation since they did not consider the allegation to be abuse.</p> <p>During an in person interview on 08/29/24 at 2:56 P.M, which include a review of her Written Witness Statement, the Administrator said she had not conducted an investigation since she had not considered the incident an allegation of abuse.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>41107</p> <p>Based on observation, 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 a Bed Rail Entrapment Assessment was completed prior to putting two quarter rails in the upright position while he/she was in bed.</p> <p>Findings include:</p> <p>Review of the Facility's Policy titled Bed Safety and Bed Rails, dated as revised August 2022, indicated the following:</p> <ul style="list-style-type: none"> -the resident's sleeping environment is evaluated by the interdisciplinary team, -bed frames, mattresses, and bed rails are checked for comparability and size prior to use, and -the use of bed rails or side rails (including temporarily raising the sides rails for episodic use during care) is prohibited unless certain criteria for use of the bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. <p>The Policy also indicated that Resident assessment also determines potential risks to the resident associated with the use of bed rails, including accident hazards and restricted mobility.</p> <p>Resident #1 was admitted to the Facility in December 2024, diagnoses included Parkinson Disease, dementia, history of falling, schizoaffective disorder, and depression.</p> <p>Review of Resident #1's Skin Care Plan, dated as revised 05/29/24, indicated he/she required the use of two quarter side rails to assist with mobility and transfers.</p> <p>However, further review of the Medical Record indicated there was no documentation to support Facility staff had completed Bed Rail Assessment for risk of entrapment.</p> <p>Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/19/24, indicated Resident #1 had severe cognitive impairment, evidenced by a Brief Interview for Mental Status (BIMS) of 0/15, and he/she required maximal assistance from staff for all mobility.</p> <p>Review of Resident #1's ADL Care Plan, dated as revised 08/12/24, indicated interventions included the addition of a concave/perimeter mattress.</p> <p>During an observation and interview on 08/29/24 at 3:37 P.M., the Surveyor observed Resident #1's bed system with the Director of Maintenance. The Director of Maintenance said he did not have documentation to support that the bed rails had been tested for safety, after Resident #1's concave mattress was put on his/her bed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Maintenance said the Nursing Department typically notified him if a bed system test needed to be completed, and said the only Bed System Measurement Device Test Results Worksheet he could provide for Resident #1 was from 04/04/24, (which was prior to both the bed rails and concave mattress being put into use).</p> <p>Review of a Bed System Measurement Device Test Results Worksheet, dated 04/04/24, indicated that Resident #1's bed system had been evaluated with the use of his/her previous mattress (which included the model number).</p> <p>There was no documentation to support that after the scoop/concave mattress was added to Resident #1's bed in August 2024, that the use of side rails were re-assessed for risk of entrapment.</p> <p>During a telephone interview on 09/11/24 at 12:28 P.M., the Director of Nurses (DON) said she did not know when the upper quarter bed rails were added to Resident #1's bed. The DON said when Resident #1's siderails were added to the bed they should have been tested with use of his/her previous mattress and then tested again once the concave mattress was added.</p>		