

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 07/29/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who had an indwelling catheter and whose Physician's orders included daily irrigation of the indwelling catheter, the Facility failed to ensure Resident #1 was provided with catheter care including but not limited to catheter irrigation, in accordance with his/her Physician's orders. Findings include: Review of the Facility policy titled Catheter Irrigation, Open System, revised October 2010, indicated the following: The purpose of this procedure is to maintain patency of the catheter. Unless specifically ordered by the Physician, do not apply a clamp to any catheter. Resident #1 was admitted to the Facility in February 2012, diagnoses included but not limited to Multiple Sclerosis (nerve damage that disrupts communication between the brain and the body that can result in numbness, weakness, and trouble walking), Dementia, and neuromuscular dysfunction of the bladder. Review of Resident #1's July 2025 Physician's orders related to indwelling catheter care indicated the following: Acetic Acid Irrigation solution 0.25%-instill 30 milliliters (ml) of acetic acid solution through the catheter and clamp off. Let the solution sit in the bladder for 30 minutes. After 30 minutes, unclamp the foley and flush with 30 ml of sterile water and reattach the BSD (bedside drainage bag), start date 3/14/25. Review of the Medication Administration Record for July 2025 indicated Resident #1 was administered Acetic Acid solution 0.25%, 30 ml catheter irrigation daily, on the day shift. During an interview on 07/29/25 at 2:20 P.M., Nurse #2 said that she worked the day shift, full time, on the [NAME] unit and had regularly performed Resident #1's bladder irrigation treatment. Nurse #2 said that when she performs the catheter irrigation she cleans around the tubing, and using a piston syringe, she inserts 30 ml of Acetic Acid into the catheter then reattaches the catheter tubing to let the liquid drain back into the bag. Nurse #2 said she had not been clamping off the catheter and waiting 30 minutes then unclamping before flushing out the solution, Nurse #2 and the surveyor reviewed the Physician's order and Nurse #2 said she had not performed Resident #1's catheter irrigation as ordered by the Physician. During an interview on 7/29/25 at 2:40 P.M., the Assistant Director of Nurses said Nurse #2 was responsible for following the Physician's order for Resident #1's catheter irrigation and she had not.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who had a gastrostomy tube (G-tube, placed through the abdomen into the stomach, for feedings, liquids and medications) in place to meet his/her nutritional and fluid intake needs, and whose physician's orders included specific administration rates and volumes for formula feeds and water flushes, the Facility failed to ensure that Resident #1 was provided with appropriate treatment and services when Resident #1 was administered formula feeds and flushes at an incorrect rate and volume. Findings include: Review of the Facility policy titled Enteral Feeding-Safety Precautions, date revised November 2018, indicated the following: All personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. The facility will remain current in and follow accepted best practices in enteral nutrition. Preventing errors in administration: Check the following information: rate of administration (ml/hour- [milliliter per hour]). Review of a Facility Grievance/Concern Form dated, 02/21/25, indicated a visitor had observed Resident #1's tube feeding formula and water flushes to be placed in the incorrect enteral pump bags resulting in Resident #1 getting incorrect volumes of formula and water. Review of the Facility Investigation, dated 02/26/25, indicated the Nursing Supervisor had been notified on 02/21/25, by Resident #1's visitor, that Resident #1's formula feeding bag and water flush bag had been reversed resulting in Resident #1 not receiving the prescribed amount of formula and water. Resident #1 was admitted to the Facility in February 2012, diagnoses included but not limited to Multiple Sclerosis (nerve damage that disrupts communication between the brain and the body that can result in numbness, weakness, and trouble walking), Dementia, and Gastrostomy (G-tube, placed through the abdomen into the stomach, for feedings, liquids and medications) status. Review of Resident #1's Care Plan indicated the following: Tube feeding as ordered, date initiated 11/01/23. Flush feeding tube as ordered, date initiated 11/01/23. Review of Resident #1's Physician's orders for the Month of February 2025, related to G tube feed and water flushes indicated his/her orders included the following: Change tube feeding set every 24 hours, every night shift, date initiated 09/22/24. Enteral feed order, Jevity 1.5, per feeding tube, 45 milliliters (ml) per hour continuous, every shift, date initiated 09/23/24. Flush G-tube with 200 cc (cubic centimeter) every four hours, date initiated 09/23/24. During a telephone interview on 07/30/25 at 8:30 A.M., Nurse #1 said that Resident #1's formula and water flush was administered through a feeding pump using a two-bag system. Nurse #1 said that she could not recall the exact Physician's orders for Resident #1 back in February but said that the formula feeding was set at a certain rate of milliliters per hour and the water flush was set to give a certain amount of water every four hours. Nurse #1 said that she had been assigned Resident #1 on 02/21/25 on the night shift and that sometime between 5:00 A.M. and 6:00 A.M., she had removed and replaced the feeding pump tubing, formula and water flush. Nurse #1 said that she became aware of the mistake (that the Jevity formula and water were in the wrong bag) when she was called by the Nursing Supervisor and informed that the tubing and pump had not been set up correctly. During a telephone interview on 7/30/25 at 4:30 P.M., the Nursing Supervisor said that she had worked the evening shift on 02/21/25 when she was approached by Resident #1's visitor and informed that the tube feeding formula was in the water flush bag and water was in the tube feeding bag. The Nursing Supervisor said that switching the bags resulted in Resident #1 not receiving his/her tube feeding and water flushes as ordered by the Physician. During an interview on 7/29/25 at 2:40 P.M., the Assistant Director of Nursing said that Resident #1's formula feeding and water flush system had been set up incorrectly resulting in Resident #1 not being administered his/her tube feeding as prescribed by the Physician.</p>		