

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 09/12/2024
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>48206</p> <p>Based on interview, policy and record review, the facility failed to provide one Resident (#59), out of a total sample of 17 residents, the right to participate in their plan of care.</p> <p>Specifically, the facility failed to inform Resident #59 in advance of a medication treatment and the risks and benefits of the medication when the Resident was prescribed a new anti-psychotic (type of medication used to treat symptoms of psychosis including hallucinations [sights, sounds, smells, tastes, or touches that a person believes to be real but are not real] and delusions [false beliefs]) medication.</p> <p>Findings include:</p> <p>Review of the facility policy titled Psychotropic Medication Use, revised July 2022, indicated:</p> <ul style="list-style-type: none"> -Residents, families, and/or the Representative are involved in the medication management process. -When determining whether to initiate, modify, or discontinue medication therapy, the Interdisciplinary Team (IDT) conducts an evaluation of the resident. The evaluation will attempt to clarify whether the actual and intended benefit of the medication is understood by the resident/representative. -Residents (and/or representative) have the right to decline treatment with psychotropic medications. -The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. <p>Resident #59 was admitted to the facility in August 2023, with diagnoses including Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations).</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 7/10/24, indicated that Resident #59:</p> <ul style="list-style-type: none"> -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total 15. <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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-received an antipsychotic (psychotropic medication primarily used to manage psychosis (including delusions, hallucinations, paranoia or disordered thought) and the antipsychotic medication was administered on a routine basis.</p> <p>During an interview on 9/12/24 at 8:56 A.M., Resident #59 said that when he/she was hospitalized in August 2024 and returned to the facility, no one reviewed his/her medications with him/her. Resident #59 further said he/she was not aware that he/she had taken Olanzapine (antipsychotic) medication or that his/her psychotropic medications were different from before he/she was hospitalized . Resident #59 said the Olanzapine had not been discussed with him/her upon return from the hospital.</p> <p>Review of Resident #59's August 2024 Physician's Orders indicated:</p> <p>-Olanzapine (antipsychotic) 5 mg (milligrams), give 1 tablet by mouth one time a day, initiated 8/6/24, discontinued 8/28/24</p> <p>Review of Resident #59's August 2024 Medication Administration Record (MAR) indicated the Resident received the following medications:</p> <p>-Olanzapine, administered daily from 8/7/24 - 8/28/24 (22 total doses)</p> <p>Review of the medical record failed to provide evidence that the initiation of treatment with Olanzapine medication, and risks and benefits of Olanzapine, were reviewed with Resident #59 prior to the administration of the medication.</p> <p>Further review of the medical record indicated an Informed Consent for Psychotropic Medication for Olanzapine was signed by the Resident on 8/28/24.</p> <p>During an interview on 9/11/24 at 2:31 P.M., the surveyor and the Physician reviewed Resident #59's medical record. The Physician said Resident #59 was readmitted from a recent hospitalization on Olanzapine and Aripiprazole (atypical antipsychotic). The Physician said that she reviews if psychotropic medications are needed to make sure medications are given in the right dose and are effective. The Physician said that she made the decision to discontinue the Olanzapine on 8/28/24 on her own and the recommendation did not come from nursing or psychiatric services. The Physician was unable to provide additional information that treatment with Olanzapine was discussed with Resident #59 prior to administration of the medication.</p> <p>During an interview on 9/12/24 at 10:12 A.M., the surveyor and the Director of Nursing (DON) reviewed Resident #59's medical record. The DON said that after a hospitalization , if a resident had new psychotropic medications, the admitting Nurse would obtain a consent at the time of readmission. The DON said that consents should be obtained before psychotropic medication is provided. The DON said that Resident #59 received the Olanzapine from 8/6/24 - 8/28/24 and consent should have been obtained before administration of the medication and it had not been.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>47901</p> <p>Based on record review and interview, the facility failed to notify the Physician of a significant change in condition for one Resident (#16), out of a total sample of 17 Residents.</p> <p>Specifically, the facility staff failed to notify the Physician/Nurse Practitioner (NP) so treatment could be altered when Resident #16 was identified with significant weight loss by the Registered Dietician.</p> <p>Findings include:</p> <p>Review of the facility policy titled Weight Management, undated, indicated:</p> <ul style="list-style-type: none"> -Newly admitted residents are weighed weekly for four weeks. -Residents are weighed a minimum of monthly by the 7th of each month, with more frequent weights obtained as ordered or deemed necessary. -Check the previous monthly weight(s) for any significant weight change. If there is a significant weight change of plus/minus 5 percent (%) in 30 days (1 month), 7.5% in 90 days (3 months) or 10% in 180 days (6 months), schedule the resident to be reweighed within 24 hours. -Weights are verified and documented in the medical record as they are obtained. -The entire interdisciplinary team (IDT) must be involved in the resident's care needs to manage unplanned weight change. Each member performs tasks consistent with their area of expertise. <p>Review of the facility policy titled Change in a Resident's Condition or Status, revised February 2021, indicated:</p> <ul style="list-style-type: none"> -The facility promptly notified the resident, his or her attending Physician, and the resident representative of changes in the resident's medical/mental condition and or status. -The Nurse will notify the resident's attending Physician when there has been a significant change in the resident's physical/emotional/mental condition. <p>Resident #16 was admitted to the facility in May 2024, with diagnoses including Muscle Wasting and Atrophy (also known as muscle atrophy - the loss of muscle tissue or muscle mass that cause muscles to weaken, shrink or shorten and can lead to a decrease in strength and mobility), Bipolar Disorder (a mental health condition that causes extreme mood swings that include emotional highs [mania or hypomania] and lows [depression]) and Developmental Delay (a delay in reaching language, thinking, social or motor skills milestone).</p> <p>Review of the May 2024 Physician's orders indicated:</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Weight every evening shift every Thursday for 4 weeks, initiated 5/9/24.</p> <p>-Weight every evening shift starting on the 1st and ending on the 1st every month, initiated 5/9/24.</p> <p>Review of the Physician Progress Note, dated 5/15/24, indicated:</p> <p>-Weight 223.8 pounds (lbs.)</p> <p>-Nutrition - continues regular diet with thin liquids, will continue with weekly weights monitoring once every Thursday in the evening for 4 weeks and will be followed by a Dietitian.</p> <p>Review of Resident #16's Weights and Vitals report provided by the facility on 9/10/24 indicated:</p> <p>-5/9/24: 223.8 lbs.</p> <p>-5/30/24: 224 lbs.</p> <p>-7/24/24: 220.3 lbs.</p> <p>-8/13/24: 199 lbs.</p> <p>-8/14/24: 198 lbs.</p> <p>-8/15/24: 198.8 lbs.</p> <p>-9/1/24: 197.4 lbs. (11.8% change indicating significant weight loss in less than 180 days)</p> <p>Review of the Nutritional Risk Evaluation Quarterly Assessment, dated 8/14/24 indicated:</p> <p>-Significant weight loss of 9.9% in less than 30 days and 11.2% weight loss in 90 days.</p> <p>-Weight on admission was 224 lbs, with a follow-up weight on 5/30/24: 224 lbs.</p> <p>-No June weight to assess.</p> <p>-Weight on 8/13/24: 199 lbs. per nursing.</p> <p>-Resident triggered for significant weight loss.</p> <p>Review of the medical record indicated no documented evidence that the Physician or the NP were notified of Resident #16's significant weight loss when identified by the Dietitian on 8/14/24.</p> <p>During an interview on 9/10/24 at 1:54 P.M., the NP said typically the Director of Nursing (DON), or nursing staff communicate any resident weight loss to her. The surveyor and the NP reviewed Resident #16's medical record and the NP said Resident #16's weights had not been communicated to her. The NP further said had the weights been reported to her, she would have reviewed the Resident's clinical record to see if any follow-up would have been warranted.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901</p> <p>Based on observation, interview, record and policy review, the facility failed to ensure the plan of care was assessed and revised for two Residents (#6, #21) and that a care plan meeting was held for one Resident (#59), out of a total sample of 17 residents.</p> <p>Specifically, the facility staff failed to:</p> <ol style="list-style-type: none"> 1. For Resident #6, assess and revise the Resident's Care Plan to include measurable goals for falls prevention after the Resident sustained a fall. 2. For Resident #21, obtain a Physician order and revise the Resident's Care Plan to include the use of mattress bolsters and floor mats after the Resident sustained a fall. 3. For Resident #59, provide evidence that an interdisciplinary care plan meeting was held, or that the Resident had participated in the care planning process following an MDS assessment completed on 4/18/24. <p>Findings include:</p> <p>Review of the facility policy titled Care Planning - Interdisciplinary Team, revised March 2022, indicated:</p> <ul style="list-style-type: none"> -Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). -The IDT includes but is not limited to: <ul style="list-style-type: none"> <Resident's attending physician <Registered Nurse with responsibility for the resident <Nursing assistant with the responsibility for the resident <Member of food and nutrition services staff <the Resident and/or Resident's Representative <Other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. -The resident, the resident's family and or/the residents legal representative .are encouraged to participate in the development of and revisions to the resident's care plan. <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Care plan meetings are scheduled at the best time of day for the resident and the family when possible.</p> <p>1. Resident #6 was admitted to the facility in August 2023, with diagnoses including Encephalopathy (a disease of the brain that can be caused by disease, injury, drugs or chemicals and alters brain function, which can cause confusion), Bipolar Disorder (a mental health condition that causes extreme mood swings that include emotional highs [mania or hypomania] and lows [depression]), Schizoaffective Disorder (a mental health condition that is a combination of schizophrenia and mood disorder symptoms such as depressive episodes, hallucinations (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real) and delusions (false beliefs), and manic episodes), and Muscle Weakness (decreased strength in the muscles).</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 7/3/24, indicated Resident #6 was cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 99 (indicating unable to assess) and had visual hallucinations.</p> <p>Review of Activities of Daily Living (ADL) Care Plan, revised 9/5/23, indicated Resident #6 required assistance with ADL related to impaired mobility and included the following interventions:</p> <ul style="list-style-type: none"> -Provide assist with mobility/positioning as needed when fatigued. -Provide assist with transfers as needed when fatigued. -Allow for periods of rest if resident becomes fatigued. <p>Review of the Incontinence Care Plan, revised 7/17/24, indicated Resident #6 had mixed bladder [sic] incontinence related to impaired mobility and included the following interventions:</p> <ul style="list-style-type: none"> -Ensure the Resident has unobstructed path to the bathroom. -Establish voiding (urinating) patterns. -Observe for/document/report to MD (medical doctor) as needed for possible medical causes of incontinence. <p>Review of the Nursing Progress Note, dated 8/9/24, indicated Resident #6 was found standing between the bathroom door and the room with his/her brief soaked. The Nurse informed the Resident that she was getting a clean brief and while the Nurse was looking in the closet, the Nurse heard a big noise and found the Resident on the floor lying on his/her back. The Nurse indicated the Resident hit his/her head but was able to move his/her legs. The Resident reported a headache, and was transferred to the emergency room for further evaluation.</p> <p>Review of Resident #6's Care Plan did not indicate assessment of what led to the fall on 8/9/24, and any interventions implemented to prevent further falls by the Resident.</p> <p>On 9/11/24 at 2:06 P.M., the Director of Nursing (DON) said all falls are reviewed and assessed by the IDT, and interventions would be implemented to prevent further falls, but this was not completed for Resident #6.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #21 was admitted to the facility in June 2022, with diagnoses including Cognitive Impairment (trouble remembering, learning new things, concentrating or making decisions that affect everyday life), Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Insomnia (sleep disorder with trouble falling and/or staying asleep), and Muscle Weakness.</p> <p>Review of the MDS assessment dated [DATE], indicated Resident #21 was severely cognitive impaired as evidenced by a BIMS score of 3 out of 15.</p> <p>On 9/6/24 at 9:04 A.M., the surveyor observed Resident #21 lying in bed with his/her eyes closed. The surveyor observed that the Resident was lying on a mattress with bolsters (a foam device used to prevent slipping or sliding out of the mattress) and had mats on the floor.</p> <p>Review of Resident #21's medical record including the Resident's Care Plan, did not indicate the use of mattress bolsters and floor mats.</p> <p>On 9/10/24 at 10:18 A.M., the surveyor and Nurse #6 reviewed the Medication Administration Record (MAR) and the Treatment Administration Record (TAR). Nurse #6 said residents with bolsters on the bed and mats on the floor would have Physician's orders and would be assessed every shift. Nurse #6 said Resident #21 did not have orders to the assess the need for and the use of placement of mattress bolsters on the bed and mats on the floor.</p> <p>During an interview on 9/10/24 a at 11:13 A.M., the DON said Resident #21 had utilized the mattress with bolsters and used the mats on the floor long before the DON started working in the facility. The DON said there should have been a Physician's order in place for the use of the bolsters on the mattress and mats on the floor and the Care Plan should have been revised to include the use of the bolsters and mats on the floor.</p> <p>48206</p> <p>3. Resident #59 was admitted to the facility in August 2023, with diagnoses including Depression and Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations).</p> <p>Review of the Resident's clinical record showed evidence that a MDS (Minimum Data Set) Assessment was completed on 4/18/24, and indicated that Resident #59 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15.</p> <p>Review of the Resident's clinical record did not provide evidence of involvement of the Resident and/or their Representative in the care planning process or that a care plan meeting had been held following the MDS Assessment completed on 4/18/24.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/11/24 at 7:50 A.M., the Director of Social Services (DSS) said that care plan meetings will include the Resident and/or their Representative and the IDT consisting of the Director of Social Services, the Activity Director, Rehabilitation services if involved with the Resident, and the MDS Nurse or Assistant Director of Nursing (ADON). If the Resident does not attend, the IDT will still hold the care plan meeting which is typically documented as a care plan meeting note. The DSS said that she was out sick in April when Resident #59's care plan meeting would have been held. The surveyor requested documentation that a care plan meeting was held relative to the 4/18/24 MDS assessment.</p> <p>During a follow-up interview on 9/11/24 at 11:51 A.M., the DSS said that there was no evidence that a care plan meeting was held relative to the 4/18/24 MDS assessment.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>50138</p> <p>Based on record review and interview, the facility failed to provide services that met professional standards of quality for one Resident (#25), out of a total sample of 17 residents.</p> <p>Specifically, the facility staff failed to transcribe (to put into written word or print) a verbal order (a Physician order that is received in person via spoken word or over the telephone) for a medication change into the medical record, resulting in the verbal order not being implemented and Resident #25 not receiving an updated medication as ordered by the Physician.</p> <p>Findings include:</p> <p>Review of facility policy titled Telephone Orders, revised February 2014, indicated:</p> <ul style="list-style-type: none"> -Verbal telephone orders may be accepted from each resident's attending Physician. -Verbal telephone orders may only be received by licensed personnel (Registered Nurse (RN), Licensed Professional Nurse (LPN), Pharmacist, Physician, etc.). -Orders must be reduced to writing (transcribed), by the person receiving the order, and recorded in the resident's medical record. <p>Resident #25 was admitted to the facility in March 2024, with diagnoses including Gastro Esophageal Reflux Disease (GERD - a condition that causes heartburn or acid indigestion) and Irritable Bowel Syndrome (IBS - condition that affects the large intestine and can cause abdominal pain, bloating, and changes in bowel habits).</p> <p>Review of the Consultant Pharmacist Recommendations to Prescriber, dated July 2024, indicated:</p> <ul style="list-style-type: none"> -Resident #25 currently receiving Protonix (Pantoprazole [a medication prescribed to treat GERD]) 40 milligrams (mg) twice daily. -Please consider switch to Prilosec OTC (Prilosec over the counter- a medication prescribed to treat GERD) . please specify Prilosec OTC consider starting dose of 20 mg daily and monitor. <p>The Physician/Prescriber Response on the Consultant Pharmacist Recommendations to Prescriber form indicated:</p> <ul style="list-style-type: none"> -Agreement with the recommendation. -Signed by the Director of Nursing (DON) not the ordering Physician, on 7/30/24. <p>Review of the Physician's Order Summary Report, provided 9/12/24, indicated:</p> <ul style="list-style-type: none"> -Protonix 40 mg, give1 tablet once time a day, initiated 3/31/24, active <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/12/24 at 12:06 P.M., the DON said she received the Pharmacist recommendations for Resident #25 and called the Resident's Physician to obtain a verbal order for a change of Protonix 40 mg by mouth twice daily to Prilosec OTC 20 mg by mouth daily. The DON said she then signed and dated the pharmacy recommendation on 7/30/24. The DON said the new order had been entered into the Resident's electronic medical record.</p> <p>Further review of the active Physician's orders, as of 9/12/24, did not indicate evidence the Physician's verbal order to change Resident #25's medication from Protonix 40 mg by mouth twice daily to Prilosec OTC 20 mg by mouth daily had been transcribed and implemented.</p> <p>During a follow-up interview on 9/12/24 at 12:27 P.M., the DON said she had spoken with Resident #25's Physician on 7/30/24 and received a verbal order to change Protonix 40 mg by mouth twice daily to Prilosec OTC 20 mg by mouth daily. The DON said there was no evidence that the verbal order she obtained had been entered into Resident #25's medical record. The DON further said she had given the verbal order to another Nurse on 7/30/24 to transcribe but was unable to recall which Nurse. The DON said Resident #25 was not getting the correct medication as ordered by the Physician. The DON said all Residents should receive medications as ordered by the Physician to treat his/her medical conditions correctly.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206</p> <p>Based on observation, interview, policy and record review, the facility failed to provide activities to meet the needs of one Resident (#28), out of a total sample of 17 residents.</p> <p>Specifically, the facility failed to provide activities of interest for Resident #28 based on their plan of care, comprehensive assessment, and preferences.</p> <p>Findings include:</p> <p>Review of the facility policy titled Activity Evaluation, revised June 2018, indicated:</p> <ul style="list-style-type: none"> -The activity evaluation is used to develop an individual activities care plan .that will allow the resident to participate in activities of his/her choice and interest. -The activity evaluation and activities care plan identifies if a resident is capable of pursuing activities independently or if supervision and assistance are needed. <p>Resident #28 was admitted to the facility in December 2023 with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment).</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #28 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of zero out of a possible 15.</p> <p>Review of the Activity Assessment, dated 2/26/24, indicated the following preferences for Resident #28:</p> <ul style="list-style-type: none"> -Preference for afternoon participation in activities. -Somewhat important to have books/magazines to read. -Very important to listen to music. -Very important to keep up with the news. -Somewhat important to do things with people. -Very important to do favorite activities. <p>Review of the Activities Note, dated 6/19/24, indicated:</p> <ul style="list-style-type: none"> -Resident #28 is alert and able to make his/her needs known. -He/she had attended parties, television, and pet visits. <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff continue to invite/encourage the Resident to join group programs, offer supplies and 1:1 (individual) visits as tolerated.</p> <p>Review of the Activity Care Plan, last revised 7/17/24, indicated:</p> <p>-Resident #28 is dependent on staff for activities, cognitive stimulation, and social interaction due to physical limitations, cognitive deficits.</p> <p>-Resident #28 had a plastic tool box to use to keep his/her hands busy.</p> <p>-Resident liked fishing, music, sports, to keep up with the news, and to read.</p> <p>-Staff to provide informal 1:1 visits for socialization to include facility happenings, upcoming events, and scheduled programs.</p> <p>During an observation on 9/6/24 at 9:17 A.M., the surveyor observed Resident #28 lying in bed, sleeping after the breakfast meal was completed. The surveyor did not observe any television or radio in the Resident's room.</p> <p>During a telephone interview on 9/6/24 at 1:00 P.M., Resident #28's Representative said the Resident was bored and staff don't know how to keep him/her busy.</p> <p>During an observation on 9/10/24 at 10:07 A.M., the surveyor observed Resident #28 sleeping in bed. The surveyor did not observe any television or radio in the Resident's room.</p> <p>During an observation on 9/10/24 at 12:07 P.M., the surveyor observed Resident #28 seated alone at a table in the South Dining Room. At 12:21 P.M., the staff was observed moving Resident #28 to another table with a resident and their visiting family member. The surveyor did not observe Resident #28 engaging with the other resident or visitor at the table.</p> <p>During an observation on 9/10/24 at 3:59 P.M. the surveyor observed Resident #28 seated alone at an empty table in the South Dining Room in the same location where he/she was observed at 12:21 P.M. The surveyor did not observe any activity or reading materials in front of the Resident, and there were no staff, other Residents, or visitors in the South Dining Room at the time. The surveyor did not observe any music to be playing and the television in the room was off.</p> <p>Review of the September 2024 Recreation Participation Record indicated Resident #28 was greeted by Recreation staff on 9/6/24, 9/7/24, 9/8/24, 9/9/24, and 9/10/24 and was provided with 1:1 cognition game on 9/10/24. Further review of the Recreation Participation Record did not indicate that Resident #28 participated in any additional activities from 9/6/24 through 9/9/24.</p> <p>Review of the CNA (Certified Nurses Assistant) Flow Sheet for September 2024 did not indicate that any individual or group activity was provided to Resident #28 from 9/6/24 - 9/9/24.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/12/24 at 9:04 A.M., CNA #1 said that Resident #28 is not very social but he/she will color or read and that staff will give him/her a fidget board from the Activities department. CNA #1 said staff try to keep Resident #28 occupied and Activities staff will do 1:1 activities with him/her. CNA #1 said she would ask about activity preferences from the nursing or activity staff, and resident participation in any activities would be documented.</p> <p>During an interview on 9/12/24 at 9:15 A.M., the Activities Director (AD) said the Activity Department includes herself and two other staff. The AD said activities staff provide 1:1 visits to residents which are documented on the Recreation Participation forms. The AD said that Resident #28 did better with 1:1 activities, the staff have a toolbox setup for him/her, and that a busy board was available in the South Dining Room. The AD further said Resident #28 mostly preferred chit-chatting, coloring, and distractions with his/her hands. The surveyor and the AD reviewed the September 2024 Recreation Participation Record for Resident #28, and the AD said that there was no documentation of additional activities provided to the Resident on 9/6/24, 9/7/24, or 9/8/24. The AD said that on 9/10/24, a cognitive game was provided to the Resident by an activity staff member, but she was unsure of what the staff did as a cognitive interaction or what time that activity was provided.</p> <p>During a follow-up interview on 9/12/24 at 9:52 A.M., the AD said that she was unable to provide specifics of the cognitive game activity provided on 9/10/24 or if that activity occurred between 12:21 P.M. and 3:59 P.M.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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>42761</p> <p>Based on observation, interview, record and policy review, the facility failed to provide an environment was free of accidental hazards, relative to swallowing safety during one meal for one Resident (#10) out of a total sample of 17 residents.</p> <p>Specifically, facility staff failed to provide Resident #10 with necessary interventions, in accordance with the Resident's plan of care, to ensure the Resident's safety while eating his/her breakfast meal when the Resident had a diagnosis of Dysphagia (difficulty swallowing), required staff assistance for securing his/her dentures in place, and required verbal cues for safety while eating, which increased the Resident's risk for choking.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Assistance with Meals, revised March 2022, indicated the following:</p> <ul style="list-style-type: none"> -Residents should receive assistance with meals in a manner that meets the individual needs of each resident. -Facility staff will serve resident trays and will help residents who require assistance with eating. <p>Resident #10 was admitted to the facility in February 2016 with diagnoses including Parkinson's Disease (progressive degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination) and Dysphagia (difficulty swallowing foods or liquids).</p> <p>Review of Resident #10's Activity of Daily Living (ADL) Care Plan, initiated 12/30/20 and revised 12/6/23, indicated the following:</p> <ul style="list-style-type: none"> -Needs to be continually supervised -may need cues to slow down -and may require assist with meal at meal times <p>Review of Resident #10's Dysphagia Care Plan, initiated 2/3/21 and revised 12/6/23, indicated the following:</p> <ul style="list-style-type: none"> -Continual supervision when eating, provide assistance as needed. -Encourage Resident to chew and swallow each bite. -Encourage small sips/bites and cue as needed. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If coughing occurs, no food/liquids until coughing resolves.</p> <p>Review of Resident #10's active Physician's orders, initiated 8/15/23, indicated the Resident required a puree (food texture that is changed from a solid texture to smooth, with no lumps and pudding-like) diet texture with thin liquids due to signs/symptoms of Dysphagia.</p> <p>Review of Resident #10's Dental Exam Report, dated 11/16/23, indicated the following:</p> <ul style="list-style-type: none"> -Complaint of loose dentures. -Use adhesive to improve retention. -Use denture adhesive as needed. <p>Review of Resident #10's Speech Therapy (ST) Evaluation, dated 7/13/24, indicated the following:</p> <ul style="list-style-type: none"> -The Resident was referred for a ST evaluation due to complaints of increased swallowing difficulty at meals including increased cough. -The Resident's diet was puree solids and thin liquids. -The Resident's oral motor structure (parts of the mouth that work together to help with eating) and function was impaired. -The Resident's cognitive-communicative skills were impaired. -The Resident's lower dentures were loose. <p>Further review of the ST Evaluation indicated the Resident demonstrated clinical signs of Dysphagia with puree texture foods as evidenced by:</p> <ul style="list-style-type: none"> >oral residue (food/liquid remaining in the mouth after swallow), >poor attention to task, >suspected premature (early) spillage into the pharynx (muscular tube that connects one's nose and mouth to the lungs and stomach), >coughing after swallow, >decreased self monitoring, >wet vocal quality prior to and after swallowing. <p>General swallow techniques/precautions were recommended and no changes to the Resident's plan of care were recommended.</p> <p>Review of Resident #10's Minimum Data Set (MDS) Assessment, dated 7/17/24, indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of total possible 15.</p> <p>-The Resident required substantial/maximal assistance (helper does more than half the effort) for oral hygiene.</p> <p>On 9/11/24 between 8:15 A.M. and 8:32 A.M., the surveyor observed the following in the South Unit Dining Room:</p> <p>-Resident #10 sat with a plate of scrambled eggs on the table in front of him/her.</p> <p>-The Assistant Director of Nursing (ADON) was present in the Dining Room.</p> <p>-The Resident put a spoonful of scrambled eggs into his/her mouth, began to chew, then started to cough.</p> <p>-The Resident began to cough repetitively, then stopped coughing and the ADON immediately approached the Resident, using the palm of her hand forcefully on the Resident's back multiple times.</p> <p>-The Resident began to cough repetitively again, for a short time, then intermittently, and continued to eat his/her scrambled eggs.</p> <p>-The surveyor observed staff provide Resident #10 with a cup of apple juice at 8:23 A.M.</p> <p>-The surveyor observed Resident #10 take a bite of eggs, chew, cough, then gag, and take a drink of juice from his/her cup.</p> <p>-The surveyor observed some of the juice exit from the front of the Resident's mouth and run down his/her chin.</p> <p>-Resident #10 then cleared his/her throat and took a heaping spoonful of scrambled eggs.</p> <p>-The surveyor observed Resident #10's bottom dentures protrude over his/her bottom lip and partially out of his/her mouth multiple times while he/she was eating.</p> <p>-The surveyor observed Resident #10 fully load the bowl of his/her spoon with a heaping amount of scrambled eggs and place the eggs into his/her mouth under his/her bottom dentures that were not secured in place.</p> <p>-The Resident began to chew the eggs, with the bottom dentures continuing to move forward out of his/her mouth, and he/she began to gag.</p> <p>-The surveyor observed the Resident repeat placing a heaping spoonful of scrambled eggs under his/her bottom teeth and gag one more time, and the ADON instructed Certified Nurses Aide (CNA) #1 to remove the Resident's dentures at 8:27 A.M.</p> <p>-The surveyor observed CNA #1 remove Resident #10's dentures as instructed, and the Resident completed eating his/her meal.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-At no time during the observation, through the time the Resident's dentures were removed, did the surveyor observe that the Resident's dentures were secured in his/her mouth.</p> <p>-At no time during the observation, did the surveyor observe staff encourage the Resident to chew and swallow each bite, encourage small bites of food, or ensure the Resident did not continue to eat until coughing was resolved.</p> <p>During an interview on 9/11/24 at 9:00 A.M., CNA #1 said that Resident #10 was always assisted out of bed and with personal care on the night (11:00 P.M. through 7:00 A.M.) shift, so she was not sure what assistance was provided for Resident #10's oral care in the morning. CNA #1 said that Resident #10's teeth (dentures) were consistently loose and she thought the Resident would benefit from the use of denture adhesive. CNA #1 said she was not sure if the Resident had any denture adhesive, but if he/she did, the denture adhesive would most likely be in the Resident's top night stand drawer.</p> <p>At that time, the surveyor, CNA #1 and Resident #10 entered the Resident's room. Resident #10 said he/she had denture adhesive in the top night stand drawer. CNA #1 opened the night stand drawer and the surveyor observed a tube of denture adhesive cream in the drawer. The Resident removed the denture adhesive cream and said that when the denture adhesive cream was put on his/her dentures, the dentures would stick forever. Resident #10 said he/she had adhesive cream on his/her dentures the previous day, but he/she did not think anybody put any adhesive cream on his/her dentures that morning. CNA #1 offered to apply the denture adhesive cream to the Resident's dentures, the Resident accepted, then said he/she would apply the adhesive cream themselves. The surveyor observed the Resident make several attempts to put the adhesive cream on his/her dentures, but the Resident was unable to squeeze the tube with enough force to expel any adhesive cream. CNA #1 then assisted Resident #10 with applying the adhesive cream to the Resident's dentures.</p> <p>During an interview on 9/11/24 at 9:38 A.M., the Speech Language Pathologist (SLP) said that he evaluated Resident #10 within the last month or two due to the Resident having increased coughing episodes when he/she ate. The SLP said that Resident #10 had difficulty swallowing, difficulty managing his/her own secretions at times, and experienced coughing episodes when eating. The SLP said that no changes were recommended to Resident #10's diet when he evaluated the Resident as the Resident was already on a puree diet. The SLP said that for safety, the Resident required continual supervision while eating. The SLP said staff should provide the interventions indicated in the Resident's care plan for encouraging small bites, chewing and swallowing each bite, and ensuring that the Resident's dentures were secured in place.</p> <p>During an interview on 9/11/24 at 11:00 A.M., the ADON said she supervised Resident #10 at the breakfast meal that same morning. The ADON said she recognized that the Resident was having difficulty managing his/her breakfast meal, that the Resident was coughing while eating and that she had provided assistance using her hand on the Resident's back when the Resident was coughing during the meal. The ADON said she knew the Resident was not choking and had positive air exchange, but was having difficulty. The ADON said she did not know that the Resident's care plan indicated required interventions for encouraging small bites and encouraging the Resident to chew and swallow each bite. The ADON further said once she recognized the Resident's bottom dentures were not secured in place, she instructed CNA #1 to remove them from the Resident's mouth. The ADON said there was no way the Resident had been provided with adhesive cream for his/her dentures that morning with the way the Resident's bottom dentures were moving around his/her mouth.</p>		

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<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>47901</p> <p>Based on interview, record and policy review, the facility failed to provide appropriate care and services for a nephrostomy tube (a thin flexible tube that drains urine from the kidney into a bag outside the body) according to professional standards of practice for one Resident (#372), out of a total sample of 17 residents.</p> <p>Specifically, the facility staff failed to flush Resident #372's nephrostomy tubes as ordered by the Physician to prevent blockage and increased risk of infection.</p> <p>Findings include:</p> <p>Review of the facility policy titled Nephrostomy Tube Care, revised October 2010, indicated:</p> <ul style="list-style-type: none"> -The purpose of this procedure is to provide guidelines for the care of the resident with a percutaneous (through the skin) nephrostomy tube. -Verify that there is a Physician's Order. -Review the resident's care plan to assess for any special needs of the resident. <p>Review of the facility policy titled Catheter Care, Urinary, revised 9/2014 indicated: to maintain an unobstructed urine flow.</p> <p>Review of the Management of Patients with Nephrostomy Tubes: Nursing toolkit, revised November 2022, (retrieved from: https://aci.health.nsw.gov.au/__data/assets/pdf_file/0011/807095/ACI-Management-patients-nephrostomy-tubes-nursing-toolkit.pdf) indicated:</p> <ul style="list-style-type: none"> -A Medical Officer must order flushing (frequency and amount of fluid to be instilled) or removal of a nephrostomy tube. -A Medical Officer or a Registered Nurse experienced in the procedure must perform flushing of the nephrostomy tube. -A Medical Officer prescribes flushing of the nephrostomy tube with 2 -10 milliliters (ml) of sterile normal saline as a single procedure. Following a medical officer's review, the frequency of flushing will be adjusted according to treatment needs and outcome. -The flushing of the nephrostomy tube is done using a 10 ml syringe. It should be a gentle, slow flush. It is not necessary to draw back or retrieve the small amount of normal saline that may remain, as this will drain out naturally. <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #372 was admitted to the facility in September 2024, with diagnoses including Malignant Neoplasm of the Bladder (cancer of the bladder), Muscle Weakness (decreased strength in the muscles), Intestinal Obstruction (a gastrointestinal condition in which digested material is prevented from passing normally through the bowels), and palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness).</p> <p>Review of Resident# 372's Discharge Summary information (Patient Care Referral Facility and Home Care Page 2) indicated:</p> <p>-Bilateral Nephrostomy tubes draining clear yellow urine, every 8-hour flushes.</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 9/12/24, indicated Resident #372 was cognitively intact as indicated by a Brief Interview of Mental Status (BIMS) score of 14 out of total possible 15.</p> <p>During an interview on 9/6/24 at 10:45 A.M., Resident #372 said his/her only concern was the need to have his/or nephrostomy tubes flushed twice a day as he/she did at home, which was not occurring at the facility.</p> <p>Review of the September 2024 Physician's orders indicated:</p> <p>-9/7/24: Flush nephrostomies daily with 10 ml (milliliters) of normal saline every day shift.</p> <p>During an observation and interview on 9/10/24 at 10:11 A.M., Resident #372 said that he/she had repeatedly asked the facility staff to flush his/her nephrostomy tubes, and the facility staff informed him/her that there was no Physician's order to do this. The Resident further said that he/she was afraid of a potential obstruction and had requested the facility staff to provide him/her with supplies so that he/she could flush the nephrostomy tubes as he/she had been doing twice daily when previously at home.</p> <p>On 9/10/24 at 10:46 A.M., the surveyor and Nurse #6 reviewed the Medication Administration Record (MAR) and the Treatment Administration Record (TAR). Nurse #6 said there were no orders in the Administration Records to flush Resident #372's nephrostomy tubes.</p> <p>On 9/10/24 at 10:58 A.M., the Director of Nursing (DON) said the facility reviews resident orders with the Physician when the residents are admitted to the facility. The DON said she reviewed the discharge paperwork for Resident #372 on 9/7/24, after he/she had been admitted to the facility, and noted the order to flush the nephrostomy tubes had not been entered into the Electronic Medical Record (EMR). The DON said she entered the orders incorrectly and there were no orders on the Administration Records (MAR or TAR) to flush the Resident's nephrostomy tubes.</p> <p>Please Refer To F726</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>42761</p> <p>Based on interview, record review, and review of the Facility Assessment Tool, the facility failed to ensure that Licensed Nurses (#6, #1, #5, and #4) had the specific competencies and skill sets to care for the needs of one Resident (#372) relative to nephrostomy tube (a thin flexible tube that is surgically inserted through the skin, into the kidney and drains urine into a bag outside the body) care.</p> <p>Specifically, facility staff failed to ensure Licensed Nurses were assessed for competency to care for nephrostomy tubes when:</p> <ul style="list-style-type: none"> -Resident #372 was admitted to the facility with bilateral (right and left side) nephrostomy tubes. -The Facility Assessment indicated staff at the facility could provide care for residents with diseases of the genitourinary (genital and urinary organs or functions) system and that special treatments provided included ostomy (surgically created opening between an internal organ and the body's surface) care. <p>Findings include:</p> <p>Review of the Facility Assessment, dated 8/7/24, indicated the following:</p> <ul style="list-style-type: none"> -Diseases and conditions typical for a resident in the facility included diseases of the genitourinary system. -Special treatments provided by facility staff included treatment for ostomy care. -The number/average number of residents who required ostomy care was zero to five. - . education was completed monthly and as needed, based on regulatory requirements and facility identified needs . <p>Review of Nurse #6's Competency Evaluation dated 5/6/24, indicated Nurse #6 had been assessed for competency in the following areas:</p> <ul style="list-style-type: none"> -Medication -Admission Assessment -Cracking (technique used to remove the protective tape and slowly open the cylinder valve to the tank, blowing excess dust away from the opening) Oxygen Tank -Sterile (free from living germs or microorganisms) Wound Care -Tube Feeding (device used to send nutrition from a bag directly into one's body) <p>(continued on next page)</p>		

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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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Foley Catheter (device that drains urine from one's bladder into a collection bag outside the body) Care/Change</p> <p>-PEG (percutaneous endoscopic gastrostomy: a surgery to place a feeding tube which allows one to receive nutrition through the stomach)</p> <p>-Colostomy (surgical opening in one's abdomen that enters the colon and allows stool to exit the body)</p> <p>-IV (intravenous: administration of fluids or medication into a vein)</p> <p>Further review of Nurse #6's Competency Evaluation included no evidence that Nurse #6 had been assessed for competency to provide care for nephrostomy tubes.</p> <p>Review of Nurse #1's Competency Evaluation dated 6/10/24, indicated Nurse #1 had been assessed for competency in the following areas:</p> <ul style="list-style-type: none"> -Medication -Admission Assessment -Cracking Oxygen Tank -Sterile Wound Care -Tube Feeding -Foley Catheter Care/Change -PEG -Colostomy -IV <p>Further review of Nurse #1's Competency Evaluation included no evidence that Nurse #1 had been assessed for competency to provide care for nephrostomy tubes.</p> <p>Review of Nurse #5's Competency Evaluation dated 7/22/24, indicated Nurse #5's competency was assessed for the following areas:</p> <ul style="list-style-type: none"> -Medication -Admission Assessment -Cracking Oxygen Tank -Sterile Wound Care <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Tube Feeding</p> <p>-Foley Catheter Care/Change</p> <p>-PEG</p> <p>-Colostomy</p> <p>-IV</p> <p>Further review of Nurse #5's Competency Evaluation included no evidence that Nurse #5 had been assessed for competency to provide care for nephrostomy tubes.</p> <p>Review of Nurse #4's Competency Evaluation dated 8/19/24, indicated Nurse #4 had completed a self-assessment for competency in the following areas:</p> <ul style="list-style-type: none"> - Medication - Admission Agreement - Cracking Oxygen Tank - Sterile Wound Care - Tube Feeding - Foley Catheter Care/Change - PEG - Colostomy - IV <p>Further review of Nurse #4's Competency Evaluation included no evidence that Nurse #4 was assessed for competency by the Staff Development Coordinator (SDC) to provide care in the above self-assessed areas and that Nurse #4 was also assessed for competency to provide care for nephrostomy tubes.</p> <p>Resident #372 was admitted to the facility in September 2024, with a diagnosis of Malignant (condition that is dangerous to one's health) Neoplasm (abnormal growth of tissue that can be cancerous or non-cancerous) of the Bladder.</p> <p>Review of the Patient Care Referral provided to the facility from the hospital dated 9/5/24, indicated that Resident was being transferred to the facility with bilateral nephrostomy tubes in place.</p> <p>Review of Resident #372's Nursing Note dated 9/5/24, indicated the Resident was admitted to the facility with bilateral nephrostomy tubes.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Daily Nursing Attendance Records indicated the following:</p> <ul style="list-style-type: none"> -Nurse #3 and Nurse #4 were assigned to care for Resident #372 on 9/5/24. -Nurse #1 and Nurse #5 were assigned to care for Resident #372 on 9/6/24. -Nurse #1 and Nurse #6 were assigned to care for Resident #372 on 9/7/24. <p>During an interview on 9/11/24 at 11:45 A.M., the Assistant Director of Nursing (ADON) said that she also worked as the Staff Development Coordinator (SDC) at the facility. The ADON said she was on vacation when Resident #372 was admitted to the facility, but if she had been there, she would have started education with licensed staff right away relative to the care of nephrostomy tubes to ensure the Licensed Nurses were able to provide the necessary care for Resident #372. The ADON further said the Licensed Nurse competency evaluations did not include nephrostomy tube care.</p> <p>During an interview on 9/12/24 at 8:15 A.M. the Director of Nursing (DON) said that the special treatments indicated as ostomies in the Facility Assessment included nephrostomy tubes. At the time, the surveyor and the DON reviewed the competency evaluations completed for Nurse #1, Nurse #3, Nurse #4, Nurse #5, and Nurse #6. The DON said the competency evaluations did not include assessment of Licensed Nurse competencies relative to nephrostomy tubes. The DON said competency assessment for nephrostomy tubes needed to be added to the Licensed Nurses' competency evaluations. The DON also said she began to provide education relative to providing care for Resident #372's nephrostomy tubes to the Licensed Nurses on 9/7/24 (after the Resident's admission to the facility). The DON said she had not kept record of which staff had been educated.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>42761</p> <p>Based on record reviewed and interview, the facility failed to ensure that the Director of Nursing (DON) did not serve as the Charge Nurse when the facility had an average daily occupancy of greater than 60 residents.</p> <p>Specifically, the facility failed to ensure the DON did not serve as Charge Nurse, providing direct resident care, when the facility's daily occupancy was greater than 60 residents:</p> <ul style="list-style-type: none"> -on four dates during the Quarter Three (April 1, 2024 through June 30, 2024) Payroll Based Journal (PBJ) Staffing Data Report period where the facility reported excessively low weekend staffing. -on three dates over the four week time frame prior to the survey start date of 9/6/24. <p>Findings include:</p> <p>Review of the facility's Quarter Three PBJ Staffing Data Report indicated the facility reported excessively low weekend staffing.</p> <p>Review of the facility's Daily Nursing Attendance Reports for the Quarter Three reporting period indicated the DON served as Charge Nurse on the following four dates:</p> <ul style="list-style-type: none"> -5/15/24 (Wednesday) on the Back Unit, on the Night (11:00 P.M. through 7:00 A.M.) Shift. -5/18/24 (Saturday) on the Back Unit, on the Night Shift. -5/19/24 (Sunday) on the Back Unit, on the Day (7:00 A.M. through 3:00 P.M.) Shift. -6/16/24 (Sunday) on the Back Unit, on the Evening (3:00 P.M. through 11:00 P.M.) Shift. <p>Review of the DON's Missed Punch Form, dated 5/15/24, indicated the DON worked from 11:00 P.M. through 7:30 A.M. on Wednesday 5/15/24.</p> <p>Review of the DON's Time Card, date range 5/12/24 through 5/25/24, indicated the DON worked:</p> <ul style="list-style-type: none"> -from 12:45 P.M. through 7:00 A.M. on 5/18/24 (Saturday). -from 7:00 A.M. through 3:00 P.M. on 5/19/24 (Sunday). <p>Review of the DON's Missed Time Punch Form, dated 6/16/24, indicated the DON worked from 3:00 P.M. through 11:30 P.M. on Sunday 6/16/24.</p> <p>Review of the facility's Daily Census Reports indicated the facility's in-house resident occupancy was:</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-67 on 5/15/24.</p> <p>-68 on 5/18/24 and 5/19/24.</p> <p>-63 on 6/16/24.</p> <p>Review of the facility's Daily Nursing Attendance Reports for 8/11/24 through 9/10/24 indicated the DON was scheduled to work as Charge Nurse on the following dates:</p> <p>-8/24/24 (Saturday) on the Back Unit, on the Day Shift.</p> <p>-8/27/24 (Tuesday) on the Back Unit, on the Night Shift.</p> <p>-9/3/24 (Tuesday) on the Front Unit, on the Day Shift.</p> <p>Further review of the Daily Nursing Attendance Report indicated the DON was also scheduled to work in the DON role on Tuesday, 9/3/24 from 7:00 A.M. through 3:00 P.M.</p> <p>Review of the DON's Time Card, date range 8/18/24 through 8/31/24 indicated the DON worked:</p> <p>-from 9:26 A.M. through 1:55 P.M. on 8/24/24 (Saturday)</p> <p>-from 12:50 A.M. through 7:00 A.M. on 8/27/24 (Tuesday)</p> <p>Review of the DON's Time Card for 9/1/24 through 9/12/24 indicated the DON worked as Charge Nurse:</p> <p>-from 7:00 A.M. through 3:00 P.M. on 9/3/24 (Tuesday).</p> <p>Review of the facility's Daily Census Reports indicated the facility's in-house resident occupancy was:</p> <p>-69 on 8/24/24.</p> <p>-67 on 8/27/24.</p> <p>-69 on 9/3/24.</p> <p>During an interview on 9/11/24 at 4:37 P.M., the DON said that staff at the facility would call her to come in and work on a Unit when a scheduled Nurse did not show up or called out of work and a replacement could not be found. The DON further said working as Charge Nurse interfered with her ability to perform her responsibilities as DON.</p> <p>During a follow-up interview on 9/12/24 at 8:15 A.M., the DON said she has had to work on the Units as Charge Nurse several times since she was hired in May 2024. The DON further said she worked as the Charge Nurse the same dates that were reflected on the facility's Daily Nursing Attendance Reports: 5/15/24, 5/18/24, 5/19/24, 6/16/24, 8/24/24, 8/27/24, and 9/3/24.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206</p> <p>Based on interview, policy and record review, the facility failed to provide appropriate treatment and services to attain the highest practicable mental and psychosocial well-being for one Resident (#59), out of a total sample of 19 residents.</p> <p>Specifically, the facility failed:</p> <ul style="list-style-type: none"> -to develop an individualized care plan to address the emotional and psychosocial needs of Resident #59, -to monitor and provide ongoing assessment as to whether the care approaches were meeting the emotional and psychosocial needs of the Resident after he/she experienced Suicidal Ideation (SI- verbal expressions of thoughts of harming oneself that may or may not lack specific intent), and -to review and revise the Resident's care plan after expression of SI, hospitalization , and re-admission to the facility. <p>Findings include:</p> <p>Review of the facility policy titled Behavioral Assessment, Intervention, and Monitoring, revised March 2019, indicated:</p> <ul style="list-style-type: none"> -Nursing staff will identify, document, and inform the Physician about specific details regarding changes in an individual's mental status including: <ul style="list-style-type: none"> <onset, duration, intensity, and frequency of behavioral symptoms; <any recent precipitating or relevant factors of environment triggers (e.g. medication changes, infection, recent transfer from the hospital); and <appearance and alertness of the resident and related observations -New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others -The care plan will incorporate findings from the comprehensive assessment .and be consistent with current standards of practice -Interventions and approaches will be based on a detailed assessment of physical, psychological, and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><A description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment and precipitating factors or situation</p> <p><Targeted and individualized interventions for the behavioral and psychosocial symptoms, the rational for the interventions and approaches, specific and measurable goals for targeted behaviors, and how the staff will monitor for effectiveness of the interventions.</p> <p>-If the resident is being treated for altered behavior or mood, the interdisciplinary team (IDT) will seek and document any improvements or worsening in the individual's behavior, mood, and function.</p> <p>Resident #59 was admitted to the facility in August 2023, with diagnoses including Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations), and Alcohol Abuse.</p> <p>Review of the Nursing Progress Note, dated 6/7/24, indicated:</p> <ul style="list-style-type: none"> -Resident was crying uncontrollably -Resident was unable to be redirected -Resident stated I want to kill myself. If I had the means I would have done it already. -Resident requested to go to the hospital -Resident was transferred to the emergency room <p>Review of the Hospital Emergency Department (ED) Provider Note dated 6/7/24, indicated Resident #59:</p> <ul style="list-style-type: none"> -Had a history of Anxiety -Had two prior suicide attempts last year -Anxiety had been worsening -Increased Depression that morning -Stated if he/she had a means to kill him/herself, he/she would have done it <p>Review of the Nurse Practitioner (NP) Note dated 6/11/24 indicated:</p> <ul style="list-style-type: none"> -Resident was sent to the ED for SI on 6/7/24 and returned the next day -Resident stated he/she became suicidal as a result of domestic and family problems <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident said he/she felt this way before</p> <p>-Resident reported breakthrough Anxiety</p> <p>-Resident stated that he/she might start talk sessions with psych [sic]</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #59:</p> <p>-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total 15.</p> <p>-reported symptoms of Depression including loss of interest, Depression, and fatigue in the past several days prior to the assessment.</p> <p>Review of the Plan of Care initiated 8/9/23, indicated Resident #59 had diagnoses of Anxiety and Depression and the goal was that the Resident will have improved mood state: happier, calmer, no [signs or symptoms] of Depression, Anxiety, or sadness through the review date.</p> <p>Review of the care plan interventions indicated:</p> <p>-Behavioral Health Consults as needed (psycho-geriatric team, Psychiatrist etc), initiated 8/9/23</p> <p>-Resident needs time to talk, encourage Resident to express feelings, initiated 8/9/23</p> <p>Further review of the Plan of Care failed to indicate person-centered or targeted individualized interventions to attain the highest practicable mental and social well-being for Resident #59 or that the care plan interventions were revised after 8/9/23.</p> <p>During an interview on 9/12/24 at 8:56 A.M., the Resident said that he/she had been having negative thoughts about him/herself in June and was transferred to the Emergency Department. Resident #59 said that when he/she returned from the hospitalization , he/she did not recall meeting with the facility Social Worker (SW). The Resident further said that he/she was supposed to get weekly therapy visits but the visits only started recently.</p> <p>Review of the Psychiatric Evaluation and Consultation, dated 6/10/24, indicated:</p> <p>-Requested evaluation by nursing upon return from hospitalization related to making SI statements.</p> <p>-Plan to coordinate with staff to monitor changes.</p> <p>-Interventions: validation, active listening, emotional support, and psycho-education when confronting current stressors.</p> <p>-Patient will avoid trigger situations, practice grounding skills daily, and focus on things that he/she can change.</p> <p>-Patient will find a day structure and reach out to the nursing staff if he/she has concerns.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Continue psychotherapy to provide patient with emotional support.</p> <p>Review of the Psychological Services Progress Note, dated 6/13/24, indicated:</p> <p>-Met with Resident .to assess for worsening Depression and Anxiety symptoms</p> <p>-[Resident] was hospitalized after reporting SI ideation</p> <p>-Interventions included: active listening, empathy, safety planning</p> <p>-[Resident] asked Therapist to come back again</p> <p>-Plan: Therapist will follow up with [Resident] next week for mood rating and emotional support</p> <p>Review of the Psychosocial Services Progress note, dated 7/4/24, indicated:</p> <p>-Resident had not met for therapy since 6/13/24</p> <p>-Resident agreed to meet again for emotional support next week</p> <p>Review of the Medical Record failed to indicate that any supportive visits or assessments were made by the facility's Social Services team following the Resident's hospitalization for SI or that the evaluations and recommended interventions by Psychological Support Services from visits conducted on 6/10/24, 6/13/24, and 7/4/24 had been reviewed.</p> <p>During an interview on 9/11/24 at 2:13 P.M., the Director of Social Services (DSS) said that she was notified about Resident #59's SI statements and hospital transfer on 6/10/24. The DSS said that she recalled meeting with the Resident on 6/10/24. The DSS said they discussed the Resident's trigger for SI on 6/7/24 related to family issues and the DSS has since provided additional supportive visits to Resident #59. The DSS said that her supportive visits should have been documented and had not been. The surveyor and the DSS reviewed Resident #59's Plan of Care relative to Depression and Anxiety. The DSS said that she reviews care plans as needed and quarterly, and that Resident #59's mood care plan was not revised after 6/7/24, and should have been.</p> <p>During an interview on 9/12/24 at 10:12 A.M., the Director of Nursing (DON) said that Resident #59's care plan should have been reviewed and revised when he/she returned from the hospital after expression of SI and the care plan had not been revised.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901</p> <p>Based on policy and record review, and interview, the facility failed to review and address the Pharmacist Medication Review recommendations for two Residents (#6 and #56), out of a total sample of 17 residents.</p> <p>Specifically, the facility failed to:</p> <ol style="list-style-type: none"> 1. For Resident #6, verify and/or confirm that the Pharmacist recommendations were reviewed or addressed. 2. For Resident #56, verify and/or confirm that the Pharmacist recommendations were reviewed or addressed. <p>Findings include:</p> <p>Review of the facility's policy, titled Documentation and Communication of Consultant Pharmacist Recommendations, undated, indicated:</p> <ul style="list-style-type: none"> -A record of the Consultant Pharmacist's observations and recommendations is made available in an easily retrievable form to Nurses, Physicians, and the care planning team. -Comments and recommendations concerning drug therapy are communicated in a timely fashion. -The Consultant Pharmacist and the facility follows up on his/her recommendations to verify action has been taken. <p>1. Resident #6 was admitted to the facility in August 2023, with diagnoses of Encephalopathy (a brain disease that alters brain function, which can cause confusion), Bipolar Disorder (episodes of mood swings ranging from depressive lows to manic highs), Schizoaffective Disorder (a mental health condition that is a combination of Schizophrenia and mood disorder symptoms such as depressive episodes, hallucinations (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real) and delusions (false beliefs), and manic episodes), and Muscle Weakness (decreased strength in the muscles).</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 7/3/24, indicated Resident #6 was cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 99 (indicating unable to access), and had visual hallucinations.</p> <p>Review of Resident #6's Pharmacy Progress Notes, indicated:</p> <ul style="list-style-type: none"> -10/3/23: Recommendations made, review Clinical Pharmacy Report -12/6/23: Recommendations made, review Clinical Pharmacy Report <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the clinical record did not indicate the specific pharmacy recommendations for the listed dates of 10/3/23 and 12/6/23.</p> <p>During an interview on 9/11/24 at 1:34 P.M., the Director of Nursing (DON) said that they were unable to find the pharmacy recommendations during the time of October 2023 and December 2023. The DON said that she would have to contact the pharmacy to have the recommendations faxed over, since it was not located in the Resident's record, and have the Physician address the recommendation.</p> <p>The facility was unable to provide evidence of the pharmacy recommendations being reviewed at the time of survey exit.</p> <p>48206</p> <p>2. Resident #59 was admitted to the facility August 2023, with diagnoses including Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Anxiety (intense, excessive, and persistent worry and fear about everyday situations).</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #59 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total 15. The MDS Assessment further indicated Resident #59 received Antipsychotic (Antipsychotic-psychotropic medication primarily used to manage psychosis (including delusions, hallucinations, paranoia or disordered thought), Antianxiety (psychotropic medication used to manage anxiety), Antidepressant (psychotropic medication used to manage Depression), Hypnotic (psychotropic medication used to induce sleep), and Opioid (class of drugs to treat pain that derive from, or mimic, natural substances found in the opium poppy plant) medications.</p> <p>Review of Resident #59's Pharmacy Review Notes indicated:</p> <p>-9/13/23: Recommendations made, review Clinical Pharmacy Report</p> <p>-10/3/23: Recommendations made, review Clinical Pharmacy Report</p> <p>-11/3/23: Recommendations made, review Clinical Pharmacy Report</p> <p>-4/2/24: Recommendations made, review Clinical Pharmacy Report</p> <p>-5/6/24: Recommendations made, review Clinical Pharmacy Report</p> <p>Review of the clinical record did not indicate the specific pharmacy recommendations for the listed dates of 9/13/23, 10/3/23, 11/3/24, 4/2/24, and 5/6/24.</p> <p>During an interview on 9/11/24 at 3:45 P.M., the Director of Nursing (DON) said that she was unable to provide evidence of the Pharmacy reviews on 9/13/23, 10/3/23, 11/3/24, 4/2/24 and 5/6/24.</p> <p>The facility was unable to provide evidence of the pharmacy recommendations being reviewed at the time of survey exit.</p>		

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NAME OF PROVIDER OR SUPPLIER Keystone Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Keystone Drive Leominster, MA 01453	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206</p> <p>Based on interview, policy and record review, the facility failed to ensure that one Resident (#59), out of a total sample of 17 residents, was free from the risks of side effects resulting from the unnecessary use of psychotropic medications.</p> <p>Specifically, the facility failed to ensure that appropriate monitoring for adverse consequences and side effects via an Abnormal Involuntary Movement Scale (AIMS) assessment (a clinical outcome checklist completed by a healthcare Provider to assess the presence and severity of adverse outcomes, such as abnormal movements of the face, limbs, and body) was completed timely in accordance with standards of practice.</p> <p>Findings include:</p> <p>Review of the facility policy titled Psychotropic Medication Use, revised July 2022, indicated:</p> <p>-Psychotropic medication management includes:</p> <p><adequate monitoring for efficacy and adverse consequences; and</p> <p><preventing, identifying, and responding to adverse consequences.</p> <p>-Residents receiving psychotropic medications are monitored for adverse consequences .</p> <p>Review of the National Library of Medicine (NLM), dated 5/15/23</p> <p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10292174/ indicated but was not limited to:</p> <p>-The Abnormal Involuntary Movement Scale (AIMS) is administered every three to six months to monitor the patient for the development of TD (tardive dyskinesia - a syndrome characterized by abnormal involuntary movements of the patient's face, mouth, trunk, or limbs).</p> <p>Resident #59 was admitted to the facility in August 2023, with diagnoses including Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations) and Alcohol Abuse.</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 7/10/24, indicated Resident #59:</p> <p>-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total 15.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-received an antipsychotic (psychotropic medication primarily used to manage psychosis (including delusions, hallucinations, paranoia or disordered thought) and the antipsychotic was administered on a routine basis.</p> <p>Review of the August 2024 Physician's orders indicated:</p> <p>-Olanzapine (antipsychotic) 5 mg, give 1 tablet by mouth one time a day, initiated 8/6/24, discontinued 8/28/24</p> <p>-Aripiprazole (antipsychotic) 5 mg, give 1 tablet by mouth one time a day, initiated 8/6/24, active</p> <p>Review of the August 2024 Medication Administration Record (MAR) indicated Resident #59 received the following medications as ordered:</p> <p>-Olanzapine, administered from 8/7/24 - 8/28/24</p> <p>-Aripiprazole, administered from 8/7/24 - 8/31/24</p> <p>Review of the September 2024 Physician's orders indicated:</p> <p>-Aripiprazole 5 mg, give 1 tablet by mouth one time a day, initiated 8/6/24, active</p> <p>Review of the September 2024 MAR indicated Resident #59 received the following medications as ordered:</p> <p>-Aripiprazole, administered from 9/1/24 - 9/11/24</p> <p>Review of Resident #59's Abnormal Involuntary Movement Scale (AIMS) assessment dated [DATE], indicated the Resident was assessed for abnormal movements and none were present.</p> <p>Review of the medical record failed to indicate that an updated AIMS had been completed every three to six months as required, since August 2023.</p> <p>Further Review of the medical record failed to provide evidence that a plan of care was developed to monitor for adverse consequences and side effects related to antipsychotic medication use.</p> <p>During an interview on 9/12/24 at 10:12 A.M., the surveyor and the Director of Nursing (DON) reviewed Resident #59's medical record. The DON said that an AIMS assessment is typically done every six months to assess for adverse consequences or side effects related to antipsychotic medication use. The DON said that an updated AIMS should have been completed for Resident #59 and had not been.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138</p> <p>Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards and practices for one Resident (#14), out of a total sample of 17 residents.</p> <p>Specifically, the facility staff failed to document medicated lotion treatments administered to Resident #14's lower extremities as ordered by the Physician.</p> <p>Findings include:</p> <p>Review of the facility policy titled Charting and Documentation, revised July 2017, indicated:</p> <p>-All services provided to the resident .shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident condition and response to care.</p> <p>-The following information is to be documented in the resident medical record:</p> <p><Treatments or services performed</p> <p><Medications administered</p> <p>Resident #14 was admitted to the facility in August 2024 with diagnoses including Need for Assistance With Personal Care, Adult Failure to Thrive (a syndrome of global decline in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment, weight loss, decreased appetite or poor nutrition and inactivity), and Cellulitis (potentially serious bacterial infection of the skin) of left and right lower extremities.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #14 was moderately cognitively intact as evidenced by Brief Interview for Mental Status (BIMS) score of 12 out of 15.</p> <p>Review of the September 2024 Physician's orders for Resident #14 indicated:</p> <p>-Lac-Hydrin Twelve External Lotion 12% (medicated cream to treat dry scaly skin) apply to LEs (lower extremities) topically (on the surface) two times a day for dry skin, initiated 9/4/24, active</p> <p>During an observation and interview on 9/6/24 at 10:26 A.M., the surveyor observed Resident #14 lying in bed, and dressed in a gown. The surveyor observed the skin on the Resident's right leg to be scaly, dry, flaky, red and scabbed. Resident #14 said the staff were supposed to put medicated lotion on his/her legs and feet twice a day, but this did not happen.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation and interview on 9/6/24 at 11:39 A.M., the surveyor observed Resident #14 sitting up in a wheelchair. Resident #14 said that staff provided care and had put medicated lotion on his/her legs.</p> <p>Review of the September 2024 Treatment Administration Record (TAR) for Resident #14 failed to indicate that administration of Lac-Hydrin Twelve External Lotion 12% had occurred on:</p> <p>-9/5/24 at 8:00 A.M.</p> <p>-9/7/24 at 8:00 A.M.</p> <p>-9/8/24 at 8:00 A.M.</p> <p>-9/10/24 at 8:00 A.M.</p> <p>During an observation and interview on 9/10/24 at 4:13 P.M, the Director of Nursing (DON) said the Nurses should be signing off on the TAR when treatments are provided. The DON said there should not be blank spaces for signatures on the TAR because lack of a signature on the TAR indicated that the treatment was not provided. The DON confirmed the missing signatures on the TAR for the following dates and times:</p> <p>-9/5/24 at 8:00 A.M.,</p> <p>-9/7/24 at 8:00 A.M.,</p> <p>-9/8/2024 at 8:00 A.M.</p> <p>-9/10/2024 at 8:00 A.M.</p> <p>The DON said she would look for evidence that the treatments were provided to Resident #14.</p> <p>During a follow-up interview on 9/11/24 at 1:47 P.M., the Assistant Director of Nurses (ADON) said she contacted the Nurses who failed to sign off the TAR for:</p> <p>-9/5/24 at 8:00 A.M.,</p> <p>-9/7/24 at 8:00 A.M.,</p> <p>-9//8/2024 at 8:00 A.M.</p> <p>-9/10/2024 at 8:00 A.M.</p> <p>The ADON said care had been confirmed to have been provided but the Nurses had forgotten to sign off on the TAR. The ADON said that the TAR should be signed off in accordance with facility policy and standards of care to indicate that care was delivered as ordered by the Physician.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138</p> <p>Based on observation, interview, policy and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections for three Residents (#14, #42 and #45) out of a total sample of 17 residents.</p> <p>Specifically, the facility failed to:</p> <ol style="list-style-type: none"> 1. implement Enhanced Barrier Precautions (EBP - infection prevention practice of wearing gown and gloves to reduce transmission of multi-drug resistant organisms [MDRO's-resistant bacteria that are resistant to three or more types of antimicrobial drugs] during high contact [touching] Resident care for Resident #14 as ordered by the Physician. 2. ensure that Resident's #42 and #45 were free from the risk of infection when Resident #38 expelled emesis (vomit) while seated at the same lunch table, and the facility staff did not offer to replace the Resident #42 and #45's plated meals. <p>Findings include:</p> <p>Review of facility policy titled Enhanced Barrier Precautions (EBP), revised August 2023, indicated:</p> <ul style="list-style-type: none"> -EBP's are used as an infection prevention and control intervention to reduce the spread of MDRO 's to residents. -Gown and gloves are applied prior to performing the high contact resident care activity. -Examples of high contact resident care activities requiring the use of gown and gloves for EBP's includes wound care. <p>Resident #14 was admitted to the facility in August 2024, with diagnoses including Need for Assistance With Personal Care and Cellulitis (potentially serious bacterial infection of the skin) of the left and right lower extremities.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #14 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a total 15.</p> <p>Review of Resident #14's September 2024 Physician's orders indicated:</p> <ul style="list-style-type: none"> -EBP's every shift for wounds and foley catheter (a soft flexible tube that drains urine from the bladder). -Foley catheter every shift. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Wash right heel with derma wound cleanser, pat dry, apply Calcium Alginate (absorbent wound dressing made from seaweed) followed by dry clean dressing daily.</p> <p>Review of Resident #14's Care Plan indicated the following:</p> <p>-Resident #14 had decubitus (lying position) ulcers (pressure related wounds) to BLE (bilateral [both right and left] lower extremities), effective 8/3/24.</p> <p>-Resident had EBP's, effective 8/3/24.</p> <p>-Resident had a Foley Catheter, effective 8/3/24.</p> <p>On 9/10/24 at 3:34 P.M., the surveyor observed Nurse #1 cleanse her hands with alcohol sanitizer and put on (don) gloves in the Resident's room. Nurse #1 was not observed to don a gown. The surveyor observed Nurse #1 lean against Resident #14's mattress and remove the old dressing from the Resident's right foot. Nurse #1 then discarded the old dressing in the bathroom. Nurse #1 was observed to remove her used gloves, washed her hands, and applied a new pair of gloves. Nurse #1 again leaned against the Resident's mattress and administered wound care to the Resident's foot. The surveyor observed Nurse #1 discard unused supplies into the trash, remove the used gloves, and cleanse her hands with alcohol sanitizer.</p> <p>During an interview on 9/10/2024 at 3:50 P.M., Nurse #1 said Resident #14 was ordered for EBP's. Nurse #1 said EBP's were in place to prevent Resident #14 from infection. Nurse #1 said the Resident was high risk because of Foley catheter use and wounds. Nurse #1 said she should have worn a gown to administer Resident #14's wound care but she did not.</p> <p>During an interview on 9/10/2024 at 4:00 P.M., the Infection Preventionist (IP) said all residents with wounds and/or catheters have EBP's to prevent transmission of infection to the residents. The IP said Resident #14 had wounds and a Foley catheter in place, therefore EBP's should have been followed as ordered by the Physician. The IP said Nurse #1 should have worn a gown and gloves when delivering wound care because wound care was a high contact activity.</p> <p>48206</p> <p>2. Review of the facility policy titled Blood or Body Fluids Exposure, revised July 2016, indicated:</p> <p>-All blood or body fluids should be considered potentially infectious at all times.</p> <p>On 9/10/24 at 12:39 P.M., the surveyor observed the following during the lunchtime meal in the South Unit Dining Room:</p> <p>-Resident #38 was seated at a dining table with Residents #42 and #45 to either side of him/her.</p> <p>-Resident #38 expelled emesis onto his/her plated meal while the other two seated residents (#42 and #45) were consuming their meals.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Facility staff called the Director of Nursing (DON) and the Infection Preventionist (IP) for assistance for Resident #38.</p> <p>-The DON removed Resident #38's plate and the soiled table linens from the table.</p> <p>-The IP disinfected Resident #38's seating area wearing gloves.</p> <p>-The DON offered to move Residents #42 and #45 to another table, both Residents declined and continued to eat from their original plated meals.</p> <p>-The surveyor did not observe staff offering to replace Resident #42 and #45 plated meals.</p> <p>During an interview on 9/11/24 at 11:00 A.M., the IP said staff should have removed and replaced the plated meals of Residents #42 and #45 who were seated with Resident #38 because of the potential for splash from Resident #38's emesis onto their food.</p> <p>During an interview on 9/12/24 at 8:40 A.M., the DON said that she offered the Residents seated with Resident #38 to move tables, but she did not offer to replace their plated meals and she should have.</p>