STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225355	A. Building B. Wing	11/19/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically,1. The facility failed to ensure that medications were dated once opened, according to manufacturer's guidelines in two of two medication carts observed.2. The facility failed to ensure medication and treatment carts were locked while a nurse was not present on all units.Findings include:Review of the facility policy Medication Labeling and Storage, dated February 2023, indicated The facility stores all medications and biologicals in locked compartments. Compartments containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. 1. During a medication storage task on [DATE] the surveyor identified the following on the East Unit Medication cart: -two Ventolin HFA inhalers, open and in use, not dated. During a medication storage task on [DATE] the surveyor identified the following on the [NAME] Unit Medication cart: -two Ventolin HFA inhalers, open and in use, not dated. -one Spiriva inhaler, open and in use, not dated. -one Trelegy inhaler, open and in use, not dated. During an interview and observation on [DATE] at 10:43 A.M., Nurse #3 said that each nurse is responsible for labeling the inhalers when they are opened but they did not as these inhalers are not dated when opened. During an interview on [DATE] at 10:44 A.M., the Assistant Director of Nurses (ADON) said the nurses are responsible to date the inhalers when they are opened so each nurse is aware of when they will expire. During an interview on [DATE] at 11:21 A.M., the Director of Nurses (DON) said she expects the nurse who opens a new inhaler to date it so any other nurse that administers the inhaler to a resident (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	knows when it is expired. 2. On [DATE] at 6:54 A.M., the surveyors entered the facility and observed unlocked and unattended medication and treatment carts on all three units of the facility. The surveyor was able to gain access to both medication and treatment carts where medications are stored. The surveyors observed multiple residents awake and in the hallways in the vicinities of the unlocked and unattended medication and treatment carts. On [DATE] at 8:01 A.M., on the South Unit the surveyor observed an unlocked and unattended treatment cart in the hallway. The surveyor was able to gain access to the treatment cart which contained medicated ointments and other supplies. During an interview on [DATE] at 8:04 A.M., the Director of Nurses observed the unlocked treatment cart and said that her expectation is that medication and treatment cart are locked when they are unattended. The Director of Nurses was made aware of unlocked and unattended medication and treatment carts during the surveyor's entrance into the facility and she said the expectation is that at all times, the carts are locked when unattended.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview the facility failed to maintain a clean and comfortable home like environment for one Resident (#40) out of a total sample of 21 residents. Specifically, Resident #40's privacy curtain was soiled with a blood-like substance. Findings include:Review of facility policy titled Homelike Environment, dated February 2021, indicated the following:-Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.-The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect personalized, homelike setting. These characteristics include: a clean, sanitary and orderly environment. Resident #40 was admitted to the facility in September 2021 with diagnoses that included schizophrenia, bipolar disorder and chronic kidney disease. Review of Resident #40's Minimum Data Set (MDS) Assessment, dated 9/3/25, indicated a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. On 11/18/25 at 7:49 A.M., the surveyor observed Resident #40 sleeping in bed. The privacy curtain around Resident #40's bed was observed to be soiled with a dried blood-like substance throughout the curtain. On 11/19/25 at 8:07 A.M., and 9:50 A.M., the surveyor observed the privacy curtain around Resident #40's bed to be soiled with a dried blood-like substance throughout the curtain. Resident #40 declined to participate in an interview. During an interview on 11/19/25 at 9:23 A.M., Certified Nurse Aide (CNA) #3 said that she noticed the privacy curtain was stained last night when she worked on the 3:00 P.M. to 11:00 P.M. shift but that there was no one in the facility to notify for it to be changed. She said it is blood from a bloody nose that is dried onto the curtain. She said staff should have asked housekeeping to change the curtain immediately when it was observed. During an interview on 11/19/25 at 9:43 A.M., The Director of Social Services said that she is the ambassador for Resident #40's room and checks in daily. She said that she saw the curtain was stained with a dried substance yesterday and asked someone to change it, but they did not. She said it was not home-like to have a stained privacy curtain. During an interview on 11/19/25 at 12:48 P.M., the Director of Nurses observed the stains on the privacy curtain and said that staff should have immediately reported the staining and had the curtain replaced.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to develop a plan of care for one Resident (#29) and failed to implement a plan of care for two Residents (#4 and #51) out of a total sample of 21 residents. Specifically:1. For Resident #29 the facility failed to develop a plan of care for a pacemaker.2. For Resident #4 the facility failed to implement a physician's order for the use of a low air loss mattress.3. For Resident #51 the facility failed to implement a physician's order for a soft blue boot to the left foot. Findings include: Review of the facility policy titled Pacemaker, Care of a Resident with dated revised September 2023 indicated the following: For each resident with a pacemaker, document the following in the medical record and on pacemaker identification card on admission: a. The name address and telephone number of the cardiologist. b. Type of pacemaker. c. Type of leads. d. Manufacturer and model. e. Serial number. f. Date of implant. g. Paced rate. Further review indicated that the pacemaker battery will be monitored remotely through the telephone or an internet connection. The resident's cardiologist will provide instructions on how and when to do this. Make sure the medical identification card that indicates he or she has a pacemaker. The medical record must contain this information as well. 1. Resident #29 was admitted to the facility in June 2022 with diagnoses including cognitive impairment, angina pectoris, and presence of a pacemaker. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #29 scored a 1 out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. Review of the clinical record indicated Resident # 29 has a cardiac pacemaker. Further review failed to indicate the type of pacemaker. Review of the physician orders failed to indicate orders for the care of the pacemaker. Review of the care plan dated revised 5/6/25 failed to indicate directives for the care of the pacemaker. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/25 at 7:55 A.M. Nurse #1 said she has been Resident #29's full time nurse since she started a year and a half ago. Nurse #1 then said that since she has worked here Resident #29 has not had a pacemaker check. Nurse #1 said that she would expect there to be a physician's order for the care of the pacemaker. During an interview on 11/19/25 at 8:17 A.M. the Director of Nursing said that she would expect a physician's order to be present directing the nursing staff on how to care for the pacemaker. 2. Resident #4 was admitted to the facility with diagnoses that included kyphosis, dysphagia, hypotension, and altered mental status. Review of Resident #4's most recent Minimum Data Set (MDS) assessment, dated 9/10/25, indicated he/she scored a 9 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairments. The MDS also indicated the Resident is at risk for developing pressure ulcers and has one unhealed stage 3 pressure ulcer. Review of Resident #4's most recent Norton Scale (Scale for predicting risk of pressure ulcers), dated 4/10/25, indicated he/she scored a 14 indicating the Resident is at moderate risk for developing pressure ulcers. Review of Resident #4's physician order, dated 4/2/25, indicated Low Air Loss Mattress weight 114 every shift for preventive skin care check proper functioning. Review of Resident #4's November 2025 Treatment Administration Record (TAR), indicated from November 1st through November 18th every shift the order of the Low Air Loss Mattress was signed off as administered by nursing staff. Review of Resident #4's actual skin integrity care plan, dated 9/9/25, indicated low air loss mattress, settings according to weight. Review of Resident #4's active Certified Nurse Aide (CNA) Kardex (form that explains the needs of the Resident), indicated low air loss mattress, settings according to weight. During observations made throughout survey the Resident was in bed and not on an air mattress. During an interview on 11/19/25 at 9:08 A.M., Certified Nurse Aide (CNA) #1 said she takes care of Resident #4 often and the Resident stays in bed. CNA #1 said the Resident has not been on an air mattress. During an observation and interview on 11/19/25 at 9:08 A.M., Nurse #2 said if a Resident has an order for an air mattress, then an air mattress should be in place. Nurse #2 said Resident #4 is not on an air mattress, and the Resident is in bed. During an interview on 11/19/25 at 11:41 A.M., the Director of Nurses (DON) said Resident #4 is at risk for skin breakdown and the air mattress should be in place as ordered as it is an intervention for their skin. 3. Resident #51 was admitted to the facility with diagnoses that included hemiplegia and hemiparesis, dysphagia, muscle wasting and atrophy, and major depressive disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #51's most recent Minimum Data Set (MDS) assessment, dated 9/3/25, indicated he/she scored a 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. The MDS also indicated the Resident is at risk for developing pressure ulcers. Review of Resident #51's most recent Norton Scale (Scale for predicting risk of pressure ulcers), dated 6/13/25, indicated he/she scored an eight indicating he/she is at high risk for developing pressure ulcers. Review of Resident #51's physician order, dated 5/30/25, indicated Please make sure that his/her left toes have support at all times. Review of Resident #51's physician order, dated 10/27/25, indicated Soft blue boot to left foot to assist with foot drop prevention. Monitor skin integrity with donning and doffing every shift remove for care. Review of Resident #51's progress notes for November 2025 failed to indicate that the Resident refused his/her soft blue boot. Review of Resident #51's limited physical mobility care plan, dated 6/24/25, indicated Soft blue boot to left foot to assist with foot drop prevention. Monitor skin integrity with donning and doffing. Review of Resident #51's active Kardex, indicated Soft blue boot to left foot to assist with foot drop prevention. Monitor skin integrity with donning and doffing. On 11/18/25 at 7:53 A.M., 8:54 A.M., and 11/19/25 at 9:09 A.M., Resident #51 was in bed without a boot on his/her left foot. The soft blue boot was observed on his/her chair throughout survey. During an interview and observation at 9:09 A.M., Nurse #1 said the Resident is in bed and does not have a boot on his/her left foot. Nurse #1 said if the Resident has an order for the boot, then it should be on but is not. Nurse #1 said his/her left foot is just resting on the mattress. During an interview on 11/19/25 at 11:21 A.M., the Assistant Director of Nurses (ADON) said the Resident should have a blue boot on at all times and remove for care. The ADON said the boot is in place to prevent foot drop. During an interview on 11/19/25 at 11:40 A.M., the Director of Nurses (DON) said she expects that Resident #51 would have the blue boot on at all times and remove for care to prevent skin breakdown and foot drop.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to implement Occupational Therapy (OT) recommendations for one Resident (#47) for the treatment of a contracture to the left hand. Specifically, the facility failed to implement the use of an orthotic device for the maintenance and treatment of a contracture. Findings include:Review of facility policy titled Resident Mobility and Range of Motion, dated as revised July 2017, indicated the following:-Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM (range of motion).-Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. Resident #47 was admitted to the facility in April 2024 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other reduced mobility, Review of the Minimum Data Set (MDS) Assessment, dated 8/27/25, indicated that Resident #47 is rarely or never understood and was assessed by staff to have severe cognitive impairment. Review of the MDS Section GG indicated: Functional Limitation in Range of Motion of the Upper extremity: impairment on one side. On 11/18/25 at 8:01 A.M., the surveyor observed Resident #47 sleeping in bed. The surveyor observed his/her left hand to be in a tight fist with no orthotic device in place. On 11/19/25 at 9:20 A.M., the surveyor observed Resident #47 up out of bed and in his/her wheelchair. On Resident #47's left hand, his/her third, fourth and fifth finger were tight, in a fist. No orthotic device or brace was in place to the left hand. On 11/19/25 at 10:39 A.M., and 12:34 P.M., the surveyor observed Resident #47 in the dining room. His/her left hand was in a fist without any orthotic device or brace in place. Review of the OT Discharge summary dated [DATE] indicated the following:-LT (long term) goal met on 7/13/25: 100% carryover of carrot splint wearing tolerance.Skilled interventions: skilled interventions provided: skilled treatment interventions focused on education and training patient and care givers in environmental modifications, positioning maneuvers and splinting/ orthotic schedule in order to improve overal QOL (quality of life) and prevent further contractures.-D/C Recs (Discharge recommendations): DC (discontinue) skilled OT. Tolerates LUE (left upper extremity) carrot splint 5+ hours with no signs of pain redness or discomfort Review of Resident #47's active plan of care failed to indicate interventions for the limited range of motion in the left hand. Review of physician's orders indicated the following:-Adaptive equipment: left hand splint, remove for care, dated 4/2/25. Review of active and discontinued physician's orders failed to indicate use of the carrot splint as recommended by Occupational Therapy. During an interview on 11/19/25 at 10:59 A.M. Rehab Staff #1 said that the carrot splint was an active ongoing recommendation that was being implemented overnight for the Resident. During a phone interview on 11/19/25 at 12:13 P.M., Nurse #5 said that she works overnight at the facility, most recently working last night. She said she takes care of Resident #47 regularly. She said that there is no treatment in place for the left hand overnight. She said there are no braces or orthotic devices ordered and she said, I don't even think you could get anything in there. During an interview on 11/19/25 at 12:34 P.M., Certified Nurse Aide # 4 said that she is assigned to care for Resident #47 regularly and that the Resident does not utilize any type of orthotic device or brace for the left hand. During an interview on 11/19/25 at 12:36 P.M., the Assistant Director of Nurses said that when recommendations are received from therapy, it is therapies responsibility to enter the orders into the Electronic Medical Record, then nursing review them with the providers and approves the orders. During an interview on 11/19/25 at 12:51 P.M., the Director of Nurses said that she would expect that all therapy recommendations are reviewed with the physician and implemented as ordered or recommended, but that the carrot splint was not implemented as recommended. She said the process in the facility is to review all recommendations provided at the facilities morning meeting with the interdisciplinary team to ensure all (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations are followed up on and implemented. During a follow up interview on 11/19/25 at 1:19 P.M., Rehab Staff #1 said that when therapy has recommendations for orthotic devices or braces, they report the recommendations to nursing to have approved with the physician but said that therapy does not enter these orders or recommendations into the electronic medical record.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a trauma screen and develop a comprehensive trauma care plan related to Post Traumatic Stress Disorder (PTSD) that identified triggers and interventions for one Resident (#40) out of a total of 21 sampled Residents. Findings include:Review of facility policy, titled Trauma Informed Care and Culturally Competent Care, dated as revised August 2022, indicated the following:-Purpose: to guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice and to address the needs of trauma survivors by minimizing triggers and/or re-traumatization.-Trauma-informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma- informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.-Resident Screening: Perform universal screening of residents, which includes a brief, non- specialized identification of possible exposure to traumatic events.-Resident Assessment: Assessment involved an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers.-Resident Care Planning: Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate.-Identify and decrease exposure to triggers that may re-traumatize the resident. Resident #40 was admitted to the facility in September 2021 with diagnoses that included schizophrenia, bipolar disorder and chronic kidney disease. Review of Resident #40's Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. The MDS failed to indicate a diagnosis of PTSD. Review of a Nurse Practitioner note, dated 9/19/25, indicated the following:4. Anxiety, insomnia, schizophrenia, PTSD, bipolar disorder, paranoia, restless legs, unstable: continue psych services. Review of Resident #40's medical record failed to indicate a trauma assessment was completed. Review of the medical record indicated a social services note, dated 10/16/25, which indicated the following:This writer attempted to complete the Trauma questionnaire and resident refused at this time. Will continue to support and follow. Review of Resident #40's active care plans indicated the following focuses:-[Resident] carries a diagnosis of schizophrenia and bipolar disorder and PTSD (Post Traumatic Stress Disorder).-The resident uses psychotropic medications r/t (related to) bipolar schizophrenia DO (disorder) and PTSD.-PTSD [Resident] may experience feelings of sadness, emptiness, anxiety, uneasiness, bodily complaints, characterized by ineffective coping, low self-esteem, tearfulness, motor agitation, withdrawal from care/ activities related to Clinical Cond. causing mood problem with as PTSD following fire in his/her home. Resident #40's active plan of care failed to indicate specific triggers placing the Resident at risk for re-traumatization. During an interview on 11/19/25 at 9:35 A.M., The Director of Social Services said that the trauma assessment form used in the facility is about a year old and should be completed on all residents in the facility. She said that Resident #40 has a diagnosis of PTSD related to a house fire. She further said that October of 2025 was the first and only attempt that she had made to complete a trauma assessment on Resident #40. The Director of Social Services said that the Resident's PTSD care plan should include specific triggers to prevent re-traumatization, and if unable to identify triggers, then that should be included as well in the care plan. During an interview on 11/19/25 at 10:56 A.M., Nurse #4 said that as far as she knows, Resident #40 does not have PTSD based on looking in her medical record and she is not aware of any concerns or triggers for the Resident that staff should be aware of. During an interview on 11/19/25 at 12:42 P.M., the Director of Nurses said that residents with PTSD need to have timely trauma assessments completed and personalized care plans created with triggers for potential traumatization and staff should be made aware of those triggers. She said that Resident #40 has PTSD and staff need to know his/her triggers.