STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075299	A. Building B. Wing	02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chelsea Place Care Center LLC	25 Lorraine St Hartford, CT 06105

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review and interviews for one sampled resident (Resident #1) reviewed for pressure wounds, the facility failed to ensure a comprehensive care plan for a resident with refusals of care. The findings include: Resident #1's diagnoses included non-pressure chronic ulcers, diabetes mellitus, and dysphagia. The admission Minimum Date Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition and required partial/moderate assistance with bathing and lower body dressing. The Resident Care Plan (RCP) dated 12/6/2023 identified Resident #1 was at risk for skin breakdown related to bilateral wounds on heels on admission. Interventions directed a pressure reduction mattress as appropriate, encourage/assist resident with repositioning and off-loading heels, treatment as ordered, monitor for worsening condition/infection, and wound tracking per protocol. Clinical record review identified the following: Review of nursing notes for the month of December 2023 identified Resident #1 refused medications three (3) times on 12/13 and twice on 12/14/2023. Review of wound notes dated 12/20/2023 at 3:18 PM identified Resident #1 requested to not be followed by the wound care team. Review of nursing notes for the month of January 2024 identified Resident #1 refused medications five (5) times on 1/6, 1/7, 1/8, 1/9, and 1/17/2024. Review of nursing notes for the month of January 2024 identified Resident #1 refused wound care four (4) times on 1/4, 1/14, 1/21, and 1/24/2024. Review of nursing notes for the month of February 2024 identified Resident #1 refused medications two (2) times on 2/10 and 2/11/2024. Review of the RCP failed to identify a care plan for refusals of care, and refusals of medications or wound care treatment. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 2/20/2024 at 3:15 PM identified if a resident is exhibiting behaviors of repetitive refusals, the resident should be care planned for refusing care and interventions to include refusals. The DON identified she was unaware that Resident #1 refused medications and wound dressing changes and indicated the care plan should include refusals of care. Review of the Care Plan Policy dated 11/16/2023 directed in part, to develop a comprehensive person-centered plan of care for residents and contains interventions to be utilized. 47460

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #1) reviewed for nutrition, the facility failed to ensure a reweight was obtained timely for a resident and failed to ensure the dietician and physician were notified timely of a significant weight loss. The finding includes: Resident #1's diagnoses included diabetes mellitus, severe protein-calorie malnutrition, chronic non-pressure ulcers, dysphagia, and adjustment disorder. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition and was independent for eating. The Resident Care Plan (RCP) dated 12/6/2023 identified Resident #1 was at risk for alteration in nutritional status related to diabetes, malnutrition, hyperlipidemia, and dysphagia. Interventions directed to provide diet and supplements as ordered, offer alternate meal choice as indicated, obtain weights as order, monitor diet tolerance, monitor for aspiration/symptoms of hyper/hypoglycemia, provide assistance with meals as needed and referral to dietician as indicated. Review of Resident #1's weights identified the following: a. An admission weight obtained by RN #1 for Resident #1 dated 12/2/2023 identified Resident #1's weight was 148.6 lbs. b. A weight obtained by the DON for Resident #1 dated 12/6/2023 identified Resident #1's weight as 134 lbs. A difference of 12.6 lbs. or a 10.33% difference. Review of the clinical record and facility documentation failed to identify a re-weight was performed on after the weight was obtained on 12/6/2023, and failed to identify documentation of significant weight change or notifications to the physician and dietician. Review of the nursing progress notes from 12/2 to 12/27/2023 failed to reflect information regarding Resident #1's significant weight loss. Interview with the DON on 2/20/2024 at 3:15 PM identified if a resident has a significant weight loss, the dietician and physician should be notified of the change. The DON indicated Resident #1 was on weekly weights, and the dietician reviews the weights on a weekly basis. The DON identified she did not notify the dietician or physician of Resident #1's weight change on 12/6/2023, but believed she delegated the task to the nursing staff but was unsure of whom she delegated too, and it should have been reported. The DON was unable to provide documentation that a reweight was obtained or the physician and dietician were notified of the loss on 12/6/2023. Interview with the Registered Dietician (RD) #1 on 2/20/2024 at 3:35 PM identified if a resident experiences a gain or loss of five (5) pounds, she expects the nursing staff to perform a re-weight and to notify her of the change in weight. RD #1 identified she was not notified of Resident #1's 12.6 lb. weight loss on 12/6/2023 and indicated because she was on leave at that time the facility brought all weight related concerns to the Medical Director or APRN #1. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 2/21/2024 at 10:05 AM identified if a resident experiences a significant weight loss, the facility staff will notify her and RD #1 of the change in condition. APRN #1 identified in most cases, a resident will be placed on weekly weights and will order additional supplementation to promote weight gain. APRN #1 identified while reviewing her progress notes, there was no indication or areas of concerns related to weight loss during the period of 12/6/2023 for Resident #1. APRN #1 identified she did not recall the facility notifying her regarding the significant weight loss for Resident #1 on 12/6/2023 and indicated she would have written a progress note addressing the weight loss concern if she was notified. Review of the Weight Policy dated 11/19/2023 identified residents with a weight variance of 5% more or less than the previous month will be re-weighed. The charge nurse will notify the dietician when a 5% more or less variance is noted. The Policy further directed to notify the physician and responsible party when there is a significant weight fluctuation of 5% more or less and update the resident plan of care.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review and interviews for one resident (Resident #1) reviewed for nutrition, the facility failed to ensure the clinical record was complete and accurate to include accurate treatment documentation, and failed to ensure medical record access was maintained to ensure records were available timely. The findings include: a. Resident #1's diagnoses included non-pressure chronic ulcers, diabetes mellitus, and dysphagia. The admission Minimum Date Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition and required partial/moderate assistance with bathing and lower body dressing. The Resident Care Plan (RCP) dated 12/6/2023 identified Resident #1 was at risk for skin breakdown related to bilateral wounds on heels on admission. Interventions directed a pressure reduction mattress as appropriate, encourage/assist resident with repositioning and off-loading heels, treatment as ordered, monitor for worsening condition/infection, and wound tracking per protocol. An APRN order dated 12/2/2023 directed the left heel wound to be cleanse daily with normal saline, fluff gauze, packing 4x4 inch gauze, cover with 4x4 inch gauze, abdominal pad, wrap with kerlix wrap and ace bandage. An APRN order dated 12/2/23 directed the right heel wound to be cleanse daily with normal saline, peri (area around wound) wound care barrier spray, apply calcium alginate with silver dressing, cover with 4x4 inch gauze, abdominal pad, kerlix wrap, ace bandage daily. A physician's order dated 12/30/23 directed to cleanse wound left and right heel daily with normal saline, pat dry, apply Mesalt to wound bed, cover with 4x4 inch gauze, abdominal pad, wrap with kerlix wrap, ace bandage daily on 7:00 AM to 3:00 PM shift and as needed. Review of the Treatment Administration Record (TAR) for December 2023 failed to reflect that staff provided wound treatments on 12/11, 12/14 and 12/31/23 in accordance with physician orders. Review of the Treatment Administration Record (TAR) for January 2024 failed to reflect that staff provided treatment on 1/29/2024 as ordered. Interview and review of clinical documentation with DNS and RN #2 on 2/20/2024 at 3:18 PM indicated the blank areas on the December TAR for 12/11, 12/14, 12/31/2023 and January TAR for 1/29/2024 for wound care treatments to the left and right heels were not documented, but should have been and that if wound care was not documented on the TAR, it should be documented in the progress notes. RN #2 indicated the facility does not have a documentation policy. Interview with LPN #1 on 2/21/2024 at 8:39 AM identified that she performed the treatment on 12/14/2023 and it was possible that she forgot to document it on the TAR. Interview with RN #1 on 2/21/2024 at 8:44 AM identified that she could not remember if she performed or documented providing wound care on 12/11/2023 and that she would chart in the computer if she provided care. RN #1 indicated that if the resident refused care, she would document the refusal. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #3 on 2/21/2024 at 9:03 AM identified that she may have forgotten to chart that she performed wound care on Resident #1's left and right heels on the 1/29/2024. Interview with LPN #2 on 2/21/2024 at 9:22 AM identified that she documents wound care treatment on the TAR. Review of the blank areas for the left and right heel wound care on 12/31/2023, LPN #2 indicated she forgot to chart the treatment was provided, and that it was an oversight. b. Review of the clinical record for Resident #1, the facility failed to provide the Medication Administration Record (MAR) for December 2023. Interview with DNS and RN #2 on 2/21/24 at 10:30 AM indicated that the facility could not locate the December 2023 MAR, but identified the facility should have the records. Although a policy for documentation was requested, RN #2 indicated that the facility did not have a policy. 47460