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	10/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on clinical record review, facility documentation, observations and interviews, for two (2) of six (6) residents reviewed for resident rights (Resident #1 and Resident #2), the facility failed to ensure that language used within close proximity of residents was appropriate. The findings included: 1. Resident #1 had a diagnoses that included paranoid schizophrenia. A quarterly Minimum Data Set (MDS) dated [DATE] identified that the resident had a Brief Interview for Mental Status (BIMS) of three (3), indicative of severe cognitive impairment and required set-up with Activities of Daily Living (ADLs). A care plan dated 9/20/24 identified that the resident required assistance with ADL's with interventions including explanation of care, and to report any decline in ADLs to the therapy department. 2. Resident #2 had diagnoses that included encephalopathy. A quarterly MDS dated [DATE] identified a Brief Interview for Mental Status (BIMS) of three (3), indicative of severe cognitive impairment and required extensive assistance with ADLs. A care plan dated 7/20/24 identified that the resident required assistance with ADLs with interventions including explanation of care, and to report any decline in ADLs to the therapy department. Observation on 10/21/24 at 8:40 AM identified that Resident #1 and Resident #2 were seated adjacent from the nurse's station. Social Worker #1 was noted to exit a residents room and approach the nurse's station saying in a loud voice No, No, No, its too early for this F**king S**t. Interview with a psychiatric practioner on 10/21/24 at 8:42 AM identified that she had heard the inappropriate comment that SW#1 had made in the presence of residents while she was charting at the nurse's station. Interview with SW#1 on 10/21/24 at 8:45 AM identified that she never should have used swear words in the presence of residents. She explained that Resident #8 was being discharged that morning and none of h/her things had been packed up yet, she was upset and that is why she made the comment. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075299	A. Building B. Wing	10/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nurses (DON) on 10/21/24 at 9:15 AM identified that the language that was used by SW #1 in the presence of residents was inappropriate. The Resident's [NAME] of Rights directed the residents have the right to be treated with consideration, respect and full recognition of the resident dignity and individuality. The residents had a right to receive quality care and services with reasonable accommodation of resident individual needs and preferences, except when resident health or safety or the health of safety of others would be endangered by such accommodation.

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	10/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record review, facility documentation, facility policy and interviews for one (1) of four (4) residents (Resident #4) reviewed for abuse, the facility failed to ensure the residents were free from physical abuse within the facility. The findings include: Resident #4's diagnoses included anxiety disorder, mood disorder and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of seven (7) indicative of impaired cognition, exhibited no behaviors and required extensive assistance with bed mobility, transfers and toileting. The Resident Care Plan (RCP) dated 9/25/24 identified that Resident #4 has the potential for a mood problem related to the allegation of physical abuse by a caregiver with interventions that included to obtain behavioral health consults as needed, monitor/document/report any risk for harm to self, monitor/record mood, social service support visits per policy and the resident is to always receive two staff for care. Review of the facility Reportable Event (RE) dated 9/25/24 identified that a staff member (LPN #1) reported that on 9/25/24 at 2:30 PM she responded to screaming from Resident #4's room and observed another staff member (NA #1) holding Resident #4 by the wrists and both Resident #4 and NA #1 were screaming at each other. The RE reported that when the resident was asked what happened, he/she stated that NA #1 twisted his/her wrists and pulled his/her hair and subsequently complained of pain to the left wrist. NA #1 was redirected out of Resident #1's room and sent home pending investigation, the police were notified, the APRN was notified, and x-rays were ordered and obtained to both of Resident #4's wrists with negative results. Interview with Resident #4 on 10/23/24 at 2:55 PM identified that Resident # 4 had pointed out NA #1 to the surveyor in the hallway stating, the one in the red, she hurt me. The resident reported that it caused her pain and hurt her feelings. Interview with LPN #1 on 10/25/24 at 12:36 PM identified that she was sitting at the nurse's station charting when she heard yelling from down the hall (although she could not understand what was being said). She reported that when she approached Resident #4's room, Resident #4 was sitting in his/her wheelchair outside of the bathroom door and NA #1 was holding Resident #4 by both of his/her wrists. She identified that when NA #1 saw that she was standing there, she let go of the resident and walked out of the room as Resident #4 yelled, I hate you and I'm going to call the police. She reported that Resident #1 then reported to her that NA #1 got angry because h/she was trying to toilet him/herself, and NA #1 hurt his/her wrists. LPN #1 identified that NA #1 then re-entered the room yelling at Resident #1 exclaiming that the resident was lying and that he/she did not do any of that. LPN #1 reported that she told NA #1 that she needed to leave the room immediately, accompanied her out into the hallway and called the nursing supervisor (RN #1). (continued on next page)

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	10/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on 10/23/24 at 10:55 AM identified that on 9/25/24 at around 2:40 PM she heard Resident #4 yelling, so she went to respond and when she entered the room, she observed Resident #4 in his/her wheelchair in the bathroom and reported that she checked his/her brief and it was soiled so she told the resident she was going to put him/her in the bed to change their brief, to which the resident agreed. She identified that she pushed the resident in the wheelchair into the room and he/she started to get upset and yell at NA #1 not to touch him/her. NA #1 reported that Resident #4 then started to hit and scratch her, so she yelled for NA #2 to help and then grabbed his/her arms to stop him/her and then LPN #1 and NA #2 entered the room and she stepped back from the resident and left the room, identifying that she did not touch the resident's hair, hit him/her, twist his/her arms or yell at the resident, she was only yelling for help. Additionally, she reported that although she should have immediately backed away from the resident, she was trying to prevent the resident from scratching her, as Resident #4 had a history of hitting and scratching staff. Interview with RN #1 on 10/23/24 at 10:01 AM identified that LPN #1 called her following LPN #1's observation of the incident and Resident #4's allegation towards NA #1 on 9/25/24. She reported that she immediately responded to the resident's room, where Resident #4 reported that a NA#1 held her wrists and pulled her hair. She reported that she assessed the resident, and no swelling or discoloration was noted to either wrist, but that the resident was complaining of wrist pain so she notified the APRN and obtained an order for x-rays to be completed of both wrists. She identified that she did not talk with NA #1, as RN #2 (Prior DNS) came to the unit to retrieve her and sent her home pending investigation. Interview with the Administrator on 10/23/24 at 11:45 AM identified that the facility unsubstantiated the abuse allegation as they believed that NA #1 held Resident #4's wrists to protect herself from harm and although it may not have been the best decision, NA #1 did what she needed to do in the moment and the Administrator reported that she did not believe there was any malicious intent, as Resident #4 had a history of hitting and scratching staff during care. She identified that she believed that LPN #1 misinterpreted what she saw and reported that when the social worker met with Resident #4, his/her description of the event differed from his/her original statement. She reported that subsequent to the 9/25/24 allegation, Resident #4 is now a two-person assist for all care. Although attempted, an interview with RN #2 (Prior DNS) was not obtained. Review of the Abuse CT policy dated 3/20/24 directed, in part, that residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. It identified that the residents have the right to be free from abuse and neglect.