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	11/08/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on review of facility documentation and staff interviews for 1 of 3 residents (Resident #40) reviewed for Beneficiary Notification, the facility failed to ensure the notification was received by the responsible party timely to ensure the responsible party was aware of his/her rights. The findings include: Resident #40's diagnosis include dementia and Schizophrenia. The Annual Minimum Data Set assessment dated [DATE] indicated Resident #40 was severely cognitively impaired. The PPS (Prospective Payment System) Part A (Medicare part A) Discharge (End of Stay) MDS dated [DATE] indicated Resident #40's Medicare stay ended on 5/9/2024. On 11/05/24 at 3:10 PM during an interview and facility document review with the MDS Nurse (RN #9) of the facility Beneficiary Notification paperwork including the Notification of Medicare Non-Coverage for Resident # 40 identified the notification was dated as provided timely and emailed to the resident's responsible party on 5/7/2024. Although the date of notification on the form indicated a call/verbal notification, a note written on the form indicated an email was sent requesting the repsonsible party to sign and return the forms. RN #9 indicated the party responsible never responded to the email or contacted the MDS department therefore the notification remained unsigned. Although RN #9 was able to produce an electronic verification of an email delivery was complete, However, RN # 9 was not able to provide any follow up via phone or any attempts of a registered letter to the responsible party to ensure the responsible party received notice of Medicare coverage ending and receipt of the Skilled Nursing Facility Advanced Beneficiary Notification (SNFABN). The facility was not able to provide evidence the responsible party received the Notice of Medicare Non-Coverage (NOMNoC) forms making him/her aware of their right to appeal the decision.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observations of the Environment, review of facility documentation, review of facility policy and staff interviews, the facility failed to ensure toilets in 2 shower rooms were maintained in a safe manner and the facility failed failed to ensure a safe and sanitary environment to promote a home like environment and for 1 of 8 residents reviewed for the environment for (Resident #79), the facility failed to maintain a homelike environment by ensuring the resident bathroom was free of holes and peeling paint and for 1 sampled resident (Resident # 193), the facility failed to ensure the resident's personal clothing was labeled according to facility practice and not missing. The findings included: 1. An observation and interview on 11/04/24 at 7:10 AM of unit 2 behavioral unit shower room bathroom with RN #9 identified the toilet with the toilet seat on the floor next to the side of the toilet. Further observations identified the toilet with small amount of floating bowel movement and a dried-out miss-shaped used face cloth on the handrail next to the toilet. RN # 9 indicated she/he was not aware of the condition of the bathroom and indicated s/he would call maintenance to come fix the toilet. The off going 11-7 AM Nurse, LPN # 5 was unaware of the shower area bathroom condition during the third shift. An observation and interview with Housekeeper #1 on 11/04/24 at 7:45 AM of the shower room on second floor next to the nurse station (A/B wing) identified the toilet had moved slightly off the base not allowing for one to sit straight on the toilet seat, but slightly skewed to the left. The bolts holding the toilet base were still attached and the sewer hole was not exposed. Housekeeper #1 indicated s/he did know the condition of the toilet and would make maintenance aware of the concern. 2. On 11/4/24 6:50 AM observations of the environment identified the following: a. 11 wheelchairs, 1 geriatric chair, 2 Hoyer lifts, 1 walker, and a set of leg rests for a wheelchair in the dinning/activities room. Observed the equipment in the dinning/activity room daily from 11/4/24 through 11/7/24. b. Observation and interview with the Director of Maintenance of rooms 223, 232, 238, 240, 242 on 11/6/24 at 2:00 PM identified the following issues: room [ROOM NUMBER] a hole in the wall behind the headboard that tunneled approximately 4 inches. room [ROOM NUMBER] the ceiling in the bathroom had brown stains and was peeling. Holes in the wall behind the headboard and an outlet behind the headboard did not have a cover. room [ROOM NUMBER] the vanity upper part in the bathroom was warped and wood was rough with pieces missing. room [ROOM NUMBER] there were holes in the wall behind the headboard. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] there was a hole in the wall behind the headboard. There was also no cover on the telephone outlet. The Maintenance Director at the time of the observations identified he does environmental rounds 2 times per week and enter every room. The Maintenance Director further stated he does not do a comprehensive assessment of each room every time, he focuses on one area, for example the beds. Upon further interview with the Maintenance Director on 11/6/24 identified that he was not notified about issues in the resident rooms, he discovers the issues on rounds. He also indicated he has fixed the holes in the walls numerous times but the residents keep pushing the beds against the walls causing more damage. Interview on 11/7/24 at 9:41 AM with Activity Aide #1 identified resident equipment is left in the dinning/activity room until the residents wake up and start their day. She identified items are not stored there, she said they are just there when the residents are in bed. Observation on 11/7/24 at 11:00 AM identified that there were 3 wheelchairs, 1 walker, and 1 set of leg rests in the dinning/activities room when an activity was in process. Although requested policies for environment and for equipment storage were not provided. 3. Resident #79's diagnoses included dementia, weakness and falls. The quarterly MDS assessment dated [DATE] identified Resident #79 had short-term and long-term memory problems and was frequently incontinent. The MDS assessment also indicated the resident required set-up or clean-up assistance for toileting and required partial/moderate assistance with personal hygiene. On 11/04/2024 at 9:42 AM observation identified an outlet cover near the foot of Resident #79's bed and next to the baseboard heater. The cover was missing the top screw, was tilted to one side, and did not cover the hole in the wall. Additionally, the resident's bathroom was observed to have a hole in the wall by the exit. Between the sink and the toilet, the bathroom wall was noted to have yellow paint peeling, exposing a green and gray surface. On 11/7/2024 at 1:15 PM, an observation and interview with the Maintenance Director indicated the cover was not an electrical cover, but it may have been a cover used to close the hole left over from a piece of equipment related to the baseboard heat. Additionally, the Maintenance Director identified the green surface exposed from the peeling paint in the bathroom was most likely the old paint and indicated s/he thought the paint was peeling off due to the soap dispenser being directly over the area and not having a tray to catch the excess soap. The Maintenance Director also indicated that when s/he does environmental rounds s/he may go to the bathrooms but if they are being occupied s/he will not go into the bathroom. Additionally, the Maintenance Director identified that if staff noted something in need of repair, they could place the need for the repair into the computer, and it would prompt maintenance to repair it. 4. Resident #193 was admitted on [DATE] with diagnoses that included unspecified bacterial infection, diabetes mellitus, and Post-Traumatic Stress Disorder (PTSD). The admission MDS assessment dated [DATE] identified Resident #193 was cognitively intact and indicated things such as choosing what clothes to wear and taking care of their personal belongings were very important to the resident. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/2024 at 12:05 PM during an interview with Resident #193 identified s/he had sent her/his clothes to the laundry during the first week of being a resident at the facility. Resident #193 identified s/he had sent a navy-blue sweatshirt and sweatpants, as well as three t-shirts. Resident #193 indicated s/he had received the t-shirts back but not the sweatshirt and sweatpants. Additionally, Resident #193 indicated NA#4 had helped her/him pack his/her clothes in a plastic bag and placed a note in the bag requesting that the clothes be labeled. Resident #193 further indicated s/he spoke to a social worker and filed a grievance. On 11/5/2024 at 11:52 AM, an interview with Social Worker (SW) #2 indicated she was aware of the resident's missing belongings, she/he reported it to the Director of the Laundry, and that a laundry assistant had spoken with the resident. However, SW #2 could not recall the name of the laundry assistant. Social Worker #2 indicated some of the resident's items were found and that others were still missing but staff was still looking for the items. Social Worker #2 was unable to locate a Missing Personal Property form, or a grievance related to the missing belongings. On 11/6/2024 at 12:32 PM, an interview with NA#4 identified she had written the resident's name on the tags of the resident's blue sweatshirt and sweatpants and helped Resident #193 place his/her clothes in a bag. Additionally, NA#4 indicated she had placed a paper note asking for the clothes to be labeled inside the laundry bag. NA#4 indicated that she had not been informed by the laundry regarding a particular process for having residents' clothing labeled and indicated the nurse aides had come up with the process of placing a note in the bag and there had not been any problems. On 11/7/2024 at 1:46 PM, an interview with the Director of the Laundry indicated she was not aware Resident #193 was missing her/his blue sweatshirt and sweatpants. The Director of the Laundry also indicated the process for getting residents' clothes labeled was for the resident or nursing staff to hand-deliver the clothes to the laundry and request that a label be placed. The Director of Laundry indicated that laundry staff would not be able to go through every piece of paper that is placed in a laundry bag because staff are sorting laundry, they may miss notes that may be placed in the laundry bag. The Director of the Laundry indicated she did not know if the staff on the units had been educated regarding the process. The facility policy for Personal Clothing did not identify a process specific to for managing resident's clothing, however the policy did indicate that follow up is needed to ensure that any clothing brought in by families after the resident's admission is labeled properly. 48792 48880