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	11/20/2024

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on review of the clinical record, facility documentation, facility policy and interviews for five (5) of eleven (11) residents (Residents #1, 2, 3, 8 and 9) reviewed for abuse, the facility failed to ensure the residents were free from misappropriation of the resident's medications. The findings include: 1. Resident #1 was admitted with diagnoses that included osteomyelitis, and contractures. An annual Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of eight (8) indicative of moderately impaired cognition, and occasionally experienced pain in the last five (5) days. The Resident Care Plan (RCP) dated 3/25/2024 identified Resident #1 was at risk for skin breakdown. RCP directed to assist with repositioning changes, and wound care as ordered. A physician order dated 5/2/2024 directed to administer Oxycodone (a narcotic pain medication) immediate release (IR) 10 milligram (mg) tablet by mouth every eight (8) hours. A review of the controlled substance distribution record (CDSR) #118721 received 5/7/2024, identified LPN #1 had documented on 5/7/2024 one tablet of Oxycodone IR 10 mg had been popped in error and on 5/8/2024, LPN #1 identified that another Oxycodone IR 10 mg tablet had been dropped. Neither had a co-signature that the tablet was destroyed. Review failed to identify accounting for the Oxycodone tablets removed from the resident supply on 5/7 and 5/8/2024. 2. Resident #2 was admitted with diagnoses that included polyneuropathy (damage of the peripheral nerves, affecting the skin, muscles and organs) and diabetes mellitus. The quarterly MDS assessment dated [DATE] occasionally experienced pain in the last five (5) days. The RCP dated 3/27/2024 identified that Resident #2 had pain due to neuropathy, scoliosis (curvature of the spine) and osteoporosis (bones become weak and brittle). A physician progress note dated 3/27/2024 identified Resident #2 was alert and oriented to person, place and time. A physician order dated 3/27/2024 directed to administer Oxycodone (a narcotic pain medication) immediate release (IR) 10 mg tablet, every night at bedtime. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Chelsea Place Care Center LLC	25 Lorraine St Hartford, CT 06105

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #2's medication administration record (MAR) and the copy of the facility yellow proof of receipt CSDR #128616, thirty (30) tablets of Oxycodone IR 10 mg tablet were delivered to the facility on [DATE]. A facility audit/reconciliation completed on 4/19/2024 identified six (6) tablets remained out of the original thirty (30). A review of Resident #2's April MAR identified that ten (10) doses were documented as administered (nightly from 4/6 to 4/16/2024), leaving 14 tablets not remaining in the card and were unaccounted for (not signed as administered). Although requested, the facility was unable to provide the actual white CSDR sheet #128613 (used by nurses to sign when the drug is removed from the card) that is required to track the disposition of Resident #2's Oxycodone IR 10 mg tablet to be given every night at bedtime, and indicated it was missing. Review failed to identify accounting for the resident's 14 Oxycodone tablets. 3. Resident #3 was admitted diagnoses that included multiple myeloma not in remission, chronic pain and sciatica (pain that radiated down the right leg from the back). The quarterly MDS assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indication the resident was alert and oriented, and occasionally experienced pain in the last five (5) days. The RCP dated 3/20/2024 identified that Resident #3 needed help with activities of daily living (ADLs) due to melanoma cancer and a history of thoracic fracture. Interventions directed to follow up on unexplained pain. A physician order dated 5/6/2024 directed to administer Oxycodone immediate release (IR) 10 mg tablet, give one tablet by mouth every four hours as needed for pain. A review of Resident #3's MAR and CSDR #118644 provided by a Department of Consumer Protection (DCP) representative for Resident #3's Oxycodone IR 10 mg tablet (directions to give one tablet by mouth every four hours as needed for pain) indicated six (6) tablets were received by the facility on 4/30/2024. A review of Resident #3's MAR identified that on 5/13/2024, at 7:00 AM, one IR 10 mg tablet of Oxycodone was signed out on the CSDR #118644, but was not signed as administered by LPN on Resident #3's MAR. Although requested, the facility was unable to provide CSDR #118644 that is required to track the disposition Resident #3's Oxycodone immediate release (IR) 10 mg tablet, give one tablet by mouth every four hours as needed for pain and indicated it was missing. Review failed to identify documentation that the Oxycodone tablet was administered to Resident #3 on 5/13/2024. 4. Resident #8 was admitted with diagnoses that included arteriosclerosis (thickened and hardened arteries) of the right leg and lower left leg with ulcerations (open wounds) and opioid dependence. The quarterly MDS assessment dated [DATE] identified Resident #8 had a BIMS of fifteen (15) indicating the resident was alert and oriented. The RCP dated 3/20/2024 identified that Resident #8 had an alteration in skin left leg with a full thickness trauma wound reporting a pain level 8 on a scale of 1 to 10. The RCP directed to treatment as indicated. A physician's order dated 4/9/2024 directed to administer Oxycodone IR 5 mg tablet, give one tablet by mouth every eight hours as needed for pain. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #8's MAR and CSDR #128899 for Resident #8's Oxycodone IR 5 mg tablet identified that LPN #1 signed out one (1) IR 5 mg tablet of Oxycodone on 4/14/2024 at 10:00 PM, 4/15/2024 at 6:00 AM and 4/22/2024 at 5:00 AM, but the three (3) doses were not signed as administered by LPN #1 on Resident #8's MAR. Review failed to identify accounting for the three (3) Oxycodone tablets removed from the resident supply on 4/14, 4/15 and 4/22/2024. 5. Resident # 9's diagnoses included cancer and osteomyelitis. An admission MDS assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicating the resident was alert and oriented. The RCP dated 12/28/2024 identified Resident #9 had pain due to multiple surgeries, cancer and needed medication to manage the pain. Interventions directed to provide pain medication as ordered and observe effectiveness, and if breakthrough pain to offer another one of the prescribed pain medications. A physician's order dated 1/22/2024 directed to administer Oxycodone IR 10 mg tablet, give one tablet by mouth every eight hours as needed for pain. A review of Resident #9's MAR and CSDR numbered #117755 provided by DCP representative for Resident #9's Oxycodone IR 10 mg tablet, give one tablet by mouth every eight hours as needed for pain, identified that on 1/29/2024, at 6:00 PM, one (1) IR 10 mg tablet of Oxycodone was signed out on the CSDR #117755 and documented as dropped on the floor by LPN #1 but lacked a co-signature by another nurse to indicate that the tablet was destroyed or wasted. Although requested, the facility was unable to provide CSDR #117755 disposition tracking form during survey. Review failed to identify accounting for the resident's Oxycodone tablet removed from the resident supply on 1/29/2024. Interview and review of investigative documents on 11/18/2024 at 9:30 AM with the former DNS/RN #3, who completed a 5/2024 suspected drug diversion investigation for LPN #1, identified she met with LPN #1 on 5/10/2024 after a monthly audit that identified missing CDSR sheets, obscured signatures on some sheets and instances of failure of LPN #1 to follow facility policy for proper controls for narcotics. RN #3 indicated some resident's white CDSR sign out sheets for the narcotics were missing, some of the sheets contained illegible signatures and sheets that required two (2) nurse's signatures for destroyed drugs lacked a second signature. RN #3 indicated the questionable CDSR sheets involved LPN #1. RN #3 interviewed LPN #1 who identified she did not notify the supervisor or another nurse when another signature was required on the CDSR sheets when she popped a drug out in error or dropped a medication on the floor. The DNS identified the missing CDRS sheets, and the medication documentation issues led her to report LPN #1 to the DCP as she may have been diverting narcotics, and a representative of that department was on site on 5/15/2024. Review of LPN #1's employee file identified a employee corrective action form dated 5/10/2024 identified that LPN #1 had been found documenting several discrepancies in the controlled drug sheets. LLPN #1's employment was terminated because she did not respond to facility attempts to contact her regarding the discrepancies. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Connecticut Consumer Protection report, Case Number 2024-1269 dated 9/26/2024 identified that two (2) Drug Control Agents met with LPN #1 on 9/12/2024, where LPN #1 admitted to diverting Oxycodone from the facility for her own personal use. Although attempted, an interview with LPN #1 was not obtained during the survey. The facility policy-controlled substance handling directed in part, that all controlled drugs were subject to special handling, storage and record keeping. A controlled drug accountability record (CDRS sheet) will be prepared and immediately following an administration of a dose, the licensed nurse will enter the date of time of administration, dose administered, signature of the nurse administering. If one or more doses of the controlled substance is removed from the container and cannot be returned to the blister pack it must be destroyed in the presence of two licensed nurses and documented by both nurses in the accountability record. All controlled substance accountability records and audit records on file for a period of no less than five years. The facility policy Abuse CT dated 3/20/2024 directed in part that abuse, neglect, exploitation, and/or mistreatment of residents or misappropriation of resident property is prohibited. Misappropriation of Resident Property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings without the resident's consent.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on review of the clinical record, facility documentation, facility policy and interviews for five of eleven (11) residents (Residents #1, 2, 3, 8, and 9) reviewed for misappropriation, the facility failed to ensure the State Agency was notified timely of an allegation of misappropriation when an alleged diversion was identified. The findings include: 1. Resident #1 was admitted with diagnoses that included osteomyelitis, and contractures. An annual Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of eight (8) indicative of moderately impaired cognition, and occasionally experienced pain in the last five (5) days. The Resident Care Plan (RCP) dated 3/25/2024 identified Resident #1 was at risk for skin breakdown. RCP directed to assist with repositioning changes, offer right hand wrist splints and wound care as ordered. A physician order dated 5/2/2024 directed to administer Oxycodone (a narcotic pain medication) immediate release (IR) 10 milligram (mg) tablet by mouth every eight (8) hours. A review of the controlled substance distribution record (CDSR) #118721 received 5/7/2024, identified LPN #1 had documented on 5/7/2024 one tablet of Oxycodone IR 10 mg had been popped in error and on 5/8/2024, LPN #1 identified that another Oxycodone IR 10 mg tablet had been dropped. Neither had a co-signature that the tablet was destroyed. 2. Resident #2 was admitted with diagnoses that included polyneuropathy (damage of the peripheral nerves, affecting the skin, muscles and organs) and diabetes mellitus. The quarterly MDS assessment dated [DATE] occasionally experienced pain in the last five (5) days. The RCP dated 3/27/2024 identified that Resident #2 had pain due to neuropathy, scoliosis (curvature of the spine) and osteoporosis (bones become weak and brittle). A physician progress note dated 3/27/2024 identified Resident #2 was alert and oriented to person, place and time. A physician order dated 3/27/2024 directed to administer Oxycodone (a narcotic pain medication) immediate release (IR) 10 mg tablet, every night at bedtime. A review of Resident #2's medication administration record (MAR) and the copy of the facility yellow proof of receipt CSDR #128616, thirty (30) tablets of Oxycodone IR 10 mg tablet were delivered to the facility on [DATE]. A facility audit/reconciliation completed on 4/19/2024 identified six (6) tablets remained out of the original thirty (30). A review of Resident #2's April MAR identified that ten (10) doses were documented as administered (nightly from 4/6 to 4/16/2024), leaving 14 tablets not remaining in the card and were unaccounted for (not signed as administered). Although requested, the facility was unable to provide the actual white CSDR sheet #128613 (used by nurses to sign when the drug is removed from the card) that is required to track the disposition of Resident #2's Oxycodone IR 10 mg tablet to be given every night at bedtime, and indicated it was missing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #3 was admitted diagnoses that included multiple myeloma not in remission, chronic pain and sciatica (pain that radiated down the right leg from the back). The quarterly MDS assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indication the resident was alert and oriented, and occasionally experienced pain in the last five (5) days. The RCP dated 3/20/2024 identified that Resident #3 needed help with activities of daily living (ADLs) due to melanoma cancer and a history of thoracic fracture. Interventions directed to follow up on unexplained pain. A physician order dated 5/6/2024 directed to administer Oxycodone immediate release (IR) 10 mg tablet, give one tablet by mouth every four hours as needed for pain. A review of Resident #3's MAR and CSDR #118644 provided by a Department of Consumer Protection (DCP) representative for Resident #3's Oxycodone IR 10 mg tablet (directions to give one tablet by mouth every four hours as needed for pain) indicated six (6) tablets were received by the facility on 4/30/2024. A review of Resident #3's MAR identified that on 5/13/2024, at 7:00 AM, one IR 10 mg tablet of Oxycodone was signed out on the CSDR #118644, but was not signed as administered by LPN on Resident #3's MAR. Although requested, the facility was unable to provide CSDR #118644 that is required to track the disposition Resident #3's Oxycodone immediate release (IR) 10 mg tablet, give one tablet by mouth every four hours as needed for pain and indicated it was missing. 4. Resident #8 was admitted with diagnoses that included arteriosclerosis (thickened and hardened arteries) of the right leg and lower left leg with ulcerations (open wounds) and opioid dependence. The quarterly MDS assessment dated [DATE] identified Resident #8 had a BIMS of fifteen (15) indicating the resident was alert and oriented. The RCP dated 3/20/2024 identified that Resident #8 had an alteration in skin left leg with a full thickness trauma wound reporting a pain level 8 on a scale of 1 to 10. The RCP directed to treatment as indicated. A physician's order dated 4/9/2024 directed to administer Oxycodone IR 5 mg tablet, give one tablet by mouth every eight hours as needed for pain. A review of Resident #8's MAR and CSDR #128899 for Resident #8's Oxycodone IR 5 mg tablet identified that LPN #1 signed out one (1) IR 5 mg tablet of Oxycodone on 4/14/2024 at 10:00 PM, 4/15/2024 at 6:00 AM and 4/22/2024 at 5:00 AM, but the three (3) doses were not signed as administered by LPN #1 on Resident #8's MAR. 5. Resident # 9's diagnoses included cancer and osteomyelitis. An admission MDS assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicating the resident was alert and oriented. The RCP dated 12/28/2024 identified Resident #9 had pain due to multiple surgeries, cancer and needed medication to manage the pain. Interventions directed to provide pain medication as ordered and observe effectiveness, and if breakthrough pain to offer another one of the prescribed pain medications. A physician's order dated 1/22/2024 directed to administer Oxycodone IR 10 mg tablet, give one tablet by mouth every eight hours as needed for pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #9's MAR and CSDR numbered #117755 provided by DCP representative for Resident #9's Oxycodone IR 10 mg tablet, give one tablet by mouth every eight hours as needed for pain, identified that on 1/29/2024, at 6:00 PM, one (1) IR 10 mg tablet of Oxycodone was signed out on the CSDR #117755 and documented as dropped on the floor by LPN #1 but lacked a co-signature by another nurse to indicate that the tablet was destroyed or wasted. Although requested, the facility was unable to provide CSDR #117755 disposition tracking form during survey. Review of the State Agency Facility Licensing & Investigation Section (FLIS) Reportable Events website failed to identify the State Agency was notified. Interview and review of facility investigative documents on 11/18/2024 at 9:30 AM with the former DNS/RN #3 identified she completed an investigation on 5/2024 for suspected drug diversion. RN #3 identified the facility suspected drug diversion by LPN #1 and the results of the facility investigation led her to report LPN #1 to the Department of Consumer Protection (DCP) for possible narcotic diversion, and a representative of that Department was on site on 5/15/2024. The DNS stated she did not notify the State Agency FLIS and she was unaware that diversion of resident's medications was abuse/misappropriation. The facility Abuse CT Policy dated 3/20/2024 directed in part that misappropriation of resident property is prohibited. Misappropriation of Resident Property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings without the resident's consent. The Policy further directed allegations of abuse will be promptly reported, and misappropriation of property was to be reported to the Department of Public Health immediately but not more than 2 hours after the allegation is made.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on review of the clinical record, facility documentation, facility policy and interviews for nine of eleven residents (Residents #1, 2, 3, 4, 5, 6, 7, 8 and 9) reviewed for misappropriation, the facility failed to maintain controlled drug accountability records controls sheets (CDSR) as required. The findings include: 1. Resident #1 was admitted with diagnoses that included osteomyelitis, and contractures. An annual Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of eight (8) indicative of moderately impaired cognition, and occasionally experienced pain in the last five (5) days. The Resident Care Plan (RCP) dated 3/25/2024 identified Resident #1 was at risk for skin breakdown. RCP directed to assist with repositioning changes, offer right hand wrist splints and wound care as ordered. A physician order dated 5/2/2024 directed to administer Oxycodone (a narcotic pain medication) immediate release (IR) 10 milligram (mg) tablet by mouth every eight (8) hours. A review of the controlled substance distribution record (CDSR) #118721 received 5/7/2024, identified LPN #1 had documented on 5/7/2024 one tablet of Oxycodone IR 10 mg had been popped in error and on 5/8/2024, LPN #1 identified that another Oxycodone IR 10 mg tablet had been dropped. Neither had a co-signature that the tablet was destroyed. Interview and record review with the prior DNS/RN #3 on 11/18/2024 at 9:30 AM identified following CDSR forms were missing or illegible: The CDSR forms for Resident #1's Oxycodone IR 10 mg tablets every 8 hours CDSR #118750 received 5/4/2024 had something spilled on it so signatures could not be clearly identified, and all signatures appeared to all belong to LPN #1. CDSR sheet #129620 received 4/23/2024 was missing. RN #3 was unable to explain where the sheet was. CDSR sheets #129340 received on 4/17/2024 was missing. 2. Resident #2 was admitted with diagnoses that included polyneuropathy (damage of the peripheral nerves, affecting the skin, muscles and organs) and diabetes mellitus. The quarterly MDS assessment dated [DATE] occasionally experienced pain in the last five (5) days. The RCP dated 3/27/2024 identified that Resident #2 had pain due to neuropathy, scoliosis (curvature of the spine) and osteoporosis (bones become weak and brittle). A physician progress note dated 3/27/2024 identified Resident #2 was alert and oriented to person, place and time. A physician order dated 3/27/2024 directed to administer Oxycodone (a narcotic pain medication) immediate release (IR) 10 mg tablet, every night at bedtime. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #2's medication administration record (MAR) and the copy of the facility yellow proof of receipt CSDR #128616, thirty (30) tablets of Oxycodone IR 10 mg tablet were delivered to the facility on [DATE]. A facility audit/reconciliation completed on 4/19/2024 identified six (6) tablets remained out of the original thirty (30). A review of Resident #2's April MAR identified that ten (10) doses were documented as administered (nightly from 4/6 to 4/16/2024), leaving 14 tablets not remaining in the card and were unaccounted for (not signed as administered). Although requested, the facility was unable to provide the actual white CSDR sheet #128613 (used by nurses to sign when the drug is removed from the card) that is required to track the disposition of Resident #2's Oxycodone IR 10 mg tablet to be given every night at bedtime, and indicated it was missing. 3. Resident #3 was admitted diagnoses that included multiple myeloma not in remission, chronic pain and sciatica (pain that radiated down the right leg from the back). The quarterly MDS assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indication the resident was alert and oriented, and occasionally experienced pain in the last five (5) days. The RCP dated 3/20/2024 identified that Resident #3 needed help with activities of daily living (ADLs) due to melanoma cancer and a history of thoracic fracture. Interventions directed to follow up on unexplained pain. A physician order dated 5/6/2024 directed to administer Oxycodone immediate release (IR) 10 mg tablet, give one tablet by mouth every four hours as needed for pain. A review of Resident #3's MAR and CSDR #118644 provided by a Department of Consumer Protection (DCP) representative for Resident #3's Oxycodone IR 10 mg tablet (directions to give one tablet by mouth every four hours as needed for pain) indicated six (6) tablets were received by the facility on 4/30/2024. A review of Resident #3's MAR identified that on 5/13/2024, at 7:00 AM, one IR 10 mg tablet of Oxycodone was signed out on the CSDR #118644, but was not signed as administered by LPN on Resident #3's MAR. Although requested, the facility was unable to provide CSDR #118644 that is required to track the disposition Resident #3's Oxycodone immediate release (IR) 10 mg tablet, give one tablet by mouth every four hours as needed for pain and indicated it was missing. Interview and record review with the prior DNS/RN #3 on 11/18/2024 at 9:30 AM identified the CSDR #129975 received on 4/30/2024 for Resident #3's Oxycontin Extended Release (ER) form was missing. 4. Resident #4 was admitted with diagnoses that included bipolar disorder and post-traumatic stress syndrome. An annual MDS assessment dated [DATE] identified Resident #4 had a BIMS of fifteen (15) indicating the resident was alert and oriented. The RCP dated 2/14/2024 identified Resident #4 had back pain. Interventions directed to provide a back brace and medication as ordered. A physician's order dated 3/25/2024 directed to administer Tramadol 50 mg, one (1) tablet by mouth every 24 hours as needed for pain. A CDSR sheet # 129043 for Resident #4's Tramadol 50 mg, one (1) tablet by mouth every 24 hours as needed for pain identified smudges that obscured signatures that prevented accurate tracking of distribution of the medication. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review with the prior DNS/RN #3 on 11/18/2024 at 9:30 AM identified the CDSR #129043 received for Resident #4 on 4/12/2024 was originally found to be missing had smudges that made it difficult to read. 5. Resident #5 was admitted with diagnoses that included fracture of the right lower leg. An admission MDS dated [DATE] identified Resident #5 required assistance with ADLs. A physician history and physical dated 4/8/2024 identified Resident #5 was alert and oriented to place, time and person. A physician order dated 3/30/2024 directed to administer Oxycodone IR 5 mg tablet, give one tablet by mouth every six (6) hours as needed for pain. Although requested, the facility was unable to provide CSDR #129063 that is required to track the disposition Resident #5's Oxycodone IR 5 mg tablet and indicated the form was missing. Interview and record review with the prior DNS/RN #3 on 11/18/2024 at 9:30 AM identified the CDSR #129063 form received on 4/12/2024 for Resident #5 for Oxycodone IR 5mg, was missing. 6. Resident #6 was admitted with diagnoses that included osteoarthritis qof the right shoulder. A quarterly MDS dated [DATE] identified Resident #6 had a BIMS of fifteen (15) (was alert and oriented) and was independent for mobility. A physician order dated 3/30/2024 directed to administer to administer Tramadol 50 mg, one (1) tablet via GT every 6 hours as needed for pain. Although requested, the facility was unable to provide CSDR #128518 that was required to track the disposition of Resident #6's Tramadol 50 mg; it was missing. Interview and record review with the prior DNS/RN #3 on 11/18/2024 at 9:30 AM identified the CDSR form #128518 received on 4/4/2024 for Resident #6 for Tramadol 50 mg, was missing. 7. Resident #7 was admitted with diagnoses that included chronic pain and a history of opioid abuse. A quarterly MDS dated [DATE] identified Resident #7 had a BIMS of fifteen (15) meaning (was alert and oriented) and required limited assistance for mobility. A physician's order dated 4/27/2024 directed Hydrocodone -APAP 5mg/325mg, 1 tablet by mouth every 12 hours as needed for pain. Although requested, the facility was unable to provide CSDR #129907 that is required to track the disposition Resident #7's hydrocodone -APAP 5mg/325mg, 1 tablet by mouth every 12 hours as needed for pain; it was missing. Interview and record review with the prior DNS/RN #3 on 11/18/2024 at 9:30 AM identified the CDSR form #129907 received for Resident #7 for Hydrocodone -APAP 5mg/325mg, was missing. (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	11/20/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Resident # 9's diagnoses included cancer and osteomyelitis. An admission MDS assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicating the resident was alert and oriented. The RCP dated 12/28/2024 identified Resident #9 had pain due to multiple surgeries, cancer and needed medication to manage the pain. Interventions directed to provide pain medication as ordered and observe effectiveness, and if breakthrough pain to offer another one of the prescribed pain medications. A physician's order dated 1/22/2024 directed to administer Oxycodone IR 10 mg tablet, give one tablet by mouth every eight hours as needed for pain. A review of Resident #9's MAR and CSDR numbered #117755 provided by DCP representative for Resident #9's Oxycodone IR 10 mg tablet, give one tablet by mouth every eight hours as needed for pain, identified that on 1/29/2024, at 6:00 PM, one (1) IR 10 mg tablet of Oxycodone was signed out on the CSDR #117755 and documented as dropped on the floor by LPN #1 but lacked a co-signature by another nurse to indicate that the tablet was destroyed or wasted. Although requested, the facility was unable to provide CSDR #117755 disposition tracking form that is required to track the disposition Resident #9's oxycodone IR 10 mg tablet, give one tablet by mouth every eight hours as needed for pain; it was missing. Interview and review of investigative documents on 11/18/2024 at 9:30 AM with the former DNS/RN #3 identified CDSR sheets described above, used by the nurses to sign the medications out of the resident supply, were missing and stated she suspected the missing sheets were related to a drug diversion. RN #3 identified the controlled medications come with two (2) CDSR sheets: a white page for the nurses to sign the medications out of the resident supply, and a yellow copy that is kept in the DNS office and used to reconcile the medications to ensure the counts are accurate. RN #3 stated some of the white sheets had obscured signature, and some were missing a second signature required to verify when a medication is destroyed. Although attempted, an interview with LPN #1was not obtained during survey. The facility policy Controlled Substance Handling directed in part, that all controlled drugs were subject to special handling, storage and record keeping. A controlled drug accountability record (CDRS sheet) will be prepared and immediately following an administration of a dose, the licensed nurse will enter the date of time of administration, dose administered, signature of the nurse administering. If one or more doses of the controlled substance is removed from the container and cannot be returned to the blister pack it must be destroyed in the presence of two licensed nurses and documented by both nurses in the accountability record. All controlled substance accountability records and audit records on file for a period of no less than five years.

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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** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #12) reviewed for accidents, the facility failed to ensure complete documentation regarding resident behaviors and failed to ensure that administered medications were signed off and the effectiveness of the medications were documented on in the clinical record. Resident #12's diagnoses included dementia, schizophrenia and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #12 had a Brief Mental Interview for Mental Status (BIMS) of twelve (12) indicative of a moderate cognitive impairment and required set-up assistance for bed mobility, transfers and ambulation. The Resident Care Plan (RCP) dated 10/3/24 identified that Resident #12 has altered mood and behavior secondary to schizophrenia and will often start speaking about God and asking for forgiveness with interventions that included to observe for an indication of increased anxiety and use a calm, gentle approach in attempting verbal redirection and support. A physician's order dated 9/4/24 directed to administer Ativan 2 milligram (mg) (an anti-anxiety medication) by mouth every six (6) hours as needed for anxiety or agitation. Review of facility Reportable Event (RE) dated 11/1/24 identified that at 10:30 PM Resident #12 was running uncontrollably in the hallway and accidentally hit his/her hand on the wall causing an injury. The RE identified that the APRN was notified, and the resident was sent to the Emergency Department (ED) for evaluation where he/she was found to have a partial traumatic amputation of the left ring finger through the phalanx (bone towards the tip of the finger). Review of a narcotic disposition log identified that Ativan 2 mg was administered to Resident #12 at 7:00 PM on 11/1/24. a. Review of the November 2024 Behavior Intervention Flow Record for Resident #12 identified that the resident has a history of behaviors including jumping over objects, paranoia, delusions, restlessness, physical aggression, pacing, running in the hallway, asking others if they can help him/her find God and insomnia, but failed to document any of those behaviors for the 3:00 PM to 11:00 PM shift on 11/1/24. b. A physician's order dated 9/4/24 directed to administer Ativan 2 mg, one (1) tablet by mouth every six (6) hours as needed for anxiety or agitation. (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 #4 on 11/22/24 at 3:33 PM identified that although she did not document on the MAR for Resident #12 and should have, she did administer Ativan 2 mg to Resident #4 on 11/1/24 at 7:00 PM, reporting that she forgot to document the administration, as a lot was going on that night, and she was very busy. She identified that although she also did not document the effectiveness of the medication, the Ativan was ineffective. She reported that looking back, she should have contacted the on-call provider and requested an additional order prior to 7:00 PM, stating that Resident #12 had behaviors for at least a few hours prior to the subsequent incident where he/she hurt their hand. Additionally, she identified that she should have documented the resident's behaviors on the Behavior Intervention Flow Record but stated that she also forgot due to all the commotion on the unit that shift. Interview and clinical record review with the DNS on 11/22/24 at 3:38 PM identified that LPN #4 should have documented the administration of the Ativan 2 mg to Resident #12 on the MAR for the 11/1/24 7:00 PM dose, as well as documenting behaviors. Review of the Behavior Monitoring policy dated 11/28/23 directed, in part, that the licensed nurse will monitor and document the number of behavioral episodes by shift with initials. A blank box indicates no behavior was present that shift. Although requested, a policy on Nursing Documentation was not provided.