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	06/05/2025

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 - Some	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** Based on review of clinical records, interviews, facility documents and facility policy for five (5) of six (6) residents (Resident #1, #2, #3, #4, and #6,) reviewed for abuse, the facility failed to ensure residents were kept safe from abuse. The findings included: 1a. Resident #1 was admitted to the facility in December of 2022 with diagnoses that included paranoid schizophrenia, Type 2 diabetes mellitus, and mild cognitive impairment. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 99) and required partial assistance with bathing, dressing, and personal hygiene. The Resident Care Plan (RCP) dated 2/3/25 identified Resident #1 enjoyed smoking. Interventions directed to observe for any signs and symptoms of unsafe smoking and supervision by staff while smoking on the patio. 1b. Resident #2 was admitted to the facility in August of 2020 with diagnoses that included schizophrenia, bipolar disorder, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12) and was independent with eating, oral and personal hygiene, and mobility. The RCP dated 2/10/25 identified Resident #2 had schizophrenia, agitation, a history of inappropriate and aggressive behavior, a history of altercations with peers and staff, and often became quickly agitated. Interventions directed to observe for lethargy, mood or behavior changes, redirect when agitated, and encourage to seek assistance from staff when feeling anxious or restless. 1c. Resident #3 was admitted to the facility in November of 2021 and had diagnoses which included dementia, psychotic, mood and anxiety disturbance. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12), required set-up assistance with oral hygiene, toileting and personal hygiene and was independent with mobility. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RCP dated 2/25/25 identified Resident #3 enjoyed smoking and that he/she was independent for meeting emotional, intellectual, physical, and social needs. Interventions directed to observe for any signs and symptoms of unsafe smoking and supervision when smoking on the patio. The Reportable Event report dated 3/31/25 identified Resident #2 struck Resident #1 several times in the face. Review of written statements pertaining to the 3/31/25 incident identified Resident #1 had just finished smoking and was sitting in his/her wheelchair when a peer hit him/her once in the face. Interview with the Director of Nurses (DNS) on 6/4/25 at 10:17 AM identified Resident #1 indicated Resident #2 struck him/her in the face on 3/31/25 during a smoking session. The DNS further identified the residents were immediately separated, Resident #2 was put on 1:1 monitoring until deemed as not a harm to self or others, and was seen by psych on 4/1/25. Interview with Resident #3 on 6/4/25 at 2:11 PM identified he/she was a witness to the 3/31/25 altercation and witnessed Resident #2 hit Resident #1 in the face during a smoking session on 3/31/25. Resident #3 indicated Resident #1 was repeatedly saying he/she was dead, that Resident #2 stated he/she ain't dead and proceeded to hit him/her in the face with an opened hand. 2a. Resident #2 was admitted to the facility in August of 2020 and had diagnoses which included schizophrenia, bipolar disorder, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12) and was independent with eating, oral and personal hygiene, and mobility. The RCP dated 4/30/25 identified Resident #2 had impaired social interaction and a risk for harm, either self-directed or other-directed. Interventions directed to evaluate affect, monitor for presence of negative thoughts and feelings, and monitor for signs and symptoms of agitation. 2b. Resident #3 was admitted to the facility in February of 2024 and had diagnoses of paranoid schizophrenia, schizoaffective disorder, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was moderately cognitively impaired (Brief Mental Interview for Mental Status (BIMS) score of 11), and required set-up assistance with oral hygiene, toileting and personal hygiene. The RCP dated 4/11/25 identified a behavior problem and use of psychotropic medications. Interventions directed to encourage the resident to express feelings appropriately and to administer psychotropic medications as ordered by the physician. The Reportable Event report dated 5/6/25 identified Resident #3 alleged he/she was slapped in the face by his/her roommate, Resident #2. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #1 on 6/4/25 at 12:36 PM identified he/she was informed during second shift on 5/6/25 that Resident #3 was hit in the face that morning and did not report the incident until that evening. RN #1 indicated Resident #3 did not report any pain and Resident #3 was moved to a new room that evening as Resident #3 indicated he/she did not want to sleep in the same room as Resident #2. RN #1 identified Resident #2 had a history of anger and erratic behavior. RN #1 identified that when he/she asked Resident #2 what happened earlier that day, Resident #2 reported hitting Resident #3 in the face that morning. Interview with the DNS on 6/5/25 at 8:40 AM identified fifteen (15) minute checks were initiated for Resident #2 following the incident and Resident #2 had a history of paranoia, unpredictable behaviors, and a history of slapping people. The DNS further indicated Resident #2 was provoked by people saying things he/she did not like and would become aggressive. 3a. Resident #2 was admitted to the facility in August of 2020 and had diagnoses which included schizophrenia, bipolar disorder, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12) and was independent with eating, oral and personal hygiene, and mobility. The RCP dated 4/30/25 identified Resident #2 had impaired social interaction and a risk for harm, either self-directed or other-directed. Interventions directed to evaluate affect, monitor for presence of negative thoughts and feelings, monitor for signs and symptoms of agitation, provide verbal feedback to the resident regarding behavior, and utilize diversion techniques as needed. 3b. Resident #4 was admitted to the facility in October of 2019 and had diagnoses which included epilepsy, schizophrenia, and generalized anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was cognitively intact (Brief Mental Interview for Mental Status (BIMS) score of 15), required substantial assistance with oral hygiene, toileting, and personal hygiene, and utilized a wheelchair. The RCP dated 5/8/25 identified Resident #4 required behavior management and had an activities of daily living deficit related to multiple co-morbidities. Interventions directed to ensure the safety of the resident and others, monitor for attempts to stand unassisted and redirect as needed, and to call for assistance for standing from wheelchair. The Reportable Events report dated 5/19/25 identified Resident #2 hit Resident #4 on the head after Resident #4 threw a chair at Resident #2 and called Resident #2 an a**h*** (profanity). Interview with the DNS on 6/5/25 at 8:40 AM identified interventions were added to Resident #2's care plan following each incident (3/31/25, 5/6/25, and 5/19/25). However, the DNS further indicated he/she was unsure if anything could be done to prevent Resident #2 from reacting aggressively towards others when provoked as Resident #2 could approach another resident and hit them without any indication. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 6/5/25 at 8:52 AM identified Resident #4 pushed a chair at Resident #2 and called him/her a profanity after he/she refused to share food purchased from an outside vendor. The DNS identified Resident #2 reacted and hit Resident #4 in the head. The DNS further indicated Resident #4 was unable to stand on his/her own without assistance, so it was questionable how he/she could have thrown a chair at Resident #2. Both residents were separated, placed on fifteen (15) minute checks, evaluated by psych on 5/20/25, and deemed safe to self and others. 4a. Resident #6 was admitted to the facility in February of 2023 and had diagnoses that included dementia, depression, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had a Brief Mental Interview for Mental Status (BIMS) score of four (4), indicating Resident #6 was severely cognitively impaired. The MDS further identified Resident #6 was independent with oral and toileting hygiene, and mobility. The RCP dated 4/10/25 identified Resident #6 had a behavior problem: was threatening to staff/peers, restlessness, resistive to care, yelling/screaming related to schizophrenia, dementia, anxiety, depression, and aggressive behavior. Interventions directed to assist the resident in developing appropriate methods of coping and interacting, monitor behavior episodes, and attempt to determine the underlying cause. 4b. Resident #7 was admitted to the facility in December of 2004 and had diagnoses which included dementia, schizophrenia, and repeated falls. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6), and required partial assistance with oral hygiene, toileting, and personal hygiene. The RCP dated 4/11/25 identified Resident #7 was at risk for falls related to confusion, deconditioning, gait/balance problems, incontinence, poor communication/comprehension, psychoactive drug use, and unaware of safety needs. Interventions directed to redirect from reaching into closet/trash barrel and that the resident needs a safe environment. The Reportable Events report dated 5/11/25 identified Resident #6 was observed punching Resident #7 in the face after telling Resident #7 to stop going through the garbage. Interview with the DNS on 6/5/25 at 11:26 AM identified redness was observed on the left side of Resident #7's face following the altercation and that Resident #6 reported Resident #7 was going to hit him/her, so he/she hit him/her. The DNS further identified Resident #7 did not hit Resident #6 during the altercation. Interview with the DNS on 6/5/25 at 11:30 AM identified that residents should be free from abuse of any kind and that interventions were added to the resident's care plans following incidents of abuse with the intent of preventing further incidents from occurring. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Abuse policy directed abuse, neglect, exploitation, and or mistreatment of residents or misappropriation of resident property was prohibited and that residents would 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.