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	01/05/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of five (5) residents (Resident #3) reviewed for opioid medication administration, the facility failed to ensure the resident was treated with dignity by changing the form of a prescribed opioid medication to crushed tablets without individualized assessment or honoring the resident's expressed preference. The findings include:Resident #3 was admitted to the facility with diagnoses that included osteomyelitis of vertebra, post-traumatic stress disorder and opioid dependence. A Provider's order dated 9/17/25 directed regular diet, regular consistency.A Provider's order dated 9/17/25 directed Naloxone (Narcan) 4 mg/0.1 1 spray in nostril as needed for suspected overdose and 1 ml intramuscular as needed for suspected overdose.A Provider's order dated 9/17/25 through 9/24/25 directed Hydromorphone two (2) mg give tablets by mouth every four (4) hours as needed for pain.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), ate independently and did not hold food in mouth and/or cheeks.The Resident Care Plan dated 9/24/25 identified Resident #3 was at risk for substance use related to a history of addiction and was receiving Medication Assisted Therapy (MAT). Interventions included to evaluate the need for psych/behavioral health consults, monitor laboratory test results, suboxone as ordered daily, and communicate the facility rules that the use of alcohol and non-prescribed drugs were not permitted while in the facility.A Provider's order dated 9/24/25 through 12/5/25 directed Hydromorphone two (2) mg three tablets by mouth every six (6) hours as needed for pain.A Provider's order dated 11/29/25 through 12/5/25 directed Hydromorphone four (4) mg one tablet by mouth every six (6) hours as needed for pain.A Provider's order dated 12/3/25 directed all narcotic medication be crushed prior to administration and given in residents choice of apple sauce or pudding.A Provider's order dated 12/5/25 through 12/12/25 directed Hydromorphone four (4) mg one tablet by mouth every eight (8) hours as needed for pain.A Provider's order dated 12/13/25 through 12/15/25 directed Hydromorphone four (4) mg one tablet by mouth every eight (8) hours as needed for pain.Interview with Resident #3 on 12/19/25 at 10:30 AM identified in December of 2025 there were controlled substances being used inappropriately by other residents within the facility. Resident #3 identified his/her Hydromorphone order was changed from whole tablets to crushed tablets. Resident #3 indicated the APRN changed the order to crushed tablets to avoid misuse of the tablets. Resident #3 identified other resident's had orders that were changed to crushed tablets but were changed back to whole tablets. Resident #3 identified he/she did not want his/her medication to be crushed and confirmed the nursing staff, DNS, and APRN were aware of this preference, but the order remained to crush the tablets.Interview with APRN #1 on 12/17/25 at 1:50 PM identified that toward the beginning of December there were concerns of controlled substances being misused in the facility so she changed Resident #3's Hydromorphone to crushed tablets to ensure he/she would not pocket the medication or give the medication to (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other residents. APRN #1 identified any resident who had an order for Hydromorphone and a diagnosis of opioid use disorder had an order change from whole tablet form to crushed.Interview with the DNS on 12/19/25 at 9:36 AM identified some residents with a history of substance use disorder have controlled substances administered in a crushed form. She identified mouth checks were regularly performed after administration of controlled substances, but controlled substances were crushed to ensure they were not pocketed (the act of holding a medication in the mouth (such as in the cheek or under the tongue) instead of swallowing it as directed). She identified the facility does not have a policy for crushed medication practice. The DNS identified that she was aware Resident #3 had concerns regarding receiving Hydromorphone tablets crushed but the orders were changed to crushed form based on the APRNs discretion. She identified if a Provider's orders stated crushed tablets and a resident refused to take the medication crushed, the medication would be documented as refused.Review of the Residents [NAME] of Rights identified residents have the right to be treated with consideration, respect and full recognition of their dignity and individuality.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #5) reviewed for a change in condition, the facility failed to notify the physician and licensed nursing staff of a significant change in the resident's condition and failed to notify the physician when ordered interventions were ineffective. Specifically, the resident experienced ongoing vomiting, dry heaving, abdominal pain, and non-verbal signs of distress despite administration of PRN medications, and these changes were not timely reported or escalated. The findings include:Resident #5 was admitted to the facility with diagnoses that included chronic respiratory failure, sepsis, and heart failure.Physician's orders dated [DATE] directed Milk of Magnesia (MOM) 30 ml by mouth as needed for constipation and Bisacodyl 10 mg rectally as needed if MOM was ineffective.The Nursing admission assessment dated [DATE] identified Resident #5 was alert and oriented to time, place, person, and situation, had an indwelling Foley catheter, and was always incontinent of bowel.The Resident Care Plan dated [DATE] identified Resident #5 had bowel and bladder incontinence. Interventions included encouraging fluids during the day to promote prompted voided response, check every two hours for incontinence, use of disposable briefs and to change as needed. The RCP further identified Resident #5 was at risk for substance use related to a history of addiction. Interventions included diversion with alternative activities and evaluation of the need for psych and/or behavioral health consults.A physician's order dated [DATE] at 7:39 PM directed Ondansetron 4 mg by mouth every six (6) hours as needed for nausea and vomiting.Review of the Medication Administration Record (MAR) dated [DATE] identified Ondansetron was administered to Resident #5 at 9:00 PM for nausea and vomiting.An abdominal scan dated [DATE] at 9:11 PM identified diffuse constipation with no large or small bowel obstruction.Review of the MAR dated [DATE] identified Bisacodyl was administered to Resident #5 at 10:45 PM; however, the MAR failed to identify administration of MOM and failed to document the effectiveness of either intervention.Interview with NA #1 on [DATE] at 1:26 PM identified she was assigned to provide care for Resident #5 from 11:00 PM through 7:00 AM on [DATE] into [DATE]. She identified at the start of the shift she was notified Resident #5 vomited and she cleaned up Resident #5 and then he/she vomited again. NA #1 identified she reported the vomiting to LPN #1. NA #1 further identified that at approximately 3:00 AM Resident #5 was dry heaving and vomiting, and at approximately 6:45 AM Resident #5 was groaning and moaning with eyes closed. NA #1 identified she did not notify licensed nursing staff of the dry heaving, vomiting or groaning and moaning (non-verbal signs of pain).Interview with RN #2 on [DATE] at 1:56 PM identified she was the nursing supervisor from 8:00 AM to 8:00 PM on [DATE]. RN #2 identified she was notified by LPN #1 that Resident #5 had vomited and complained of abdominal pain. RN #2 assessed Resident #5, contacted the APRN, and received orders for a kidney, ureter, and bladder (KUB) x-ray and Ondansetron for nausea. RN #2 identified she provided shift report to RN #3 and informed her that Resident #5 had vomited, vital signs were stable, and to follow up on the KUB results.Interview with RN #3 on [DATE] at 12:15 PM identified she was the nursing supervisor from 8:00 PM to 8:00 AM on [DATE] into [DATE]. RN #3 identified that around 10:30 PM she was notified by LPN #1 that Resident #5 vomited. RN #3 assessed Resident #5, reviewed KUB results which identified constipation, and notified the APRN. The APRN ordered MOM in prune juice and a suppository, which RN #3 indicated were administered by LPN #1. RN #3 identified Resident #5 refused transfer to the hospital. RN #3 further identified she checked on Resident #5 at approximately 4:00 to 4:30 AM and observed no apparent distress. RN #3 identified that at approximately 7:30 AM she directed NA #3 to determine whether Resident #5 had a (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bowel movement following administration of the ordered medications (approximately seven and a half hours after MOM was administered). NA #3 reported Resident #5 was not responding and at approximately 7:35 AM, RN #3 called a code and CPR was initiated. Emergency Medical Services (EMS) arrived and continued the code until Resident #5 was pronounced deceased .Interview with LPN #1 on [DATE] at 2:11 PM identified she was assigned to provide care for Resident #5 during the 3:00 PM to 11:00 PM shift on [DATE] and continued care into the 11:00 PM to 7:00 AM shift on [DATE] into [DATE]. LPN #1 identified she administered Ondansetron to Resident #5 at approximately 7:30 PM and noted improvement. She identified that at approximately 10:30 PM Resident #5 vomited multiple times and she believed Resident #5 should be transferred to the hospital. LPN #1 identified she administered MOM at approximately 12:00 AM; however, the administration and outcome were not documented. LPN #1 stated she last observed Resident #5 at approximately 6:00 AM resting and requesting water. She identified she would have checked on Resident #5 if she were made aware Resident #5 was groaning and moaning at 6:45 AM.Interview with APRN #1 on [DATE] at 1:40 PM identified if PRN medications were ineffective or symptoms persisted, the physician or APRN should have been contacted for additional evaluation and orders. APRN #1 further identified Resident #5 had standing orders for Tylenol which could have been administered if Resident #5 was experiencing pain.Interview with the DNS on [DATE] at 12:00 PM identified the need for follow up assessment after the administration of MOM depends on the resident and could range anywhere from an hour to a few hours after administration. She further identified a new onset of moaning/groaning could be a sign or symptom of pain and a nurse should be notified for further assessment.Review of the Physician Notification - Change of Condition policy identified a change in condition is a significant clinical symptom(s) or development, which requires assessment and intervention. If a resident is evaluated by a charge nurse to have a change in condition, the change nurse will notify the RN supervisor. The RN supervisor will do a follow up assessment to ensure that the assessment is documented and reported to the physician. The physician will be contacted to report findings. The nurse will obtain new orders as warranted from the physician. The nurse will document in the nurses notes regarding assessments, findings, changes, physician notified and resident and/or responsible party notification.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of two (2) residents (Resident #6) reviewed for opioid use disorder, the facility failed to develop and implement a person-centered care plan with appropriate interventions to address the resident's identified risk for substance use disorder (SUD) and receipt of Medication Assisted Treatment (MAT). The findings include: Resident #6 was admitted to the facility on [DATE] with diagnoses that included psychoactive substance abuse and opioid dependence with withdrawal. The nursing assessment dated [DATE] identified Resident #6 was alert and oriented to person, time, place and situation and further identified Resident #6 used fentanyl within the past thirty (30) days.The Resident Care Plan (RCP) dated 9/23/25 identified Resident #6 was at risk for substance use related to a history of addiction and was receiving MAT. The RCP failed to identify interventions for the risk of substance use and MAT.Physician's orders dated 9/23/25 directed Naloxone (Narcan) 4 mg/0.1 ml (medication used to rapidly reverse an opioid overdose) 1 spray in nostril as needed for suspected overdose and 1 ml intramuscular as needed for suspected overdose.The Social Worker (SW) Initial assessment dated [DATE] identified Resident #6 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15).A Physician's order dated 9/24/25 directed Methadone (opioid medication used to treat opioid use disorder) 50 mg by mouth once a day for opioid use.The Medication Administration Record (MAR) identified Resident #6 was administered Methadone on 9/24/25, 9/25/25, 9/26/25, 9/27/25, 9/28/25 and 9/30/25.Review of the clinical record failed to identify psychiatric/psychology services or contracted SUD program services were offered, were provided or were refused.A note by RN #1 dated 9/30/25 at 2:13 PM identified Resident #6 was lethargic, drowsy, difficult to arouse, and fell back to sleep easily. A sternal rub was administered, and Resident #6 opened his/her eyes then immediately closed them. Resident #6 had bilateral pinpoint pupils and was administered a first dose of Narcan at 1:30 PM with no response. A second dose of Narcan was administered at 1:31 PM with a positive response and Resident #6 began to speak. Resident #6 admitted to using illegal stuff and security was called.A note by SW #1 dated 9/30/25 at 5:59 PM identified she was called to Resident #6's room by security to conduct a room search. Five (5) bags of a suspicious substance were found.An APRN note dated 9/30/25 identified she was asked to see Resident #6 due to lethargy, drowsiness, difficulty waking up with sternal rub, and receiving two (2) doses of Narcan. Resident #6 admitted to using fentanyl that he/she reported bringing into the facility at the time of admission. She ordered Resident #6 be transferred to the emergency department (ED) for further evaluation. The Narcan Administration Report dated 9/30/25 identified at 1:30 PM Resident #6 was administered Narcan due to lethargy, drowsiness, difficulty arousing and pinpoint pupils. Narcan was administered at 1:30 PM, was ineffective, and administered at 1:31 PM, which was effective. Five (5) empty packets were found by security and flushed down the toilet.The Hospital report dated 9/30/25 identified Resident #1 presented to the ED due to altered mental status. The toxicology screen drawn 9/30/25 resulted positive for opiates and fentanyl on 10/1/25. Interview with Security #1 on 12/19/25 at 10:00 AM identified Resident #6 was visited by his/her family member on the morning of 9/30/25 in his/her private room. He identified he stayed in the room during the visit and did not see any objects being passed from the family member to Resident #6. He identified Resident #6's family member did not use Resident #6's bathroom and was escorted to the lobby after the visit. Although requested, Resident #6's visitor log was not provided. He further identified that after the overdose event on 9/30/25, he was called into Resident #6's room to perform a room search. He identified that he searched Resident #6 and asked him/her to take (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her hat off. He identified five (5) empty bags tucked into his/her hat. He identified that he flushed the bags down the toilet and Resident #6 told him that the bags were brought with him/her on admission to the facility. Security #1 further identified a room search was conducted on admission to the facility but no further room searches were conducted until the 9/30/25 overdose event. Interview with RN #1 on 12/19/25 at 1:30 PM identified she was the RN supervisor on 9/30/25. She identified she was notified by the Charge Nurse of Resident #6's change in condition and that she administered the Narcan. RN #1 identified Resident #6 admitted to using illegal substances that day. Interview with the DNS on 12/19/25 at 10:00 AM identified Resident #6's risk for substance use and MAT plan of care was initiated but not completed. She identified that due to his/her known history of SUD, the RCP should have included specific interventions including supervised visits, random room searches, random urine toxicology screens and support services. She further identified Resident #6 had no prior room searches. She identified that room searches would be conducted if there was suspicion or observed contraband. She identified the police were not notified if the incident and suspected contraband found because the bags were empty. Although requested, the DNS identified the facility does not have a policy or procedure for suspected drug overdose. Interview with SW #1 on 12/19/25 at 1:50 PM identified on 9/30/25 she was called to Resident #6's room to assist with a room search. She identified she observed five (5) dime bags which contained white residue. She identified the bags were discovered tucked into the folded rim of Resident #6's hat. She further identified she ran the recovery program in the facility and the services offered were through an outside vendor who visited the facility one (1) to two (2) times per week to offer support for residents with SUD. SW #1 indicated Resident #6 was offered support for his/her SUD but refused. SW #1 could not identify why the refusal of services from a high-risk resident was not documented in the clinical record and could not identify alternative interventions offered post refusal. Review of the clinical record failed to identify refusal of treatment. Review of the Care Plan Policy directed for the care plan to contain resident's goals, resident's strengths, resident's preferences, identified problems, measurable realistic goals and the interventions to be utilized to reach the goals.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation/policy, and staff/security interviews for two of two residents reviewed for opioid overdose risk (Residents #2 and #6), the facility failed to identify and control accident hazards and provide adequate supervision and safety interventions for residents with known opioid use disorder-by admitting Resident #6 with recent fentanyl use without establishing a completed, risk based plan of care with specific controls (e.g., supervised visits, random room searches, visitor log management, random urine toxicology, and documented substance use disorder (SUD) support/refusal handling), by lacking an overdose/Narcan protocol, by failing to contact law enforcement when illegal drugs were suspected or observed, and by failing to maintain chain of custody for contraband-resulting in Resident #6 requiring two Narcan doses for suspected fentanyl overdose and Resident #2's death due to acute intoxication (fentanyl, gabapentin, sertraline). These failures resulted in a noncompliance finding of Immediate Jeopardy. The findings include:1.Resident #6 was admitted to the facility on [DATE] with diagnoses that included psychoactive substance abuse and opioid dependence with withdrawal. The nursing assessment dated [DATE] identified Resident #6 was alert and oriented to person, time, place and situation and further identified Resident #6 used fentanyl within the past thirty (30) days.The Resident Care Plan (RCP) dated [DATE] identified Resident #6 was at risk for substance use related to a history of addiction and was receiving Medication Assisted Treatment (MAT). The RCP failed to identify interventions for the risk of substance use and MAT.Physician's orders dated [DATE] directed Naloxone (Narcan) 4 mg/0.1 ml (medication used to rapidly reverse an opioid overdose) 1 spray in nostril as needed for suspected overdose and 1 ml intramuscular as needed for suspected overdose.The Social Worker (SW) Initial assessment dated [DATE] identified Resident #6 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15).A Physician's order dated [DATE] directed Methadone (opioid medication used to treat opioid use disorder) 50 mg by mouth once a day for opioid use.The Medication Administration Record (MAR) identified Resident #6 was administered Methadone on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE].Review of the clinical record failed to identify psychiatric/psychology services or contracted SUD program services were offered, were provided or were refused.A note by RN #1 dated [DATE] at 2:13 PM identified Resident #6 was lethargic, drowsy, difficult to arouse, and fell back to sleep easily. A sternal rub was administered, and Resident #6 opened his/her eyes then immediately closed them. Resident #6 had bilateral pinpoint pupils and was administered a first dose of Narcan at 1:30 PM with no response. A second dose of Narcan was administered at 1:31 PM with a positive response and Resident #6 began to speak. Resident #6 admitted to using illegal stuff and security was called.A note by SW #1 dated [DATE] at 5:59 PM identified she was called to Resident #6's room by security to conduct a room search. Five (5) bags of a suspicious substance were found.An APRN note dated [DATE] identified she was asked to see Resident #6 due to lethargy, drowsiness, difficulty waking up with sternal rub, and receiving two (2) doses of Narcan. Resident #6 admitted to using fentanyl that he/she reported bringing into the facility at the time of admission. She ordered Resident #6 be transferred to the emergency department (ED) for further evaluation. The Narcan Administration Report dated [DATE] identified at 1:30 PM Resident #6 was administered Narcan due to lethargy, drowsiness, difficulty arousing and pinpoint pupils. Narcan was administered at 1:30 PM, was ineffective, and administered at 1:31 PM, which was effective. Five (5) empty packets were found by security and flushed down the toilet.The Hospital report dated [DATE] identified Resident #1 presented to the ED due to altered mental status. The toxicology screen drawn [DATE] resulted positive for opiates and fentanyl on [DATE]. Interview with (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Security #1 on [DATE] at 10:00 AM identified Resident #6 was visited by his/her family member on the morning of [DATE] in his/her private room. He identified he stayed in the room during the visit and did not see any objects being passed from the family member to Resident #6. He identified Resident #6's family member did not use Resident #6's bathroom and was escorted to the lobby after the visit. Although requested, Resident #6's visitor log was not provided. He further identified that after the overdose event on [DATE], he was called into Resident #6's room to perform a room search. He identified that he searched Resident #6 and asked him/her to take his/her hat off. He identified five (5) empty bags tucked into his/her hat. He identified that he flushed the bags down the toilet and Resident #6 told him that the bags were brought with him/her on admission to the facility. Security #1 further identified a room search was conducted on admission to the facility but no further room searches were conducted until the [DATE] overdose event. Interview with RN #1 on [DATE] at 1:30 PM identified she was the RN supervisor on [DATE]. She identified she was notified by the Charge Nurse of Resident #6's change in condition and that she administered the Narcan. RN #1 identified Resident #6 admitted to using illegal substances that day. Interview with the DNS on [DATE] at 10:00 AM identified Resident #6's risk for substance use and MAT plan of care was initiated but not completed. She identified that due to the known history of SUD, the RCP should have included specific interventions including supervised visits, random room searches, random urine toxicology screens and support services. She further identified Resident #6 had no prior room searches. She identified that room searches would be conducted if there was suspicion or observed contraband. She identified the police were not notified if the incident and suspected contraband found because the bags were empty. Although requested, the DNS identified the facility does not have a policy or procedure for suspected drug overdose. Interview with SW #1 on [DATE] at 1:50 PM identified on [DATE] she was called to Resident #6's room to assist with a room search. She identified she observed five (5) dime bags which contained white residue. She identified the bags were discovered tucked into the folded rim of Resident #6's hat. She further identified she ran the recovery program in the facility and the services offered were through an outside vendor who visited the facility one (1) to two (2) times per week to offer support for residents with SUD. SW #1 indicated Resident #6 was offered support for his/her SUD but refused. SW #1 could not identify why the refusal of services from a high-risk resident was not documented in the clinical record and could not identify alternative interventions offered post refusal. Review of the clinical record failed to identify refusal of treatment. Review of the Notification of Hazardous or Precautionary Items form identified hazardous items, which the resident may not have in their possession while on facility property, include intoxicating substances and illegal drugs. If illegal drugs or dangerous/illegally maintained weapons are suspected or detected, the facility will contact the local law enforcement agency for assistance. The IJ template was presented to the Administrator on [DATE] at 3:28 PM for F689 failure to provide adequate supervision and implement necessary safety interventions for a resident with a known history of opioid use disorder and recent fentanyl use.The facility submitted a removal plan, which included ensuring new admissions with a known recent history of substance use would be evaluated for appropriate supervision based on a person-centered risk evaluation and with interventions initiated based on the level of risk. Nursing supervisors would be educated to ensure the RCP on admission, for residents with SUD, contained interventions to provide adequate support. Audits of RCPs for new admissions with a history of SUD would be conducted to ensure appropriate interventions and adequate supervision. The removal plan was accepted by the State Agency on [DATE] at 6:34 PM. 2. Resident #2 was admitted to the facility in February of 2025 with diagnoses that included opioid dependence, cocaine dependence and adjustment disorder.The (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	physician's orders dated [DATE] directed Naloxone (Narcan) 4 mg/0.1 ml 1 spray in nostril as needed for suspected overdose and Naloxone (Narcan) 4 mg/0.1 ml 1 ml intramuscular as needed for suspected overdose. The physician's order dated [DATE] directed Gabapentin 800 mg three times a day for pain. The Social Services quarterly note dated [DATE] identified Resident #2 was seen monthly and/or as needed for psychiatric services. The physician's order dated [DATE] directed room searches every shift daily. The quarterly MDS assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), was independent with bed mobility and transfers, required an assist of one staff for toilet use, and was always continent of bowel and bladder. The Resident Care Plan (RCP) dated [DATE] identified Resident #2 was at risk for substance use related to a history of addiction. Interventions included to observe signs/symptoms of withdrawal. The physician's order dated [DATE] directed Sertraline 50 mg once a day for anxiety. A nursing note by RN #3 dated [DATE] at 8:28 AM identified Resident #2 was observed sitting in a wheelchair with slightly slurred speech and dilated pupils. Resident #2 was able to follow finger movement with his/her eyes, had strong hand grasps, was able to follow directions and was alert and oriented to person, place and time. Resident #2 refused to give a toxicology sample because he/she did not need to use the bathroom. A room check was performed by staff, and no contraband was found. Resident #2 refused to go to the hospital. The RCP dated [DATE] identified Resident #2 was discovered with pupils dilated and slumped in wheelchair but was arousable. Interventions included 15 min checks, monitor laboratory tests, evaluate need for psych and reinforce recovery plan.The Room Search dated [DATE] identified no contraband found.Review of the 15 Minute Monitoring Resident Flowsheet dated [DATE] at 10:00 AM identified 15-minute checks were performed through [DATE] at 11:00 PM.A note by SW #1 dated [DATE] at 3:36 PM identified Resident #2 attended Recovery Group.A Psychotherapy note dated [DATE] identified Resident #2 was seen for mood support. Resident #2 appeared to maintain stable mood and coping with psychosocial stressors. Encouraged continued use of thought re-framing, social and independent activities for coping and relapse prevention. A DNS note dated [DATE] at 5:17 PM identified the DNS responded to a STAT (now) page on the unit at 12:50 PM. Resident #2 was on the floor in the bathroom, had a formed BM and did not respond to verbal or tactile stimuli. No pulse was found, CPR was initiated and 911 was called. Narcan was administered twice with no response. Resident #2 was transferred to the ED at 2:00 PM and the hospital called at 2:20 PM to report Resident #2 expired. Review of the hospital ED visit document dated [DATE] identified Resident #2 presented to the ED for cardiac arrest and suspected drug overdose. There was no toxicology reports identified. The document identified the physician spoke with facility staff who identified Resident #2 had a history of drug use and was noted to be hanging out with other residents who were known to use drugs. The document identified the Medical Examiner (ME) was contacted and took the case due to suspected drug use.Interview with the DNS on [DATE] at 12:00 PM identified she questioned whether to report Resident #2's unanticipated death to the State Agency. She identified the hospital record indicated the case would be picked up by the ME and she was awaiting the report. The DNS identified the facility did not contact the ME office for the cause of death. She further identified Resident #2 had no visitors the day he/she expired and no prior leaves from the facility. Review of the ME report on [DATE] identified the report was dated [DATE] and Resident #2's cause of death was acute intoxication due to the combined effects of Fentanyl, Gabapentin, and Sertraline.Re-Interview with the DNS (after review of the ME report) on [DATE] at 11:00 AM identified the RCP dated [DATE] for a risk of substance use included only one intervention which was to observe for signs and symptoms of withdrawal. The DNS identified RCPs are based on individual resident needs and additional interventions would only have been added after suspected (continued on next page)

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	075299	A. Building B. Wing	01/05/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	substance use. She identified minute 15-minute checks were performed for 72 hours after the suspected overdose on [DATE] and there was no additional monitoring thereafter. She identified there was documentation of Resident #2 attending group therapy once after [DATE], which was on [DATE], and further identified that neither the facility nor the group therapy vendor took attendance for group therapy sessions. The DNS identified that the SW was working on having an attendance list completed for each group therapy session moving forward. She identified Resident #2 had no medical reason for a decline, so when discovered unresponsive on [DATE], Narcan was administered due to a history of opioid dependence. She further identified that the facility provided annual staff education related to signs of opioid overdose and administration of Narcan, however there was no facility policy, procedure, or protocol for suspected drug overdose and Narcan administration.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for four (4) of nineteen (19) residents (Residents #7, #8, #9 and #10) reviewed for physician's visits, the facility failed to ensure physician orders were signed and dated with each physician visit per the minimum requirements of the Connecticut General Statute 19-13-D8t. The findings include:1. Resident #7 was admitted to the facility with diagnoses that included dementia and bipolar disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 00) and received antipsychotics on a routine basis.The Resident Care Plan dated 10/16/25 identified Resident #7 was at risk for complications related to the use of psychotropic drugs. Interventions included gradual dose reduction as ordered, monitor for continued need of medication related to behavior and mood and monitor for side effects.Provider orders identified monthly orders were signed by the APRN on 6/12/25. Review of Provider orders failed to identify orders signed for July 2025, August 2025, November 2025 and December 2025.2. Resident #8 was admitted to the facility with diagnoses that included dementia and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 00) and received antipsychotics on a routine basis.The Resident Care Plan dated 12/11/25 identified Resident #8 had hypertension with interventions that included to administer medications as ordered.Provider orders identified monthly orders were signed by the APRN on 10/14/25. Review of Provider orders failed to identify orders signed for November 2025 and December 2025.3. Resident #9 was admitted to the facility with diagnoses that included type II diabetes and schizophrenia.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11), received antipsychotics on a routine basis and received insulin injections for the past seven (7) days.The Resident Care Plan dated 12/29/25 identified Resident #9 had diabetes and interventions included to administer medication as ordered by the Doctor.Provider orders identified monthly orders were signed by the Physician on 9/24/25. Review of Provider orders failed to identify orders signed for October 2025, November 2025 and December 2025.4. Resident #10 was admitted to the facility with diagnoses that included schizophrenia and hyperlipidemia.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) scored of12) and received antipsychotics on a routine basis.The Resident Care Plan dated 12/11/25 identified Resident #10 had a diagnosis of schizophrenia with interventions that included to explain the importance of taking medication and the risks of not taking it. Provider orders identified monthly orders were signed by the Physician on 9/24/25. Review of Provider orders failed to identify orders signed for October 2025, November 2025 and December 2025.Interview with the DNS on 1/5/26 at 1:00 PM identified monthly orders are reviewed and signed in the medical records. She identified the practitioners, or the physician can sign off on resident orders. She further identified there is no policy for timeliness of signing off orders and that the facility follows the Connecticut Public Health Code of signing orders every sixty (60) days.

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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** Based on review of the clinical record, facility documentation, facility policy, and interviews for two (2) of three (3) residents (Resident #2 and Resident #5) reviewed for medication administration, the facility failed to maintain complete and accurate medical records by failing to document the administration of as-needed (PRN) medications and the resident's response to those medications in the medication administration record, in accordance with physician orders and facility policy. The findings include: 1. Resident #2 was admitted to the facility with diagnoses that included opioid dependance and cocaine dependence. The quarterly MDS assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was independent with bed mobility and transfers. The Resident Care Plan dated [DATE] identified Resident #2 was at risk for substance use related to a history of addiction. Interventions included to observe for signs and symptoms of withdrawal for detox, monitor laboratory test results, evaluate the need for psych/behavioral consults and reinforce the need for a plan for recovery and sobriety as a means of improving judgement and behavioral self-control to reduce probability of relapse.Physician's orders dated [DATE] directed Naloxone (Narcan) 4 mg/0.1 ml 1ml intramuscular as needed for suspected overdose and Naloxone (Narcan) 4 mg/0.1 ml 1 spray in nostril as needed for suspected overdose.A DNS note dated [DATE] at 5:17 PM identified the DNS responded to a STAT (now) page on the unit at 12:50 PM. Resident #2 was on the floor in the bathroom, had a formed BM and did not respond to verbal or tactile stimuli. No pulse was found, CPR was initiated and 911 was called. Narcan was administered twice with no response. Resident #2 was transferred to the ED at 2:00 PM and the hospital called at 2:20 PM to report Resident #2 expired. The Narcan Administration Report dated [DATE] identified at 12:50 PM Resident #2 was administered Narcan due to being unresponsive. Narcan was administered at 12:53 PM, was not effective, and a second dose was administered at 12:55 PM, and was not effective. A room search was conducted at 2:05 PM and no contraband was found.Review of the Medication Administration Record (MAR) for [DATE] failed to identify Narcan administration was documented as administered and its effectiveness.Interview with the DNS on [DATE] at 2:00 PM identified medications that are administered should be signed off in the MAR.2. Resident #5 was admitted to the facility with diagnoses that included chronic respiratory failure, sepsis and heart failure.Physician's order dated [DATE] directed Milk of Magnesia (MOM) 30 ml by mouth as needed for constipation.Physician's order dated [DATE] directed Bisacodyl Laxative 10 mg rectally as needed for constipation if MOM is ineffective.The Nursing admission assessment dated [DATE] identified Resident #5 was alert and oriented to time, place, person, and situation, had an indwelling Foley catheter, and was always incontinent of bowel.The Resident Care Plan dated [DATE] identified Resident #5 had bowel and bladder incontinence. Interventions included encouraging fluids during the day to promote prompted voided response, check every two hours for incontinence, use of disposable briefs and to change as needed. The RCP further identified Resident #5 was at risk for substance use related to a history of addiction. Interventions included diversion with alternative activities and evaluation of the need for psych and/or behavioral health consults.A physician's order dated [DATE] at 7:39 PM directed Ondansetron 4 mg by mouth every six (6) hours as needed for nausea and vomiting.Review of the Medication Administration Record (MAR) dated [DATE] identified Ondansetron was administered to Resident #5 at 9:00 PM for nausea and vomiting.An abdominal scan dated [DATE] at 9:11 PM identified diffuse constipation with no large or small bowel obstruction.Review of the MAR dated [DATE] identified Bisacodyl was administered to Resident #5 at 10:45 PM; however, the MAR failed to identify administration of MOM and failed to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document the effectiveness of either intervention.Interview with RN #2 on [DATE] at 1:56 PM identified she was the nursing supervisor from 8:00 AM to 8:00 PM on [DATE]. RN #2 identified she was notified by LPN #1 that Resident #5 had vomited and complained of abdominal pain. RN #2 assessed Resident #5, contacted the APRN, and received orders for a kidney, ureter, and bladder (KUB) x-ray and Ondansetron for nausea. RN #2 identified she provided shift report to RN #3 and informed her that Resident #5 had vomited, vital signs were stable, and to follow up on the KUB results.Interview with RN #3 on [DATE] at 12:15 PM identified she was the nursing supervisor from 8:00 PM to 8:00 AM on [DATE] into [DATE]. RN #3 identified that around 10:30 PM she was notified by LPN #1 that Resident #5 vomited. RN #3 assessed Resident #5, reviewed KUB results which identified constipation, and notified the APRN. The APRN ordered MOM in prune juice and a suppository, which RN #3 indicated were administered by LPN #1. RN #3 identified Resident #5 refused transfer to the hospital. RN #3 further identified she checked on Resident #5 at approximately 4:00 to 4:30 AM and observed no apparent distress. RN #3 identified that at approximately 7:30 AM she directed NA #3 to determine whether Resident #5 had a bowel movement following administration of the ordered medications (approximately seven and a half hours after MOM was administered). NA #3 reported Resident #5 was not responding and at approximately 7:35 AM, RN #3 called a code and CPR was initiated. Emergency Medical Services (EMS) arrived and continued the code until Resident #5 was pronounced deceased .Interview with LPN #1 on [DATE] at 2:11 PM identified she was assigned to provide care for Resident #5 during the 3:00 PM to 11:00 PM shift on [DATE] and continued care into the 11:00 PM to 7:00 AM shift on [DATE] into [DATE]. LPN #1 identified she administered Ondansetron to Resident #5 at approximately 7:30 PM and noted improvement. She identified that at approximately 10:30 PM Resident #5 vomited multiple times and she believed Resident #5 should be transferred to the hospital. LPN #1 identified she administered MOM at approximately 12:00 AM; however, the administration and outcome were not documented. Interview with the DNS on [DATE] at 12:00 PM identified it depends on the resident when a follow up assessment should be done after administering Milk of Magnesia. It could be anywhere from an hour to a few hours later.Review of the Administration Procedures for All Medications policy directed when administering as needed (PRN) medication, document the reason for giving, observe for medication actions/reactions, and record on the PRN effectiveness sheet or similar form.