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	05/28/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of three (3) sampled residents (Resident #2) who were reviewed for Resident Rights, the facility failed to allow Resident #2 to go on a leave of absence (LOA) with a family member and failed to trial unsupervised visitation. The findings include:Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of three (3) sampled residents (Resident #2) who were reviewed for Resident Rights, the facility failed to ensure Resident #2's right to go on a leave of absence (LOA) with a family member was granted and failed to trial unsupervised visitation. The findings include: Resident #2's diagnoses included cellulitis of the left lower extremity, psychoactive substance abuse, anxiety, and adjustment disorder. The Resident Care Plan dated 11/4/25 identified Resident #2 was at risk for substance use related to a history of addiction and receiving medication assisted treatment. Interventions directed to allow time for expression of feelings, provide empathy, encouragement and reassures, evaluate the need for psych/behavioral health consults, offer the opportunity to receive behavioral health services to address substance use, if determined to be at risk for illegal drug use while in the facility place on supervised visits and the interdisciplinary team (IDT) will re-evaluate weekly, if suspected of using illegal substances, the resident will be asked to provide a urine sample for urine toxicology screen (a test that measures illegal substances in the urine), the resident may be asked to have possessions or room searched if at risk of harmful items is suspected, monitor medications for potential contribution to substance use and/or drug interactions, observe after LOA for evidence of substance use and observe for signs/symptoms of withdrawal for detoxification. The admission Minimum Data Set assessment dated [DATE] identified Resident #2 was alert and oriented to person, place, and time and was independent with activities of daily living. The Situation, Background, Assessment and Recommendation (SBAR) note dated 12/1/25 at 10:00 AM identified Resident #2 had a person deliver bags of Fentanyl (an opioid pain medication) to the facility that morning. The note indicated the drugs were intercepted at the front desk at which time Resident #2 jumped at the receptionist to recover the drugs. The note identified Resident #2 reported to Emergency Medical Services (EMS) personnel he/she had used Fentanyl the day prior (11/30/25). The note identified Resident #2 was transferred to the Emergency Department (ED) at 12:00 PM. The nurse's note dated 12/1/25 at 10:51 PM identified Resident #2 returned to the facility at 10:00 PM, Resident #2 was to have no visitors, and was placed on one (1) to one (1) (1:1) observation for the next twenty-four (24) hours. The nurse's note dated 12/2/25 at 1:26 AM identified a room search was done at 5:05 PM per security with a nurse aide present, negative results and Resident #2 returned from the ED at 9:41 PM. The note indicated orders upon return: no visitors, no parcels or deliveries, and 1:1 every shift for twenty-four hours. Review of the clinical record from 12/2/25 through discharge on [DATE] identified Resident #2 remained on supervised visitation. The Travel Pass Request Form dated 4/30/26 identified Resident #2 requested a LOA on 5/2/26 from 10:00 AM to 3:00 PM. The Resident LOA Approval form dated 5/2/26 identified Resident #2's LOA request for 5/2/26 was denied, there was no reason documented (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the denial, and there was only one (1) signature of the Inter Disciplinary Team (IDT) Committee Review noted. The Travel Pass Request form dated 5/15/26 identified Resident #2 again requested a LOA from 10:00 AM to 3:00 PM. The Resident LOA Approval form dated5/15/26 identified Resident #2's LOA request for 5/16/26 was denied there was no reason documented for the denial, and there was only one (1) signature of the Inter Disciplinary Team (IDT) Committee Review noted. Review of the electronic medical record (EMR) failed to identify documentation regarding approval or denial of the LOA's. Interview with the Director of Nursing (DON) and administrator on 5/22/26 at 2:19 PM identified when a resident was admitted and has a history of substance abuse, the resident was placed on supervised visits. The DON and administrator indicated Resident #2 had been on supervised visits since the time of admission and requested LOA twice since admission and both requests were denied. The DON and administrator explained Resident #2 had a long history of substance use and shortly after admission Resident #2 had a visitor attempt to pass a candy box that contained a large amount of Fentanyl, with the intent to use and sell, and this was confiscated by the receptionist prior to the drugs being in Resident #2's possession. The DON and administrator identified Resident #2 has had no further incidents of visitors attempting to bring in drugs secondary to Resident #2 having supervised visits. The DON and administrator identified when a resident requests a LOA, the request was reviewed by the IDT team to determine approval or denial. The administrator and DON identified the IDT team was made up of the administrator, the DON, the Assistant Director of Nursing, the Minimum Data Set Coordinator, the security specialist, the social workers and if applicable the therapy team. The administrator identified Resident #2 requested a LOA on 5/2/26 as well as 5/16/26 and both visits were denied after the IDT team met and discussed the requests. The DON and the administrator identified they believe Resident #2's rights were followed as the LOA's were denied for the safety of all residents and staff. Interview with the Social Worker (SW) #1 on 5/28/26 at 9:52 AM identified Resident #2 lost his/her unsupervised visit privilege as well as his/her LOA privilege after a visitor attempted to bring in Fentanyl in a candy box last year. SW #1 indicated the rationale for these decisions was due to Resident #2's attempt to have illicit substances brought in with an intent to use and sell. SW #1 identified Resident #2 did not request any LOA's until 5/2/26, and 5/16/26. SW #1 identified Resident #2 did not have a trial of any unsupervised visits from the time of the initial incident on 12/1/25 up until his/her discharge from the facility on 5/27/26. SW #1 identified the IDT team felt that the safety of all residents outweighed the risk of granting unsupervised visits or LOA's from the facility. A second interview with the administrator and DON on 5/28/26 at 12:51 PM identified during Resident #2's time at the facility, Resident #2 had no other requests for LOA's except the two (2) for 5/2/26 and 5/16/26 and Resident #2 had not made any requests for unsupervised visits. The administrator explained the facility did not attempt a trial of unsupervised visits to evaluate if Resident #2 would pass or fail and the facility could not know if Resident #2 would pass or fail without a trial. The administrator identified Resident #2's LOA requests were denied due to his/her history of bringing in large amounts of Fentanyl, enough to sell. The administrator identified that although Resident #2's LOA requests were denied, he/she did have the option of leaving Against Medical Advice (AMA). Review of the facility policy titled Resident Rights and Responsibilities, last revised dated 7/2015, directed, in part, the facility will protect and promote the rights of each resident as set forth in the attached Residents [NAME] of Rights. Additionally, the policy directed, in part, the resident has the right to participate in community activities both inside and outside the facility, the right to be treated with consideration, respect and full recognition of dignity and individuality, the right to exercise rights as a resident and as a citizen, the facility must protect and promote resident rights and support, encourage and assist the resident in exercising those rights, the right to be treated equally with other residents and these residents rights cannot be reduced, rescinded or abrogated (cancel/revoke) by contract. Review of the facility policy titled Authorized leave of Absence, last reviewed 2/18/26, directed, in part, if a resident's health allows, and the resident's doctor agrees, a resident can spend time away from the facility visiting family or (continued on next page)

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