STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075299	A. Building B. Wing	11/08/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on clinical record reviews, resident interview, observations and staff interviews for 1 of 6 residents (Resident # 133) reviewed for respiratory care, the facility failed to ensure that call bells were answered timely and for 1 of 5 residents reviewed for Choices (Resident # 140), the facility failed to ensure the call bell was accessible to the resident. The findings included: Resident #133 was admitted with diagnoses that included chronic respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #133 was cognitively intact and required partial/moderate assistance for bed mobility. The MDS assessment also indicated the resident had experienced shortness of breath or trouble breathing when lying flat. A physician's order dated 9/18/2024 directed the administration of ipratropium-albuterol 0.5 milligrams (mg)-2.5 Milligrams (MG) (a medication that increases airflow to the lungs) every six hours. The physician's order also directed the administration of albuterol inhaler 90 micrograms (mcg) every 4 to 6 hours as needed for shortness of breath or wheezing. A provider progress note dated 10/7/2024 indicated Resident #133 had frequent exacerbations of respiratory failure and had been declining with frequent hospital admissions. During an interview with Resident #133 on 1/5/2024, the resident indicated that on occasion, she/he would be calling for his/her breathing medication, and staff would take a long time to answer the call bell. Resident #133 indicated on one occasion, the resident was scared that no staff member was coming and had to start yelling for help. The resident could not recall the exact dates but indicated that it had occurred on the day and evening shifts. Resident #133 offered to ring his/her bell in the presence of the surveyor to demonstrate staff response time to the call bell. On 11/5/2024 at 10:23 AM, Resident #133 pushed the call bell button and agreed to have the surveyor wait with him/her in his/her room. At 10:46 AM, Nurse Aide (NA) #4 entered the resident's room to ask what the resident needed (23 minutes after the resident had pushed the call bell. On 11/5/2024 at 10:53 AM, an interview with NA#4 and NA#5 indicated that although NA#4 was not the assigned nurse aide for the resident, she came into the room because she saw the call light outside the room. NA#5 indicated she was the assigned nurse aide to Resident #133 and had been helping NA#4 with another resident, but she had not seen the call bell light. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/5/24 at 11:14 AM an interview with Licensed Practical Nurse (LPN)#3 indicated Resident #133 waiting 23 minutes for the call bell to be answered was not usual. LPN#3 indicated she was not aware of any specific time limit for call bells to be answered but indicated call bells are usually answered in five minutes or less. LPN#3 also indicated she did not see the residents call light because she must have been in a room passing medications. The facility policy for call lights indicated that all call lights would be answered promptly. 2. Resident #140's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), morbid obesity, and chronic respiratory failure with hypoxia. The admission Minimum Data Set assessment dated [DATE] identified Resident #140 was cognitively intact and requires two-person physical assist for bed mobility, transfers and toilet use. The care plan dated 9/3/24 identified Resident #140 at risk for falls, Interventions included to assist with 3-4 bed mobility and evaluate fall risk. Observation on 11/04/24 at 8:30 AM identified Resident #140's call bell was not within reach. The call bell was wrapped around the overbed table and dangling to the side. Resident #140 was unable to reach his/her call bell despite attempts. Interview with LPN #2 on 11/04/24 at 8:37 AM indicated the expectation is for staff to have the call bed within reach of the resident. However, LPN #2 was unable to explain why Resident #140 call bell was not within reach. The facility Call Light policy does not indicate staff expectations for the call bell in proximity to resident. 49100

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

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

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

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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** 46046 Based on clinical record review, facility policy review and interviews for 1 resident (Resident #12) reviewed for dental, the facility failed to ensure a comprehensive care plan was developed. The findings include Resident #12's diagnosis included depression and bipolar disorder. The Annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #12 was severely cognitively impaired. An interview with charge nurse (RN #10) on 11/05/24 at 9:40 AM identified Resident #12 told the surveyor she/he had toothache and showed the surveyor her/his right lower jaw with broken and discolored teeth. RN #10 indicated Resident #12 was waiting for a tooth extraction and s/he would offer Resident # 12 medication and indicated the resident usually does not complain of discomfort. On 11/5/2024 at 9:45 AM of the clinical record identified an attempt made by the visiting dentist to see Resident #12 on 2/22/2018 but Resident#12 refused to be seen on that date. No other dental visits were found after the 2/22/2018 date until present 11/5/2024. An interview with Resident #12's responsible party, Person #3, on 11/07/24 at 9:58 AM identified Resident #12 had extraction of her/his teeth about [AGE] years ago and they tried to fit the resident for dentures, but it did not work out. In October 2024 Person# 3 signed a consent form for removal of the teeth but could not recall the date and indicates s/he was waiting for a notice of the date of the work to be done. Person #3 further indicated talking s/he speaks to Resident #12 daily and the resident had not voiced any concerns of oral pain. An interview and record review with the MDS Nurse (RN #8) on 11/08/24 from 8:45- 9:20 AM indicated the Annual Minimum Data Set, dated dated dated [DATE] indicated through the Care Area Assessments (CAA) Process of completing a comprehensive MDS (ex. Annual) the writer indicated to proceed with a dental care plan and to continue with the prior care plan, but no care plan for dental could be found in the older or present electronic documentation which started in 11/2024 per RN #8. RN # 8 further indicated the care plan should have been written and revised in the new system during the CAA completion dated 10/16/2024 but instead was 16 days overdue. The MDS Nurse RN #8, present during the interview indicated the care plans had been printed and were on the units, but no care plans were found or provided. The facility policy labeled Care Plan Policy dated 4/17/2024 notes in part within 7 days of completing MDS and CAAS, the interdisciplinary team develops, reviews and revises the plan of care to ensure it is person centered and individualized to meet the needs of the resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, review of facility policy and interviews for 1 of 1 resident (Resident # 12) reviewed for dental and 2 of 4 residents (Residents # 25 and # 460 reviewed for abuse, the facility failed to revise the residents care plan timely. The findings included : 1. Resident #12's diagnosis included depression and bipolar disorder. The Annual Minimum Data Set assessment dated [DATE] indicated Resident #12 was severely cognitively impaired. The care plan dated 10/30/2024 for at risk for decline in wellbeing due to chronic medical and psychiatric conditions. Interventions included consulting with the social worker as needed, encouraging group activities and to report any changes to the physician. An interview and record review with the MDS Coordinator Nurse (RN # 8) on 11/08/24 from 8:45 AM to 9:20 AM identified the Annual Minimum Data Set assessment dated [DATE] indicated through the Care Area Assessments (CAA) Process of completing a comprehensive directed to proceed with a dental care plan and to continue with the prior care plan. However, review of the clinical record and Resident Assessments identified no care plan for dental found in the paper chart and the electronic medical documentation system started in 11/2024. RN #8 indicated the dental care plan should have been written and revised in the new system during the CAA completion dated 10/16/2024 but was not done until (16 days later). The facility policy labeled Care Plan Policy dated 4/17/2024 noted within 7 days of completing MDS and CAAS, the interdisciplinary team develops, reviews and revises the plan of care to ensure it is a person centered and individualized plan of care to meet the needs of the resident. 2. Resident #25 's diagnoses included hemiplegia, contractor to right hand and weakness. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #25 was moderate impaired and required was dependent on staff for in bed mobility and lower body dressing. The resident also required set up assistance for eating. The care plan dated 9/4/24 with an update 11/6/24 identified resident was stuck by roommate. Interventions included to refer resident to psychiatry and social services for emotional support and to offer a room change. Interview on 11/07/24 12:02 PM interview with RN#5 indicated every discipline is responsible for filling out their part of care plan. Physical altercations are typically handled by DNS. Interview with DNS on 11/07/24 at 12:08 PM identified interventions are done immediately and residents are placed on 1-1 depending on severity. She also reported care plans should be updated the same day. DNS indicated she might have forgotten to update the care plan that day. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #460 diagnosis included Major Depressive Disorder, opioid dependence and difficulty walking. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident 460 was moderately impaired and independent with bed mobility, transfers and toilet use. The care plan dated 9/4/24 with an update on 11/6/24 noted interventions for Resident #460 to voice frustration and for staff to offer a room change. Interview on 11/07/24 12:02 PM with RN#5 indicated every discipline is responsible for filling out their part of care plan. Physical altercations are typically handled by DNS. Interview with DNS on 11/07/24 at 12:08 PM identified interventions are done immediately and residents are placed on 1-1 depending on severity. 49100

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observations, clinical record reviews, facility policy and interviews for and 3 of 6 residents reviewed for Respiratory Care(Residents.#65, #69, and #129), the facility failed to ensure oxygen supplies were stored and tabled properly and for 1 of 6 residents reviewed for Respiratory Care (Resident #196), the facility failed to provide tracheal suctioning in accordance with professional standards. The findings included: 1. Resident #65's diagnoses that included morbid obesity with alveolar hypoventilation (inadequate ventilation). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #65 was cognitively intact, required one to two person assist with activities of daily living (ADL), set up assist with eating and personal care. The Resident Care Plan (RCP) dated 10/30/24 identified Resident #65 had impaired respiratory status related to respiratory failure and pneumonia. Interventions directed to apply oxygen if saturation falls below parameters and administer respiratory treatments as ordered. The physician's orders dated 11/2/24 direct oxygen at 2L/min via nasal cannula continuously at bedtime, Change oxygen and nebulizer tubing weekly on Friday during the 3:00 PM - 11:00 PM shift. An observation with the Nursing Supervisor, RN #4 on 11/04/24 at 8:30 AM identified a nebulizing mask tucked under multiple miscellanies personal items without the benefit of a storage bag, no label affixed to the tubing /identifiable date on the tubing and oxygen tubing tucked under the bedside table with the nasal prongs in a garbage bag. An interview with RN #4 on 11/04/24 at 8:30 AM identified tubing should be stored in a clean bag and labeled with the date within the current week. Tubing was also should be labeled with the current date and changed every Friday during the 3:00 PM - 11:00 PM shift. An interview with the Director of Nursing Services on 11/6/24 at 2:05 PM identified her expectation is that respiratory equipment are stored in a clean bag when not in use and labeled within the current week. 2. Resident #69's diagnoses that included chronic obstructive pulmonary disease (COPD). The Admission MDS assessment dated [DATE] identified Resident #69 was cognitively intact and independent with ADL care. The RCP dated 9/25/24 identified Resident #69 had impaired gas exchange and at risk for COPD complications. Interventions directed to monitor for changes in respiratory rate and symptoms of heart failure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 11/04/24 at 7:50 AM with Licensed Practical Nurse, LPN #2 identified a nebulizer mask directly on the bedside table and no label affixed to the tubing/identifiable date on the tubing. An interview with LPN #2 on 11/04/24 at 7:50 AM identified the nebulizer mask should be stored in a plastic bag when not in use with a current date affixed to the tubing within the week. An interview with the Director of Nursing on 11/6/24 at 2:05 PM identified her expectation is that respiratory equipment are stored in a clean bag when not in use and labeled within the current week. Although requested, physician orders were not provided. 3. Resident #129's diagnoses that included congestive heart failure (CHF) and COPD. The quarterly MDS assessment dated [DATE] identified Resident #129 was cognitively intact and independent with ADL care. The RCP dated 9/11/24 identified Resident #129 was at risk for shortness of breath related to COPD. Interventions directed to monitor oxygen as needed and nebulizer treatments as ordered to maintain adequate respiratory status. The physician's orders dated 11/6/24 directed oxygen at 2L/min continuously, Duoneb 0.5-2.5 (3) mg/ml every six hours as needed for shortness of breath. Change nebulizer tubing weekly and as needed, change oxygen tubing weekly on Friday and as needed. An observation on 11/04/24 at 7:50 AM with LPN #4 identified the resident's oxygen tubing with no affixed label/date written on the tubing. Humification tubing had an affixed label dated 10/9/24. An interview with LPN #4 on 11/04/24 at 7:50 AM identified the oxygen and humidification tubing should have a current date affixed to the tubing within the week. An interview with the Director of Nursing Services on 11/6/24 at 2:05 PM identified her expectation is that respiratory equipment are stored in a clean bag when not in use and labeled within the current week. A review of the facility policy for oxygen administration dated 4/17/2024 directed that masks and tubing are changed weekly. Although requested, a policy for the storage of respiratory equipment when not in use was not provided. 4. Resident #196 was admitted on [DATE] with diagnoses that included brain damage, pneumonia, and sepsis. A physician's order dated 9/19/2024 directed tracheostomy care every shift and suction as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS assessment dated [DATE] identified Resident #196 was in a persistent vegetative state and dependent on facility staff for all self-care activities. The MDS assessment also indicated the resident required tracheostomy care and suctioning. On 11/6/2024 at 12:20 PM, LPN#4 was observed providing tracheal suction to Resident #196. LPN#4 donned clean gloves, poured sterile water into a non-sterile clear plastic cup, opened the drawer of the resident's nightstand, and retrieved a suction catheter from a clear plastic belongings bag. LPN#4 then proceeded to provide tracheal suctioning, obtaining pale yellow secretions; LPN#4 then placed the tip of the suction catheter into the clear plastic cup and suctioned some water to clear the catheter of secretions. LPN#4 then proceeded to provide the resident with tracheal suction again. Afterward, LPN#4 cleared the catheter with water and proceeded to store the used catheter in the clear plastic belongings bag on the resident's nightstand. In an interview on 11/6/2024 at 12:25 PM LPN #4 indicated that clean gloves were okay to use, and sterile gloves were not necessary. LPN #4 also indicated she would reuse the suction catheter until the end of her shift unless the catheter would get too soiled with secretions. On 11/6/2024 at 3:00 PM an interview with the DNS indicated for tracheal suctioning a new suction catheter should be used each time and the water used to clear the catheter in between suction passes should be sterile. The DNS further indicated sterile gloves would not be necessary as she did not think tracheal suctioning was a sterile procedure. The DNS indicated the expectation was for staff to follow the facility policy for tracheal suctioning. A review of the facility policy for tracheal suctioning identified the equipment required to perform endotracheal suctioning through a tracheostomy included: sterile suction catheter, sterile gloves, sterile drape, sterile water, and sterile cup for water. Additionally, the policy indicated that upon donning sterile gloves at least one hand is maintained sterile to remove the sterile suction catheter from the packages. 48880

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Chelsea Place Care Center LLC	25 Lorraine St Hartford, CT 06105

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on observation, review of facility policy and staff interviews for 1 of 1 resident reviewed for tracheostomy care (Resident #196), the facility failed to ensure staff were competent in providing tracheal suctioning. The findings include: Resident #196 was admitted on [DATE] with diagnoses that included brain damage, pneumonia, and sepsis. A physician's order dated 9/19/2024 directed tracheostomy care every shift and suction as needed. The quarterly MDS assessment dated [DATE] identified Resident #196 was in a persistent vegetative state and required tracheostomy care and suctioning. On 11/6/2024 at 12:20 PM, LPN#4 was observed providing tracheal suction to Resident #196. LPN#4 donned clean gloves, poured sterile water into a non-sterile clear plastic cup, opened the drawer of the resident's nightstand, and retrieved a suction catheter from a clear plastic belongings bag. LPN#4 then proceeded to provide tracheal suctioning, obtaining pale yellow secretions; then LPN#4 placed the tip of the suction catheter into the clear plastic cup and suctioned some water to clear the catheter of secretions. LPN#4 then proceeded to provide the resident with tracheal suction again. Afterward, LPN#4 cleared the catheter with water and proceeded to store the used catheter in the clear plastic belongings bag on the resident's nightstand. In an interview on 11/6/2024 at 12:25 PM, LPN #4 indicated that clean gloves were okay to use and sterile gloves were not necessary. LPN #4 also indicated that she would reuse the suction catheter until the end of her shift unless the catheter would get too soiled with secretions. LPN #4 further indicated tracheal suctioning was not taught in her formal nursing education. LPN #4 indicated that she learned suctioning from the nursing supervisors at the facility and that a respiratory therapist who came to the facility had also shown her how to manage the equipment. On 11/6/2024 at 2:43 PM an interview with the nursing supervisor (RN#6), indicated that a new suction catheter would be needed each time the resident would be suctioned and it would not be appropriate to reuse a catheter for a later time. RN#6 also indicated that she thought tracheal suctioning was not a sterile procedure and therefore sterile gloves would not be required. On 11/6/2024 at 3:00 PM an interview with the DNS indicated that for tracheal suctioning a new suction catheter should be used each time and that water used to clear the catheter in between suction passes should be sterile. The DNS further indicated that sterile gloves would not be necessary as she did not think tracheal suctioning was a sterile procedure. The DNS indicated that the expectation was for staff to follow the facility policy for tracheal suctioning. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/2024 at 12:26 PM, an interview with the Director of Respiratory Therapist contracted by the facility indicated tracheal suctioning is a sterile procedure that requires a sterile catheter, sterile gloves, and sterile water. Additionally, the Director of Respiratory Therapist indicated that he did some in-servicing with staff at the facility when the resident had recently arrived, which included how to use the bedside equipment. The Head Respiratory Therapist indicated that he did not have a sign-in sheet because sign-in sheets are only used when providing competencies, and the bedside demonstrations he covered were not considered competencies. On 11/7/2024 at 3:17 PM, an interview with the Regional Infection Preventionist (RN#3) indicated she oversaw the clinical skills day of the new employee orientation. The Nurse Skills Day Checklist dated 6/6/2024 for LPN#4 was reviewed with RN#3. RN#3 indicated the tracheostomy care sign-off in the checklist consisted of an 8-minute video showing how to cleanse a tracheostomy site and change the dressing but did not include suctioning through a tracheostomy. RN# 3 indicated that any hands-on practice of a skill would be the responsibility of each individual facility. Although requested, the facility was unable to provide documentation of staff competencies related to tracheal suctioning prior to 11/6/2024. Subsequent to the surveyor's inquiry, the facility provided education to RNs and LPNs on the policy for tracheostomy care and suctioning and started a suctioning competency. A review of the facility policy for tracheal suctioning identified the equipment required to perform endotracheal suctioning through a tracheostomy included: sterile suction catheter, sterile gloves, sterile drape, sterile water, and sterile cup for water. Additionally, the policy indicated that upon donning sterile gloves at least one hand is maintained sterile in order to remove the sterile suction catheter from the packaging.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on the tour of the kitchen, observations and staff interviews, the facility failed to ensure food storage equipment was free of hard black matter and food was stored in an organized manner and the facility failed to ensure staff applied a beard guard while preparing food. The findings included: Tour of the initial walk through of the kitchen on 11/4/24 at 6:35AM with the Food Service Director identified the following: 1. An observation of the [NAME] Refrigerator identified hard black matter in the corners of the refrigerator. Interview with the Director of Food Service on 11/4/24 at 6:42AM identified all staff are responsible to cleaning and maintaining the refrigerator area. After inquiry, kitchen staff was directed to mop/ clean the [NAME] Refrigerator. 2. Observation of the dry food storage area identified stacks of boxes (empty and filled) were on the floor and some noted falling over. Boxes were also blocking the emergency stock. Interview with the Director of Food Services on 11/4/24 at 6:48 AM indicated the boxes should not be stored in that manner. She/he further indicated the expectation is that boxes are stored in an organized manner so they can be readily accessible. The Director of Food Services also reported, empty boxes should not be on the floor. She/he indicated Dietary Aide / person assigned to stocking is responsible for ensuring boxes are stocked appropriately. 3 Observation on 11/4/24 at 6:35 AM of the of Dietary Aide #1 (with facial hair) in the kitchen identified Dietary Aide # 1 preparing breakfast juice and coffees without the benefit of bread coverage. Interview with the Director of Food Services on 11/4/24 at 6:45AM indicated staff with facial hair should have on a beard guard while in the kitchen or handling food items. The Director of Food Services was unable to explain why staff did not have beard guard on.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46046 Based on review of facility documents and interviews, the facility failed to ensure the Medical Director attended the monthly QAPI meetings for the years of 2022, 2023 and 2024. The findings include: An interview and facility document review with the Administrator on 11/8/2024 at 2:30 PM identified the Medical Director was a member of the QAPI Committee but did not attend the QAPI monthly meeting therefore she/he did not sign the attendance sheets at the meetings for the years of 2022, 2023 and 2024. The Administrator indicated the Medical Director is in the facility weekly and is up-to-updated regarding the QAPI meeting done monthly. Although, the Medical Director attends the quarterly Medical Rounds Meetings the facility was unable to provide any meetings with the Medical Director signature of attendance which identified the Medical Rounds meetings also included the QAPI meetings for the years of 2022, 2023 or 2024. The facility Policy labeled LTC Integrity QAPI Program Plan dated 11/4/2024 indicated in part, Th facility will maintain a QAPI Committee consisting of at least the Director of Nurses the Medical Director or designee and at least three other members of the facilities staff at least one being the Administrator, owner a board member or other with a leadership role and the Infection Preventionist. The committee must meet at least quarterly and as needed and may operate singly or in collaboration with the Compliance and Ethics Committee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, observations and staff interviews for 1 of 1 resident reviewed for tracheostomy care (Resident #196), the facility failed to ensure that staff used appropriate Personal Protective Equipment (PPE) when providing tracheal suctioning and failed to ensure linen was stored in sanitary manner. The findings include: 1. Resident #196 was admitted on [DATE] with diagnoses that included brain damage, pneumonia, and sepsis. A physician's order dated 9/19/2024 directed tracheostomy care every shift and suction as needed. The quarterly MDS assessment dated [DATE] identified Resident #196 was in a persistent vegetative state and required tracheostomy care and suctioning. On 11/6/2024 at 12:20 PM, LPN#4 was observed providing tracheal suction to Resident #196. Prior to entering the room, an orange sign for enhanced barrier precautions was noted on top of an isolation cart that contained gowns and masks. The enhanced barrier precautions indicated that staff performing high-contact care, such as care of or use of a tracheostomy, should wear gloves and a gown. LPN#4 entered the resident's room, donned clean gloves, and proceeded to perform tracheal suctioning. LPN #4 was observed performing two suction passes; with each pass, the resident coughed several times, and LPN#4 suctioned pale-yellow sputum. In an interview at 12:25 PM, LPN#4 indicated that she/he had not been told she/he needed to wear a gown. LPN#4 also indicated s/he did not realize the residents' enhanced barrier precautions included the use of a tracheostomy. . On 11/6/2024 at 2:43 PM an interview with (RN#6) Nursing Supervisor indicated that she was aware staff needed to wear a gown and gloves for tracheostomy suctioning. 2. An observation in the hallway outside the shower room on unit 2 behavioral unit across from the nurse's station at 11/04/24 7:10 AM identified soiled towels on the floor in hall outside the entrance to the resident shower area several feet from a laundry bin which contains laundry to be washed. The 7-3 PM charge nurse, RN #9 was noted at the nurse's station with the 11:00 PM to 7:00 AM shift charge nurse who indicated the the 11:00 AM to 7:00 AM staff must have left the soiled linen on the floor that should have place in the soiled laundry bin. After inquiry, RN # 9 instructed one of the nurse aides to place the soiled towels into the laundry bin. 48880

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observations, review of facility policy, facility documentation and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment and for 1 of 2 showers, the facility failed to ensure that sharp containers were emptied to ensure a safe environment. The findings included: 1. Observations on initial tour on 11/04/24 at 7:35 AM and again during the survey on 11/7/24 at 9:55 AM with the Director of Maintenance identified the following: a. room [ROOM NUMBER]. Marred mirror in the bathroom, marred walls in the resident room, broken tile under the bed near the window and in front of bathroom. b. room [ROOM NUMBER]. Broken/ marred wall strip/baseboard. Broken wall/baseboard strip on the side of closet. [NAME] buildup around toilet. Broken tile under the bed near the window. Garbage on the floor including (2) peanut butter jars, various pieces of cardboard, 2 cracker boxes. c. Room#304. Stained tile on ceiling. d room [ROOM NUMBER]. Marred/ missing baseboard to closet. Broken tile on the threshold of bathroom. e. room [ROOM NUMBER]. Marred bathroom door, missing baseboard wall strip just outside the bathroom door. f. room [ROOM NUMBER]. Marred bathroom door, unmarked basins on the back of the toilet with dry white spatter on the inside an out (room is occupied by two residents). g. room [ROOM NUMBER]. Stained ceiling in the bathroom. h. room [ROOM NUMBER]. Broken bottom drawer to the wardrobe, marred entrance door to the room, marred walls under light switch. i. room [ROOM NUMBER]. Broken tile in the threshold of the bathroom. j. room [ROOM NUMBER]. Hole in ceiling in bathroom dripping water, a hole covered up with foil tape outside next to bathroom, compounded unpainted walls in room. k. Sharps container not secured to wall. Found in tub (room is locked when not in use). An interview with the Director of Maintenance on 11/7/24 at 9:55 AM identified he was responsible for conducting environmental rounds twice weekly. Any environmental concern was addressed once identified. The Director of Maintenance identified that when conducting rounds, some areas of concern may be missed as an oversight. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observations of room [ROOM NUMBER] on 11/4/24 7:35 AM,11/5/24 11:15AM and on 11/6/24 2:12 PM with the Director of Nursing identified a strong smell of urine from inside the room permeating the hallways even with the door closed. An interview with the Director of Nursing Services on 11/6/24 at 2:12 PM identified she was unclear why there was an ongoing urine smell coming from room [ROOM NUMBER] and that perhaps it was from a previous resident. The room was subsequently cleaned on 11/7/24 and remained with a odor of urine. Although requested, a policy on ensuring a safe clean and comfortable environment was not provided. A review of the Maintenance Director Job Description identified duties and responsibilities included ensuring the facility was maintained in a safe and comfortable manner. 3. Observation of Residents # 7, #49's and #310's and interview with RN # 11 on 11/5/2024 at 10:45 AM identified the outside of all the resident chart binders with layers of soil. When the chart binders were handled by surveyor hands the hands had to be washed with soap and water to remove the film left behind that could not remove with the use of hand sanitizer. RN #11 identified she/he did not know who was responsible for wiping down the resident chart binders to keep them clean and indicated nursing was not responsible. 4. Observation and interview of the second floor nurse station with Housekeeper #1 on 11/6/2024 at 9:00 AM identified as a housekeeper the charts are removed from the chart racks when the racks are scheduled to be cleaned monthly. Housekeeper #1 further indicated the housekeeping manager might be able to provide more information. An observation and interview with the Housekeeping Department Manager on 11/6/2024 at 9:05 AM indicated the housekeeping department does not clean the resident chart binders only the chart racks and indicated she/he did not know who was assigned the task. 5. On 11/5/2024 at 11:28 AM, during resident screening, observation, and interview with the nursing supervisor (RN#6), identified an overfilled sharps container in the locked shower room of unit 4 C. It was observed that the container had the handles of two blue shaving razors protruding out of the top. RN #6 identified the sharps container needed to be changed. RN#6 indicated that housekeeping or maintenance would change the sharps container. 6. An observation on 11/5/2024 at 11:40 AM identified RN#6, LPN #3 removed the filled sharps container and Housekeeper #1 opened the dirty utility room so RN#6 and LPN #3 could dispose of the sharps container. On 11/5/2024 at 11:50 AM an interview with the Housekeeper #1 identified housekeeping does not change the sharps containers and the nurses were responsible for the task. Housekeeper #1 indicated that she helped the nurses unlock the dirty utility room because the nurses were having trouble finding their keys for it. Housekeeper #1 indicated both she and the nursing supervisor have keys to the dirty utility room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up interview with RN#6 on 11/5/2024 at 11:55 AM identified housekeeping is not responsible for swapping out full sharps containers and nursing is responsible for the task. RN# 6 indicated she did not know why the sharps container had gotten overfilled but indicated LPN #6 was new and had not seen the sharps container was overfilled. An observation and interview with Maintenance Worker #1 on 11/06/24 at 9:10 AM identified Resident #310's room with a towel draped across the over bed light fixture (turned off at this time), a sheet was hanging over one of the window shades and two coats hung on hangers were hanging from the shade. The wood trim that met the ceiling in the right top corner of the room above the shade was noted to be pulling away from the ceiling. Maintenance Worker #1 indicated the resident had only been at the facility for about a month and on several occasions the facility has indicated to Resident #310 that the towel could not be over the light fixture, the sheet and coats could not be hung on the window shades, but the resident just keeps putting the items back. Maintenance Worker #1 further indicated s/he informed the Maintenance Director of the problems but had not informed the nursing supervisor, Director of Nursing Service (DNS) or administrator. An interview and observation with the Maintenance Director on 11/06/24 at 9:15AM who walked up to the surveyor and Maintenance Worker #1 indicated having talked to Resident #310, but the resident still puts the item back, and further indicated s/he did not inform the nursing supervisor or the administrator of the issues. On 11/6/2024 at 9: 30 AM an interview and observation with the nursing supervisor RN #1 identified the Maintenance Worker gone and the towel removed from the overbed light fixture and no items hanging from the shade and the wood trim back in place at the corner of the wall and ceiling. However, Resident #310 was not in the room. RN #1 indicated never seeing the issues in Resident #310's room or being notified of the concerns. RN #1 was asked and agreed to talk with Resident #310 about the reason s/he tries to block the light from the fixture and the window as a solution may be found. An interview on 11/7/2024 at 2:00 PM with the Administrator indicated s/he was not informed of the issue with Resident #310's room but was made aware the shade needs to be replaced and the item was ordered today. An interview with the charge nurse, RN #9 on 11/8/2024 at 9:15 AM identified in Residents #7 and #39 urinate on the floor in the room, the residents refuse to wear incontinent briefs and sometime refuse toileting. RN # 9 indicate the residents had behaviors with urinating on the floor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7.11/08/24 09:30 AM an observation and interview with the Maintenance Director identified the unit hallway down to Resident #7 and #39's room were shared bedroom with the door closed with a foul odor increased in its intensity while walking down the hall toward the room. Once the bedroom door was opened an overpowering odor presence within the room was noted. Further observation also noted the window was open but not changing the intensity of the foul odor. The beds in the room were stripped and one mattress was on the floor, floor tiles were noted to be chipped and curling at the edges coming up from what can be seen as another layer of old tiles below this layer. One bed had hand cranks at the foot of the bed that were found to be operational as demonstrated by the Maintenance Director the other bed was an updated electric bed. The older bed had rust on the surfaces of the legs and the side rails and some of the springs under where a mattress location. The Maintenance Director indicated the residents urinate on the floor and housekeeping washes the floor several times a day, the Maintenance Director further indicated the floor tiles were replaced 1.5 years ago and last month s/he was trying to obtain some quotes to have the bedroom floor redone. He/she also indicated changing the room will not resolve the urine smell if the behavior continues to exist. An observation and interview with Resident #7 on 11/8/2024 at 9:45 in the lounge near the resident room indicated when asked if the odor in the bedroom bother him/her and s/he indicated yes. The resident was odor free, clothing dry and able to ambulate independently. An interview on 11/08/24 at 9:45AM with the Director of Housekeeping indicated the room is cleaned 3-4 times a day and more if needed. The room is on a monthly room cleaning schedule and showed the schedule with to room on this day for a deep clean. A special cleaner is used on the tiles to try to cut down on the urine odor that is within the layers of the floor tiles, but it does not improve the odor in the room much. 46046 48880