

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER The Massachusetts Veterans Home at Chelsea		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Summit Street Chelsea, MA 02150	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>41601</p> <p>Based on records reviewed and interviews, for one of four sampled residents (Resident #1) who was cognitively intact, the Facility failed to ensure staff treated him/her in a respectful manner, when on 06/21/24 during the evening shift, Nurse #1 and Certified Nurse Aide (CNA) #1 were arguing in the hallway outside of Resident #1's room, they then enter his/her room to provide care, and continued their argument in front of him/her, which made him/her feel uncomfortable.</p> <p>Findings include:</p> <p>The Facility Policy, titled Resident Rights, has no date. The Facility will treat you with dignity and respect in full recognition of your individual rights.</p> <p>Resident #1 was admitted to the Facility in February 2024, diagnoses included paraplegia, spinal abscess, lumbar spinal stenosis, lumbar osteomyelitis, and neurogenic bladder/bowel.</p> <p>Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 05/09/24, indicated that he/she had intact cognition, could communicate his/her needs, and was his/her own decision-maker. The MDS also indicated that Resident #1 required assistance from two staff members to meet his/her care needs.</p> <p>The Facility's Internal Investigation Summary Report, dated 06/24/24, indicated that Resident #1, who had filed the grievance, was in his/her room waiting for staff assistance with the nighttime routine on 06/21/24. Resident #1 overheard a disagreement among staff regarding a scheduled break time in the hallway, which continued as they entered his/her room, causing him/her significant discomfort.</p> <p>During an interview on 07/17/24, at 10:15 A.M., Resident #1 expressed his/her discomfort and loss of trust in the staff. Resident #1 said it was unprofessional for Nurse #1 and CNA #1 to enter his/her room and argue loudly in front of him/her. Resident #1 said he/she found it disrespectful that staff members did not respect his/her room and personal space. Resident #1 said he/she requested that Nurse #1 not provide care for him/her in the future.</p> <p>During a telephone interview on 07/18/24, at 11:49 A.M., Nurse #1 denied speaking loudly but admitted that discussing the break schedule with CNA #1 in Resident #1's room was disrespectful.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 07/22/24, at 12:58 P.M., CNA #1 said on 6/21/24, she was late returning from her break, and that it was already time to assist Resident #1 into bed and provide care. CNA #1 said Nurse #1 was upset about her (CNA #1) being a few minutes late because she (Nurse) #1 said she had to do Resident #1's wound care. CNA #1 said she was not trying to discuss the issue any further once she and Nurse #1 entered Resident #1's room, but said it was difficult because Nurse #1 continued discussing the break schedule. CNA #1 said she knew it was disrespectful to have that type of conversation in a residents room.</p> <p>During an interview on 07/17/24, at 9:30 A.M., the interim DON said that Resident #1 had reported that he/she had felt uncomfortable because staff members were yelling at each other in front of him/her and that he/she felt Nurse #1 was more unprofessional towards CNA #1. The DON said both Nurse #1 and CNA #1 were suspended pending an investigation into the incident.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>41601</p> <p>Based on records reviewed, review of surveillance camera video footage, and interviews for one of four sampled residents (Resident #2), who had moderate cognitive impairment, a history of behaviors, and was dependent on staff for care, the Facility failed to ensure he/she was free from abuse from staff members, when 1) on 6/29/24. Certified Nurse Aide (CNA) #4 engaged in a verbal altercation with Resident #2 and responded by throwing an object at him/her and 2) on 7/01/24, CNA #3 also engaged in a verbal altercation with Resident #2, was intimidating and confrontational while engaging with him/her, which resulted in escalating his/her behaviors.</p> <p>Findings include:</p> <p>The Facility's Policy titled Patient, Complaints, Mistreatment, Abuse or Neglect, revised 09/2018, indicated that Abuse is an overt act or an omission of care that results in the physical or emotional trauma of a patient. Examples of alleged abuse would include:</p> <ul style="list-style-type: none"> -The aggressive imposition of a caregiver on a patient in the manner of pushing, shoving or any other form of physical touching that would constitute an assault under best practices as well as Massachusetts General Law. -The use of verbal means to insult or abuse a patient by threatening, shouting, cursing or teasing, speaking in a demanding/degrading manner. <p>Resident #2 was admitted to the Facility in January 2024; diagnoses included dementia with behavioral disturbances, left leg DVT (deep vein thrombosis, blood clot), pulmonary emboli (blood clot in the lungs), and sinus arrhythmia.</p> <p>Review of Resident #2's Quarterly Minimum Set Data (MDS) Assessment, dated 04/10/24, indicated he/she had moderate cognitive impairment, required physical assistance with ADL, and ambulates independently.</p> <p>Review of Resident #1's Behavior Care Plan, reviewed and renewed with his/her January 2024 MDS, indicated that he/she exhibited or had the potential to demonstrate verbal behaviors, and included the following interventions:</p> <ul style="list-style-type: none"> -maintain a comfortable environment by reducing noise and using dim lights. -employ therapeutic and non-judgmental communication. -staff is to reapproach in an unhurried manner, often during a cooling off period. -allow time to express your feelings of getting daily care without interruption. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1) Review of the surveillance camera video footage clips (video only, no audio) provided by the Facility, dated 06/29/24 from 11:50:24 A.M. to 11:53:17 A.M., related to an incident involving Certified Nurse Aide (CNA) #4 and Resident #2, illustrated the following:</p> <ul style="list-style-type: none"> - 11:50:24, Resident #2 can be seen seated at his/her table for lunch, - 11:50:58, Resident #2 gets up and walks toward the unit hallway, - 11:51:23, CNA #4 walks toward the same hallway as Resident #2, - 11:51:31, Resident #2 can be seen passing the units' nursing station, CNA #4 can be seen behind him/her, and she stops to grab an object. - 11:51:43, Resident #2 suddenly turns back around and looks at CNA #4. - 11:51:51, CNA #4 can then be seen walking through the dining area, Resident #2 walks back to the hallway and approaches CNA #4, who was in front of the nurses' office. - 11:53:09, Resident #2 and CNA #4 can be seen engaging in a verbal altercation, Resident #2 proceeds to punch CNA #4 in the face. CNA #4 responds by throwing an object (appears to be a lunch box) at Resident #2, which does not hit him/her, - 11:53:17, CNA #4 walks back to the nursing station, grabs what appears to be a large container of sanitary wipes and moves toward Resident #2, as he/she approaches her. Staff and family members can be seen intervening to separate CNA #4 and Resident #2. <p>During an interview on 07/17/24 at 2:32 P.M., the Administrator said on 06/29/24, the Supervisor called her and said Resident #2 had punched a staff member (later identified as CNA #4) and that Resident #2 had been sent out to the hospital. The Administrator said the facility's security officer reviewed the surveillance camera video footage and reviewed the incident from 06/29/24 that had occurred between Resident #2 and CNA #4. The Administrator said CNA #4 should have tried to de-escalated the situation or should have walked away, but instead had thrown an object at Resident #2.</p> <p>Review of an email received by the Director of Nurses (DON) on 07/17/24 at 8:53 A.M. indicated it was sent from Certified Nurse Aide (CNA) #4, and included her statement regarding the incident on 06/29/24, with Resident #2. CNA #4's statement indicated that Resident #2 approached her and asked if he/she could take the plate from her, that she replied, No, I got it, and then Resident #2 punched her. CNA #4's statement indicated she was upset and mad and that she threw her lunch plate at him/her to prevent him/her from attacking me more.</p> <p>The Surveyor was unable to interview CNA #4 as she did not respond to the Department of Public Health's telephone or letter requests for an interview.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/16/24 at 1:20 P.M., Nurse #2 said she was familiar with Resident #2 and said he/she could become easily agitated. Nurse #2 said she was Resident #2's nurse on both days of the incidents (6/29/24 and 7/01/24). Nurse #2 said that on 06/29/24, Resident #2 was quiet that morning with no behaviors and had finished his/her lunch meal. Nurse #2 said Resident #2 usually goes to his/her room after the meal. Nurse #2 said she had not witnessed any confrontational interaction between Resident #2 and CNA #4, until the incident that day. Nurse #2 said after the incident, Resident #2 was sent to the hospital for further evaluation.</p> <p>2) Review of the surveillance camera video footage clips (video only, no audio), dated 07/01/24 from 11:40:57 A.M. to 11:45:18 A.M., related to the incident involving Resident #2 and CNA #3, illustrated the following:</p> <ul style="list-style-type: none"> -11:40:57, Resident #2 can be seen sitting at the dining room table with another resident who was being fed by a CNA, -11:41:25, CNA #3 can be seen, seated at another table and was providing 1:1 supervision for another resident. CNA #3 can be seen looking in the direction of Resident #2, and looks to be doing so for an extended period of time (several minutes), - 11:44:20, CNA #3 and Resident #2 can then be seen having some sort of verbal exchange, and Resident #2 appears to become agitated, - 11:44:22, Resident #2 and CNA #3 are seen simultaneously standing up, CNA #3 appears to be gesturing to Resident #2 to come to where she is standing, as if to provoke him/her, -11:44:23, Resident #2 approaches CNA #3, and CNA #3 then picks up the napkin holder from the table and motioned with it toward Resident #2, - 11:44:28, Staff members are then seen intervening and separate Resident #2 and CNA #3, Resident #2 returns to his/her table. - 11:44:38, CNA #3 can be seen looking (staring) in Resident #2's direction and Resident #2's demeanor changes and he/she looks more agitated, - 11:44:59, Resident #2 approaches CNA #3 for the second time. CNA #3 appears to try to intimidate Resident #2 by pointing her finger at him/her and waving the napkin holder in Resident #2's face, -11:45:18, Staff members again intervene, the Nurse Practitioner (NP) is able to redirect and calm Resident #2 down, he/she walks away from the dining room area and is redirected back to his/her room. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #2 said that on 07/01/24, at lunchtime, Resident #2 was seated at a different table in the dining room across from where CNA #3 was sitting with another resident, who required 1:1 supervision. Nurse #2 said she was unsure what made Resident #2 get agitated and that she had not heard the verbal interaction between Resident #2 and CNA #3. Nurse #2 said Resident #2 stood up, then moved in the direction of CNA #3. Nurse #2 said she believed CNA #3 was afraid of Resident #2, that CNA #3 had grabbed the napkin holder, but she (CNA #3) did not touch him/her. Nurse #2 said staff members intervened and Resident #2 returned his/her seat. Nurse #2 said that while she called out for help with the situation, the Nurse Practitioner was able to redirect Resident #2 and take him/her to his/her room. Nurse #2 said Resident #2 was assessed, and no injuries were noted.</p> <p>During an interview on 07/16/24 at 2:32 P.M., the Nurse Practitioner (NP) said she was coming onto the unit and noticed that Resident #2 was standing, he/she was agitated, that the dining area was noisy at the time, but that Resident #2 was not close to CNA #3 at that time. The NP said she was able to calm him/her down and took Resident #2 back to his/her room. The NP said Resident #2 was assessed, and he/she had no injuries were noted.</p> <p>During a telephone interview on 07/18/24 at 12:00 P.M., Certified Nurse Aide (CNA) #3 said that she was afraid that Resident #2 would attack her since he/she attacked another staff member over the weekend. CNA #3 denied she was looking in Resident #2 direction, said she had not tried to intimidate him/her, and denied having a verbal altercation with Resident #2. CNA #3 said she grabbed the napkin holder to defend herself.</p> <p>The Administrator said on 07/01/24, during lunch time, she received a called from the nurse that Resident #2 was agitated, that he/she approached and tried to attack CNA #3. The Administrator said she reviewed the surveillance camera video footage and reviewed CNA #3 interaction with Resident #2. The Administrator said CNA #3 responded to Resident #2 in an intimidating manner, and engaged in a verbal and threatening confrontation with Resident #2, which escalated his/her behaviors.</p>		