STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225110	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Massachusetts Veterans Home at Chelsea	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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interview, for one of three sampled residents, (Resident #1) who had a history of being resistant and combative during care, the facility failed to ensure he/she was free from the use of physical restraint, when on 6/17/25, while Resident #1 was receiving foot care from the podiatrist, the Charge Nurse laid across his/her lap/leg area to prevent him/her from moving during the procedure.Findings include:Review of the Facility Policy titled Restraints and Safety Devices, dated 11/03/23, indicated physical restraints are used only after assessment by the Interdisciplinary Team (IDT), when an alternative to restraints has been determined to be ineffective by the IDT members, and when absolutely necessary to ensure the safety of the Veteran or others. Resident #1 was admitted to the Facility in January 2024, diagnoses included cognitive social or emotional deficits, cardiovascular disease, type 2 diabetes mellitus, hypertension, hyperlipidemia, and dementia.Review of Resident #1's Quarterly Minimum Data Set (MDS) indicated he/she was significantly cognitively impaired and had an invoked Health Care Proxy (HCP). Review of the Facility's Internal Investigation Report, dated 06/18/25, indicated that the Certified Occupational Therapist Assistant (COTA) reported to his supervisor that he was asked to assist with securing Resident #1 while he/she was receiving footcare by the Podiatrist, because Resident #1 has a history of becoming combative during care. The Investigation Report indicated that the COTA reported that he felt uneasy with the method being used because it limited Resident #1's mobility during the process of receiving podiatry care. During an interview on 07/29/25 at 1:31 P.M., the Certified Occupational Therapy Assistant (COTA) said that on 06/17/25, he was asked by the Charge Nurse, who was assisting the Podiatrist in providing treatment for Resident # 1, to hold his/her right hand. The COTA said his understanding was that he was to hold Resident #1's hand gently and distract him/her with calming words. The COTA said he held Resident #1's right hand as the Charge Nurse gently laid over his/her lap/legs and held Resident #1's left hand.The COTA said during the care session (which took about 5 to 10 minutes) the Podiatrist cut multiple toenails, and that Resident #1 verbally requested numerous times for his/her feet to be left alone while the Charge Nurse was across his/her lap/legs. The COTA said he felt uncomfortable with the way we were limiting Resident #1's mobility during the process of podiatry care. The COTA said if the Charge Nurse had told him that Resident #1 had been refusing podiatry care and the only method to use to get it done was to restrain him/her, that he would not have assisted them. During an interview on 07/29/25 at 2:00 P.M., the Charge Nurse said that Resident #1 had a history of agitation with personal contact and had been refusing to see the Podiatrist for the past six months. The Charge Nurse said on 06/17/25, Resident #1 was not on the list for the Podiatrist for that day, but she asked the Podiatrist to see him/her. The Charge Nurse said she saw the COTA walking by, and she asked him for assistance. The Charge Nurse said Resident #1 needed podiatry care since he/she was diabetic and had ingrown toenails. The Charge Nurse said she made the decision for Resident 1 to have podiatry care that day. The Charge Nurse said that she laid over the knees of Resident #1, as he/she was refusing, kicking, and combative during care. The Charge Nurse acknowledged that her approach was wrong and said she should have discussed it with the physician to send Resident #1 out of the hospital to have podiatry care. During an interview on 07/29/25 at 2:30 P.M., Certified Nurse Aide (CNA) #1 said on 06/17/25, his job that day was to assist the Podiatrist in positioning residents' feet at a right angle and stay on same side of the foot with the Podiatrist. CNA #1 said the Charge Nurse was holding Resident #1's left hand and the COTA was holding his/her right hand, and immediately Resident #1 became agitated. CNA #1 said the Charge Nurse laid across Resident #1's knees gently. CNA #1 said Resident #1 verbally requested multiple times for his/her feet to be left alone. CNA #1 said that Resident #1 was yelling, Leave me alone, stop. CNA #1 said Resident #1 was forced to receive the care, it was not his/her choice. During an interview on 07/29/25 at 3:17 P.M., the Deputy Executive Director (DED) said the Charge Nurse admitted to laying across Resident #1 to keep him/her from moving. The DED said the Charge Nurse said that Resident #1 was yelling, refusing care, and that Charge Nurse had referred to the incident as a lapse in judgment

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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. Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who had a history of combativeness and resistance with care, the Facility failed to ensure staff consistently implemented interventions identified in his/her plan of care, which indicated when Resident #1 refused care that staff shouldn't force him/her, but instead should reapproach him/her when he/she is more accepting of care. On 06/17/25, although Resident #1 told staff to leave his/her feet alone, exhibited combative behavior during foot care, staff continued with care and did not implement interventions to return later.Findings include: Review of the Facility's Care Planning Policy, dated 12/15/23, indicated that the Facility will develop and implement a plan for each resident that includes the instructions needed to provide effective and person-centered care of the residents that meets professional standards of quality care. Resident #1 was admitted to the Facility in January 2024, diagnoses included cognitive social or emotional deficits, cardiovascular disease, type 2 diabetes mellitus, hypertension, hyperlipidemia, and dementia. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS), from 04/2025, indicated he/she was significantly cognitively impaired and had an invoked Health Care Proxy (HCP). Further review of the MDS Assessment indicated that Resident #1 exhibited behavioral symptoms that included rejecting care, which occurred on one to three days during the seven-day assessment period. Review of Resident #1's Activities of Daily Living (ADL's) Care Plan, reviewed and renewed with his/her 04/15/25 MDS, indicated that Resident #1 had a self-care deficit related to history of left extremity weakness and required assistance with activities of daily living. The ADL's Care Plan interventions indicated Resident #1 should be provided with foot/nail care, nails needed to be filed, and nail edges needed to be smoothed, to refer to a Podiatrist as necessary. Additional Interventions also indicated that Resident #1 has the right to refuse, if he/she refuses care, maintain safety and reapproach. During an interview on 07/29/25 at 2:00 P.M., the Charge Nurse said that Resident #1 has a history of rejecting and being combative with care and that it always takes two, sometimes three, staff members to provide care to him/her. The Charge Nurse said one of Resident #1's care plan interventions included to reapproach him/her multiple times if he/she refused care and to notify the provider. The Charge Nurse said since Podiatry was in the facility, there was no time to reapproach that day and she made the decision to have the Podiatrist see him/her. Ther Charge Nurse said Resident #1's toenail/foot care was essential, because he/she was a diabetic, his/her toenails were jagged and imbedded and that made it difficult for Resident #1 to be able wear shoes, which he/she needed to wear since he/she liked to propel him/herself in a wheelchair. During an interview on 07/29/25 at 12:53 P.M., the Assistant Director of Nursing (ADON) said Resident #1's ADL Care Plan addressed goals and interventions related to him/her rejecting care. The ADON said the Charge Nurse knew that Resident #1 was refusing podiatry care, and she should not have forced him/her to accept the treatment but instead should have sought out assistance from leadership for alternative care. The ADON said the Charge Nurse was educated to seek out help from the providers and nursing leadership when residents demonstrate noncompliance in accepting care.