2019

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

M: Chelsea Place Care Center
25 Lorraine Street
Hartford, CT 06105
PH: 860-233-8241

FLIS Staff

Millicent Reynolds)
Karen Wolek RN

Licensure Category: CCNH

Licensed Bed Bassinet Capacity: 234

Census: 217

Date(s) of onsite inspection: 11/6/19

Date(s) additional information obtained: ___

Personnel contacted: Judith Konow, Administrator

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other (e.g.strikes)*: ___

[ ] Visit **OR** Revisit for the purpose of ___

[✓] See Complaint Investigation # CT 00026320

[✓] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 11/18/19

[ ] Desk Audit ___ [ ] Amended Letter: ___ Original Ltr. ___

[ ] Citation # ___ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # ___ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to ___

REPORT SUBMITTED BY: Millicent Reynolds **DATE OF REPORT:** ___

[ ] Approval for issuance of license granted by: ___ **DATE:** 11/6/19
Supervisor/Title

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

IMPORTANT NOTICE - PLEASE READ CAREFULLY

November 18, 2019

Judith Konow, Administrator
Chelsea Place Care Center
25 Lorraine Street
Hartford, CT 06105

Dear Ms. Konow:

An unannounced visit was made to Chelsea Place Care Center which concluded on November 6, 2019 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Violations of the Connecticut General Statute and/or Regulations of Connecticut State Agencies are attached to the ePOC website for your facility.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction through the ePOC website to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by November 28, 2019.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violation(s) and you may be provided with the opportunity to be heard. If the violation(s) is/are not responded to by November 28, 2019 or if a request for a meeting is not made by the stipulated date, the violation(s) shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to the Supervising Nurse Consultant through the ePOC (as an attachment) website and direct your questions regarding the deficiencies and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

Respectfully,

Karen Gworek RN

Karen Gworek, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG:mb

Complaint #26320

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(A) and/or (m) Nursing Staff (2)(A).

1. Based on clinical record reviews, review of facility documentation and policies, and interviews for one sampled residents (Resident #1) who had an unwitnessed fall that occurred outside on the patio area, the facility failed to ensure the resident was assessed by a licensed nurse prior to the resident being moved. The findings include:
   a. Resident #1's diagnoses included severe protein calorie malnutrition, generalized weakness, chronic low back pain and spinal stenosis. The admission nursing profile dated 9/29/19 identified Resident #1 was alert to person, place and time. The baseline Resident Care Plan dated 9/29/19 identified Resident #1 was at risk for falls due to weakness and impaired gait and balance. Interventions included offering gripper socks and to educate on the use of call bell to summon help. The smoking evaluation dated 10/1/19 identified Resident #1 was appropriate for supervised smoking. A physical therapy order dated 10/4/19 directed for Resident #1 to ambulate independently with a front wheeled walker. The Situation Background Assessment Recommendation (SBAR) Communication form dated 10/7/19 identified Resident #1 had a fall outside during the 8:00 PM smoking break. The note indicated Resident #1 complained of severe pain, rating the pain ten (10) out of ten (10) and upon assessment the right thigh was swollen, firm, tender to touch, and the resident was not able to move the right leg. The note identified subsequent to physician notification Resident #1 was transferred to the hospital. A physician's order dated 10/7/19 at 9:00 PM directed to transfer Resident #1 to hospital for evaluation due to right upper leg swelling and severe pain. The Reportable Event Form dated 10/7/19 identified during the 8:00 PM smoking session, Resident #1 had an unwitnessed fall and was helped up onto a bench by another resident. The investigation identified a staff member was informed, assisted Resident #1 into a wheelchair and returned the resident to the unit. In an interview with Resident #1 on 11/6/19 at 9:20 AM, Resident #1 identified he/she had fallen on 10/7/19 outside in the smoking area when he/she went out for a supervised cigarette break at 8:00 PM. Resident #1 identified that his/her leg got numb and he/she lost his/her balance when he/she attempted to take a step. Resident #1 stated that he/she was assisted up from the ground to the bench by another resident (Resident #2) and then into a wheelchair by a staff member and Resident #2. Interview with the Staff Development Coordinator, Registered Nurse (RN) #2, on 11/6/19 at 12:50 PM, she identified that staff are in-serviced regarding falls and are instructed that the Nursing Supervisor must be called to check a resident after a fall, prior to moving the resident. Interview and review of the educational and in-servicing material with RN #2 on 11/6/19 at 1:45 PM identified the nurse aide who had moved Resident #1 on 10/7/19 from the bench to the wheelchair with the assistance of another resident had completed the competencies on falls directing if a resident falls, not to move or help the resident up, that a Registered Nurse must examine the resident before moving them, and the Nursing Supervisor must be notified of any falls right away. In an interview with the 3-11PM nurse aide, Nurse Aide (NA) #1, on 11/6/19 at 3:00 PM identified during the smoking break on 10/7/19 she was informed by Resident #2 that Resident #1 fell and needed a wheelchair. NA #1 stated she did not see Resident #1 fall and did not see the resident before leaving the smoking area to get the wheelchair. NA #1 identified that upon returning to the smoking area with the wheelchair, Resident #1 was sitting on a bench. NA

#1 stated that she moved Resident #1 from the bench to the wheelchair, took Resident #1 to his/room on the third floor and at that time she reported the fall to the charge nurse. NA #1 identified although it was the facility's practice to call the charge nurse before moving a resident after a fall, she did not inform the charge nurse of the fall until after returning the resident to his/her room. Interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1, on 11/6/19 at 3:30 PM identified she was informed of Resident #1's fall after the resident was transported from the smoking area to his/her room and back to bed by the nurse aide. LPN #1 stated that the Nursing Supervisor was informed of Resident #1's fall immediately after she was informed. An interview with the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1, on 11/6/19 at 4:10 PM identified she was notified that Resident #1 fell after Resident #1 was transported back to the unit and transferred into bed by NA #1. RN #1 stated upon assessment, Resident #1 was in a lot of pain, was unable to move the right lower extremity, and the right hip area was swollen and firm. RN #1 stated the physician was informed and Resident #1 was transported to the hospital. RN #1 indicated Resident #1 should not have been moved before being examined and NA #1 should have notified her or the charge nurse before moving Resident #1. In an interview with the Director of Nursing (DON) on 11/6/19 at 4:15 PM, she identified staff are educated not to move a resident after a fall prior to having an assessment completed by a Registered Nurse. The DON identified and provided documentation of staff education completed 10/8/19 through 10/14/19, after the 10/7/19 incident, which directs a nurse aide was to call for help, stay with the resident and not to move the resident until the Nursing Supervisor assessed the resident. Review of the facility's policy, Fall Management Program directs, in the event that a resident falls, conduct a physical assessment to determine if there are any injuries and notify the Nursing Supervisor immediately.

Plan of Correction for Violation #1:

Approved
1/17/20
KEY

IMPORTANT NOTICE - PLEASE READ CAREFULLY

November 18, 2019

Judith Konow, Administrator
Chelsea Place Care Center
25 Lorraine Street
Hartford, CT 06105

Dear Ms. Konow:

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The plan of correction shall include:

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(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

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You may wish to dispute the violation(s) and you may be provided with the opportunity to be heard. If the violation(s) is/are not responded to by November 28, 2019 or if a request for a meeting is not made by the stipulated date, the violation(s) shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to the Supervising Nurse Consultant through the ePOC (as an attachment) website and direct your questions regarding the deficiencies and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

Respectfully,

/Karen Gworek/, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG:mb

Complaint #26320

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(A) and/or (m) Nursing Staff (2)(A).

1. Based on clinical record reviews, review of facility documentation and policies, and interviews for one sampled residents (Resident #1) who had an unwitnessed fall that occurred outside on the patio area, the facility failed to ensure the resident was assessed by a licensed nurse prior to the resident being moved. The findings include:
   a. Resident #1's diagnoses included severe protein calorie malnutrition, generalized weakness, chronic low back pain and spinal stenosis. The admission nursing profile dated 9/29/19 identified Resident #1 was alert to

person, place and time. The baseline Resident Care Plan dated 9/29/19 identified Resident #1 was at risk for falls due to weakness and impaired gait and balance. Interventions included offering gripper socks and to educate on the use of call bell to summon help. The smoking evaluation dated 10/1/19 identified Resident #1 was appropriate for supervised smoking. A physical therapy order dated 10/4/19 directed for Resident #1 to ambulate independently with a front wheeled walker. The Situation Background Assessment Recommendation (SBAR) Communication form dated 10/7/19 identified Resident #1 had a fall outside during the 8:00 PM smoking break. The note indicated Resident #1 complained of severe pain, rating the pain ten (10) out of ten (10) and upon assessment the right thigh was swollen, firm, tender to touch, and the resident was not able to move the right leg. The note identified subsequent to physician notification Resident #1 was transferred to the hospital. A physician's order dated 10/7/19 at 9:00 PM directed to transfer Resident #1 to hospital for evaluation due to right upper leg swelling and severe pain. The Reportable Event Form dated 10/7/19 identified during the 8:00 PM smoking session, Resident #1 had an unwitnessed fall and was helped up onto a bench by another resident. The investigation identified a staff member was informed, assisted Resident #1 into a wheelchair and returned the resident to the unit. In an interview with Resident #1 on 11/6/19 at 9:20 AM, Resident #1 identified he/she had fallen on 10/7/19 outside in the smoking area when he/she went out for a supervised cigarette break at 8:00 PM. Resident #1 identified that his/her leg got numb and he/she lost his/her balance when he/she attempted to take a step. Resident #1 stated that he/she was assisted up from the ground to the bench by another resident (Resident # 2) and then into a wheelchair by a staff member and Resident #2. Interview with the Staff Development Coordinator, Registered Nurse (RN) #2, on 11/6/19 at 12:50 PM, she identified that staff are in-serviced regarding falls and are instructed that the Nursing Supervisor must be called to check a resident after a fall, prior to moving the resident. Interview and review of the educational and in-servicing material with RN #2 on 11/6/19 at 1:45 PM identified the nurse aide who had moved Resident #1 on 10/7/19 from the bench to the wheelchair with the assistance of another resident had completed the competencies on falls directing if a resident falls, not to move or help the resident up, that a Registered Nurse must examine the resident before moving them, and the Nursing Supervisor must be notified of any falls right away. In an interview with the 3-11PM nurse aide, Nurse Aide (NA) #1, on 11/6/19 at 3:00 PM identified during the smoking break on 10/7/19 she was informed by Resident #2 that Resident #1 fell and needed a wheelchair. NA #1 stated she did not see Resident #1 fall and did not see the resident before leaving the smoking area to get the wheelchair. NA #1 identified that upon returning to the smoking area with the wheelchair, Resident #1 was sitting on a bench. NA #1 stated that she moved Resident #1 from the bench to the wheelchair, took Resident #1 to his/room on the third floor and at that time she reported the fall to the charge nurse. NA #1 identified although it was the facility's practice to call the charge nurse before moving a resident after a fall, she did not inform

the charge nurse of the fall until after returning the resident to his/her room. Interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1, on 11/6/19 at 3:30 PM identified she was informed of Resident #1's fall after the resident was transported from the smoking area to his/her room and back to bed by the nurse aide. LPN #1 stated that the Nursing Supervisor was informed of Resident #1's fall immediately after she was informed. An interview with the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1, on 11/6/19 at 4:10 PM identified she was notified that Resident #1 fell after Resident #1 was transported back to the unit and transferred into bed by NA # 1. RN #1 stated upon assessment, Resident #1 was in a lot of pain, was unable to move the right lower extremity, and the right hip area was swollen and firm. RN #1 stated the physician was informed and Resident #1 was transported to the hospital. RN #1 indicated Resident #1 should not have been moved before being examined and NA #1 should have notified her or the charge nurse before moving Resident #1. In an interview with the Director of Nursing (DON) on 11/6/19 at 4:15 PM, she identified staff are educated not to move a resident after a fall prior to having an assessment completed by a Registered Nurse. The DON identified and provided documentation of staff education completed 10/8/19 through 10/14/19, after the 10/7/19 incident, which directs a nurse aide was to call for help, stay with the resident and not to move the resident until the Nursing Supervisor assessed the resident. Review of the facility's policy, Fall Management Program directs, in the event that a resident falls, conduct a physical assessment to determine if there are any injuries and notify the Nursing Supervisor immediately.

Plan of Correction for Violation #1:

The filing of this plan of correction does not constitute an admission of any fact or that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's commitment to comply with the legal requirements and to continue to provide high quality resident care.

Resident #1 still resides at the facility.

Residents who have an unwitnessed fall have the potential to be affected by the alleged deficient practice.

Nurses Aides were re-educted on ensuring residents are assessed by a registered nurse prior to moving a resident after a suspected fall.

Fall investigations will be audited to ensure residents were not transferred by a nurses aide prior to a registered nurse assessing them. This audit will continue for a period of 30 days and will commence as of November 26, 2019.

Results of the audit will be reported at the facility QAPI meetings.

The Director of Nursing or designee will be responsible to oversee this process.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

IMPORTANT NOTICE - PLEASE READ CAREFULLY

May 8, 2019

Judith Konow, Administrator
Chelsea Place Care Center
25 Lorraine St
Hartford, CT 06105

Dear Ms. Konow:

An unannounced visit was made to Chelsea Place Care Center which concluded on May 3, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a complaint investigation with additional information received through May 3, 2019.

Violations of the Connecticut General Statute and/or Regulations of Connecticut State Agencies are attached to the ePOC website for your facility.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction through the ePOC website to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by May 18, 2019.

The plan of correction shall include:

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You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by May 18, 2019 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed

admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to the Supervising Nurse Consultant through the ePOC (as an attachment) website and direct your questions regarding the deficiencies and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

Respectfully,

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC:mb

Complaint #25255

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (o) Medical Records (m).

1. Based on review of the clinical record review, review of facility documentation, review of facility policies and procedures and interviews for one of three residents (R #2) reviewed for behaviors, the facility failed to ensure the behavior tracking log was accurate. The findings include:
   a. R #2's diagnoses included schizoaffective disorder, bipolar, anxiety, and disruptive mood. The quarterly MDS assessment dated 2/12/19 identified that R #2 was alert/oriented, had verbal behaviors directed at others daily, and ambulated independently. The Resident Care Plan (RCP) dated 2/28/19 identified a psychosocial risk related to psychological condition with interventions directed to have a psychiatric consult as needed, and report any concerns or changes to the attending physician. Review of the physician's order dated 2/1/19 directed to administer Ativan 0.5 mg BID for agitation/yelling, and on 2/6/19 directed to administer Invega 9 mg by mouth every morning.
   Review of the clinical record identified a behavior tracking log for targeted behaviors of yelling/screaming, medication refusal, intrusive behavior, physical aggression, paranoia, and increased agitation. Review of the nurse's note written by LPN #1, dated 4/1/19 at 11:30 PM identified R #2 was very disruptive, aggressive, yelling, continuously trying to hit staff and other residents and resistive when redirected. R #2 refused PRN Ativan four times and staff had to be constantly trying to prevent physical contact when R #2 frequently went into other resident rooms yelling and holding up his/her fist. Further review identified that security was called to the unit, the supervisor was notified, and R #2 took scheduled medications at 5:00pm and 9:00pm.
   Review of the behavior tracking log on 4/1/19 for the 3-11 PM shift, identified R #2 had frequent yelling/screaming with redirection, 1:1, returned to his/her room and medication given. The log identified a zero for outcome or side effect. Additional review identified R #2 had no physical aggression, no intrusive behaviors, and no agitation during the 3-11 PM shift on 4/1/19, with zeros noted in the corresponding boxes.
   Review of the clinical record, facility documentation and interview with the Administrator and DON on 5/3/19 at 1:30 PM identified LPN #1 may have completed the behavior tracking log early in the 3-11 shift and may not have corrected the log to reflect R #2's actual behaviors. Further interview identified that the tracking log should be accurate, and the nurse should have corrected the behavior log to reflect actual resident behaviors.
   LPN #1 was unavailable for interview during the survey.
   Review of facility Behavior Monitoring Policy and Procedure directed in part, patients exhibiting behavioral symptoms will be individually evaluated to determine the behavior, the flow record will be used for patients who are taking psychotropic medications that require monitoring, and will be used as long as the patient is taking the medication. The licensed nurse will record the number of behavioral episodes by shift and a zero or blank box indicates no behavior was present that shift.

Plan of Correction for Violation #1:

Plan of Correction

The filing of this plan of correction does not constitute an admission of any fact or that the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's commitment to comply with the legal requirements and to continue to provide high quality resident care.

Resident #2 resides in the facility in stable condition. His behaviors continue to be documented on the behavior tracking log.

Residents on psychotropic medication with behaviors have the potential to be affected by the alleged deficient practice.

Licensed nurses will be educated on the Behavior Monitoring Policy and Procedure.

The medical records for residents who are on psychotropic medication will be audited to insure accurate documentation of behaviors on the behavior tracking logs. Audits will continue for a period of 30 days or until substantial compliance is achieved.

All findings will be reviewed at the facility QAPI meetings until substantial compliance is achieved.

The Director of Nursing or designee is responsible for oversight.

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Chelsea Place Care Center
25 Lorraine St
Hartford, CT 06105

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Respectfully,

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC:mb

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   Review of the behavior tracking log on 4/1/19 for the 3-11 PM shift, identified R #2 had frequent yelling/screaming with redirection, 1:1, returned to his/her room and medication given. The log identified a zero for outcome or side effect. Additional review identified R #2 had no physical aggression, no intrusive behaviors, and no agitation during the 3-11 PM shift on 4/1/19, with zeros noted in the corresponding boxes.
   Review of the clinical record, facility documentation and interview with the Administrator and DON on 5/3/19 at 1:30 PM identified LPN #1 may have completed the behavior tracking log early in the 3-11 shift and may not have corrected the log to reflect R #2's actual behaviors. Further interview identified that the tracking log

should be accurate, and the nurse should have corrected the behavior log to reflect actual resident behaviors.
LPN #1 was unavailable for interview during the survey.
Review of facility Behavior Monitoring Policy and Procedure directed in part, patients exhibiting behavioral symptoms will be individually evaluated to determine the behavior, the flow record will be used for patients who are taking psychotropic medications that require monitoring, and will be used as long as the patient is taking the medication. The licensed nurse will record the number of behavioral episodes by shift and a zero or blank box indicates no behavior was present that shift.

Plan of Correction for Violation #1: Plan of Correction

The filing of this plan of correction does not constitute an admission of any fact or that the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's commitment to comply with the legal requirements and to continue to provide high quality resident care.

Resident #2 resides in the facility in stable condition. His behaviors continue to be documented on the behavior tracking log.

Residents on psychotropic medication with behaviors have the potential to be affected by the alleged deficient practice.

Licensed nurses will be educated on the Behavior Monitoring Policy and Procedure.

The medical records for residents who are on psychotropic medication will be audited to insure accurate documentation of behaviors on the behavior tracking logs. Audits will continue for a period of 30 days or until substantial compliance is achieved.

All findings will be reviewed at the facility QAPI meetings until substantial compliance is achieved.

The Director of Nursing or designee is responsible for oversight.

Completion date 6-12-19