

03/16/2004 12:26 FAX

**State of Connecticut  
Department of Public Health  
Division of Health Systems Regulation**

IN RE: Candlewood New Milford, LLC of New Milford, CT. - Licensee  
Candlewood Valley Health & Rehabilitation Center  
30 Park Lane East  
New Milford, CT 06776

**CONSENT ORDER**

WHEREAS, Candlewood New Milford, LLC of New Milford, CT (hereinafter the "Licensee") has been issued License No. 2207-C to operate a Chronic and Convalescent Nursing Home known as Candlewood Valley Health and Rehabilitation Center (hereinafter the "Facility") by the Department of Public Health, (hereinafter the "Department"); and

WHEREAS, the Division of Health Systems Regulation ("DHSR") of the Department conducted unannounced inspections on various dates commencing on September 23, 2003 up to and including October 2, 2003 for the purpose of conducting a certification inspection and an investigation; and

WHEREAS, the Department during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of the Connecticut State Agencies in the violation letter dated November 5, 2003 (Exhibit A- copy attached); and

WHEREAS, an informal conference with respect to the November 5, 2003 violation letter was conducted on November 24, 2003 at the office of the Department; and

WHEREAS, the Licensee is willing to enter this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the Division of Health Systems Regulation of the Department of Public Health of the State of Connecticut acting herein and through Marianne Horn, its Director, and the Licensee, acting herein by Fred Rzepka, its Managing Partner, hereby stipulate and agree as follows:

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1. The Facility shall execute a contract with an Independent Nurse Consultant (INC) within two (2) weeks of the effective date of this Consent Order.
2. The Independent Nurse Consultant shall serve for a minimum of six (6) months unless the Department identifies through inspections that the continued presence of the Independent Nurse Consultant is necessary to ensure substantial compliance with the provisions of the Regulations of Connecticut State Agencies or federal requirements (42 CFR Part 483 Subpart B requirements for Long Term Care Facilities). The Department may, at its discretion, at any time or from time to time, reduce the hours of the Independent Nurse Consultant and/or responsibilities, if, in the Department's view, the reduction is warranted. The terms of the contract effected with the Independent Nurse Consultant shall include all pertinent provisions contained in this Consent Order. The Independent Nurse Consultant shall be at the Facility twenty-eight (28) hours per week.
3. The Independent Nurse Consultant shall conduct and submit to the Department an initial assessment of the Facility's regulatory compliance and identify areas requiring remediation. Said Facility evaluation shall be completed the first two (2) weeks the INC assumes the position. The Independent Nurse Consultant shall submit a weekly written report identifying the Facility's initiatives to comply with applicable federal and state statutes and regulations and the Independent Nurse Consultant's assessment of the care and services provided to patients, subsequent recommendations made by the Independent Nurse Consultant and the Facility's response to implementation of said recommendations. Copies of said reports shall be provided to the Director of Nurses, Administrator and Medical Director. The Independent Nurse Consultant's position shall be occupied and the duties of said Independent Nurse Consultant shall be performed by a single individual unless otherwise approved by the Department. The Independent Nurse Consultant shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts inclusive of holidays and weekends. Said Consultant shall confer with the Facility's Administrator, Director of Nursing Services and other staff as the

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Consultant deems appropriate concerning the assessment of nursing services and the Facility's compliance with federal and state statutes and regulations. Said Independent Nurse Consultant shall make recommendations to the Facility's Administrator and Director of Nursing Services for improvement in the delivery of direct patient care in the Facility. The Independent Nurse Consultant shall have a fiduciary responsibility to the Department. If the Independent Nurse Consultant and the Facility are unable to reach an agreement regarding the Independent Nurse Consultant's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination which, during the term of this Consent Order shall be binding on the Facility.

4. The Independent Nurse Consultant shall have the responsibility for:
  - i. Assessing, monitoring and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides and orderlies and implementing prompt training and/or remediation in the area in which said staff member demonstrated a deficit. Records of said training by the Facility shall be maintained for review by the Department;
  - ii. Recommending to the Department an increase in the Independent Nurse Consultant's monitoring hours if unable to fulfill the responsibilities within the stipulated twenty-eight (28) hours per week;
  - iii. Review of all patient care policies and procedures relative to investigating injuries, monitoring and assessing patients; and
  - iv. Assessing, monitoring and evaluating the coordination of patient care and services delivered by the various health care professionals providing services within the Facility.
5. The Independent Nurse Consultant, the Facility's Administrator, and the Director of Nursing Services shall meet with the Department every six (6) weeks for the first three (3) months after the effective of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the Independent Nurse Consultant. Said meetings shall include discussions of issues related to

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- the care and services provided in the Facility and compliance with applicable federal and state statutes and regulations.
6. Director of Nursing Service/Assistant Director of Nursing Service shall conduct random unannounced visits to the Facility to assess care/services being provided. Said visits shall occur on holidays, weekends and shall include all three (3) shifts. Documentation of observations relative to these visits shall be maintained and available for Department review.
  7. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the Independent Nurse Consultant and the Department, upon their request.
  8. The Department shall retain the authority to extend the period the Independent Nurse Consultant functions are required, should the Department determine that the Facility is not able to maintain substantial compliance with federal and state laws and regulations. Examples of violations which may cause the Department to invoke this provision include, but are not limited to, failure to notify the physician of a significant change in condition and/or failure to provide care and treatment to patients identified with unstable health conditions and/or failure to implement physician orders or plans of care. Determination of compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department. The Registered Nurse assuming the functions of the Independent Nurse Consultant shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
  9. The Administrator shall immediately notify the Department if the position(s) of Administrator, Director of Nurses, Assistant Director of Nurses, and/or Medical Director, the Infection Control Nurse and/or MDS Coordinator become vacant due to resignations. The Administrator shall provide the Department with weekly reports pertaining to recruitment efforts for any of the previously identified positions.
  10. The Licensee represents, stipulates and agrees that at all times it will employ sufficient personnel to meet the needs of the patient population. The Licensee

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15. The Facility shall appoint a credentialed Infection Control Nurse to serve a minimum of sixteen (16) hours per week. The Infection Control Nurse may not have any other duties except those relating to the monitoring of infection control principals/practices and the monitoring and training of the staff in areas related to infection control.
16. The Facility shall contract with a registered nurse credentialed in wound care. The Wound Care Consultant shall serve a minimum of eight (8) hours weekly and shall conduct training, provide oversight to nursing staff, maintain weekly statistics, observe all pressure sores, monitor preventative protocols and assessments for patients at risk.
17. The Facility shall establish a Quality Assurance Program to review patient care issues inclusive of those identified in the November 5, 2003, violation letter issued by the Department. The members of the quality assurance program shall meet at least monthly to review and address the quality of care provided to residents and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors and the Medical Director. Minutes of said meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
18. Within seven (7) days of the execution of this Consent Order the Licensee shall identify the Facility's Administrative Staff responsible for monitoring the implementation of this document.
19. The Licensee shall pay a monetary fine to the Department in the amount of twelve thousand dollars (\$12,000.00), which shall be payable by certified check to the Treasurer of the State of Connecticut and shall be posted to the Department within (2) weeks of the effective date of this Consent Order. Said check and any reports required by this document shall be directed to:

Rosella Crowley, R.N., SNC  
Division of Health Systems Regulation  
Department of Public Health  
410 Capitol Avenue, P.O. Box 340308  
MS #12HSR  
Hartford, CT 06134-0308

20. In accordance with Connecticut General Statutes Section 19a-494(a)(4) the Licensee is hereby reprimanded.
21. All parties agree that this Consent Order is an Order of the Department with all of the

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rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

- 22. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
- 23. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
- 24. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

CANDLEWOOD NEW MILFORD, LLC OF NEW MILFORD, CT.

3/16/04  
Date

By: [Signature]  
Fred Rzepka, its Manager

STATE OF OHIO

County of CUYAHOGA ss March 19, 2004

Personally appeared the above named Fred Rzepka and made oath to the truth of the statements contained herein.

My Commission Expires: 3/21/07  
(If Notary Public)

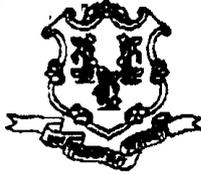
BEVERLY L. BALCER  
Notary Public, State of Ohio, Cuy. Cty.  
My commission expires Mar. 21, 2007

[Signature]  
Notary Public   
Justice of the Peace [ ]  
Town Clerk [ ]  
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

3/25/04  
Date

By: [Signature]  
Marianne Horn, R.N., J.D., Director  
Division of Health Systems Regulation



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A  
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November 5, 2003

Francis Meyer, Administrator  
Candlewood Valley Health & Rehabilitation Center  
30 Park Lane East  
New Milford, CT 06776

Dear Administrator:

Unannounced visits were made to Candlewood Valley Health & Rehabilitation Center on September 23, 24, 25, 26, 29, 30 and October 1, 2, 2003 representatives of the Division of Health Systems Regulation for the purpose of conducting a certification inspection and an investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit.

An office conference has been scheduled for November 24, 2003 at 10:30 AM in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Hartford, Connecticut.

The purpose of this meeting is to provide you with an opportunity to show why further action by this Department should not be instituted.

You may wish to be accompanied by your attorney. It is not mandatory that you attend this meeting, however, if you do not attend we will have no recourse but to institute further proceedings.

Please prepare a written Plan of Correction for the above mentioned violation(s) to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repair, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office.  
Respectfully,

*Rosella Crowley RN / JSA*

Rosella Crowley, RN  
Supervising Nurse Consultant  
Division of Health Systems Regulation

RAC/AOB/jf

cc: Director of Nurses  
Medical Director  
President

RE2003-0765



Phone: (860) 509-7400  
Telephone Device for the Deaf (860) 509-7191  
410 Capitol Avenue - MS # 12HSR  
P.O. Box 340308 Hartford, CT 06134  
An Equal Opportunity Employer

FACILITY: Candlewood Valley Health &amp; Rehabilitation Center

DATE(S) OF VISIT: September 23, 24, 25, 26, 29, 30 and October 1, 2, 2003

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT  
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES  
WERE IDENTIFIED

1. Based on clinical record reviews, and interviews for eleven of eleven sampled residents with a significant changes in condition (R#2, 6, 9, 12, 18, 19, 20, 21, 22, 24, 35), the facility failed to immediately notify the attending physician and/or responsible party of new pressure sores and/or swallowing problems.
  - a. Resident #2's diagnoses included a history of aspiration pneumonia, dehydration and dementia. A nurse's note dated 7/31/03 identified that the resident had vomited as he started to eat dinner and that the speech therapist had recommended a puree diet with nectar liquids until she could evaluate the resident. The note further identified that an update was faxed to the physician along with a request for diet change. A note dated 8/1/03 at 2:50 PM identified that the resident had poor intake, was coughing a lot during meals and that there was no response from the physician on the request for a speech evaluation and diet change. A note at 10:40 PM noted that the resident was lethargic, had no bowel sounds and very poor intake. The note identified that the physician was "faxed" an update, but did not respond. A note on 8/2/03 at 2 PM identified that the resident was put back to bed due to leaning over in chair and that the resident's son was requesting psychiatry re-evaluate the use of Seroquel. The note identified that another fax was sent to the physician. At 2:30 PM, an entry identified that a covering physician phoned after receiving a call from the resident's son and that labs were ordered. On 8/3/03 the resident was noted to have decreased breath sounds, a oxygen saturation of 84% and temperature of 101.2. The resident was sent to the emergency department and admitted with diagnoses that included aspiration pneumonia.
  - b. Resident #20's assessment dated 01/01/03 identified the resident as severely cognitively impaired and totally dependant on staff for all activities of daily living. The resident care plan dated 1/08/03 identified the resident to be at risk for aspiration with interventions that included providing honey thickened liquids. Observation of the resident on 9/25/03 during morning care at 10:30 AM noted that when the resident's bed was lowered to 30 degrees, the resident was observed to have an occasional cough. Further observation of the resident during the noon meal noted the resident being fed pureed food and thickened liquids. The resident was observed pocketing food in her mouth and swallowing was delayed. The resident continued to cough and gag and her face occasionally turned red. Interview with the charge nurse and review of the clinical record noted that since January 2003, the resident was noted to have increasing problems swallowing and respiratory congestion and that the problem had been reported to the attending physician on several occasions without changes to the plan of care. Subsequent to surveyor inquiry, the medical director saw the resident and ordered a speech evaluation. Interview with the 3-11 supervisor on 9/29/03 at 1:30 PM noted that she had

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- contacted the attending physician to report a decline in the resident's swallowing and need for suctioning in August 2003. The physician refused a request by staff for a speech therapy screen. Interview with the speech therapist on 9/29/03 at noon noted that she had performed an evaluation on the resident on 9/29/03 and found that the resident was unsafe to eat or drink without significant aspiration. Interventions were developed to lessen the risk of aspiration including feeding pudding thickened liquids and feeding only 1/2 teaspoon at a time. Interview with the Administrator and DNS on 9/29/03, noted that facility policy is to refer resident issues that are not responded to by the attending physician to the medical director and that they had failed to do so until surveyor inquiry. Nursing notes identified that the resident developed a temperature of 102.2 on 9/26/03 and congestion. Antibiotics were administered to the resident.
- c. Resident #22 was admitted to the facility on 8/26/03 with diagnoses that included a fractured hip with an open reduction of the fracture. The hospital discharge summary noted the presence of a 2.5 cm open area on the resident's coccyx that was being treated with a Tegaderm dressing. The nursing admission assessment dated 8/26/03 identified that the resident had a 2-3 cm stage two pressure sore of the coccyx, but the resident would not allow the nurse to assess the wound. Review of physician orders identified that the first treatment order for the coccyx pressure sore was entered on 9/2/03 for a chemical debriding agent, Santyl. No prior orders were noted. The treatment kardex for August identified that no treatments were provided to the coccyx wound from 8/26/03 until 8/29/03 at which time EPC cream (a barrier ointment used for protection from incontinence) was applied to the wound. A nurse's note dated 8/30/03 identified that the wound was now 7 x 6 cm and necrotic in the center with redness surrounding the wound. No treatment orders/physician notification was noted in the record until 9/2/03. A nurse's note dated 9/11/03 identified a 2 x 1 cm dark area on the left heel. On 9/14/03 notes identify foul smelling drainage from the coccyx wound. On 9/15/03 notes identify that heel protectors were provided to the resident and that the coccyx wound had a green center. On 9/16/03 the physician was notified and changed the treatment order to the coccyx. On 9/24/03 the physician was called and facility staff requested a surgical consult. On 9/26/03 the resident was transferred to the hospital for treatment and evaluation of a stage IV pressure sore of the coccyx and admitted. Review of the clinical record with the wound nurse on 10/1/03 failed to provide evidence that the physician had been notified/treatment orders obtained for the coccyx wound from admission on 8/26/03 through 9/2/03 or from 9/14-9/16/03 when the wound was noted to have foul smelling and/or green drainage. Review of the acute care record on 10/2/03 identified that the resident was in surgery for

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- debridement and grafting of the stage four pressure sore of the sacrum. The hospital record identified that the resident required intravenous antibiotics prior to surgery to treat the infection.
- d. Resident #6's assessment dated 1/16/03 identified the resident as severely cognitively impaired and dependent on staff for all activities of daily living including requiring extensive assistance for bed mobility. A nursing narrative note dated 2/10/03 on the 7 AM-3 PM shift noted a small dark area on the outer aspect of the left heel. On 2/11/03 a blister was noted on the left heel that had progressed to a blackened area on 2/24/03. Review of the nursing narrative notes noted that the physician and family were first notified of the area on the left heel on 3/4/03. Review of the clinical record with the assistant director of nursing on 9/25/03 noted that the physician and family failed to be notified on 2/11/03 when the area was first identified and/or a treatment obtained from the physician.
- e. Resident #21's diagnoses included cancer of the prostate. Review of the nurse's notes dated 8/25/03 revealed the resident had a 3.5cm x 5.5cm dark area on the left heel. A Xeroform gauze dressing was applied. On 8/27/03 the wound was documented as a 6 cm x 5 cm white macerated area with a 4 cm x 3 cm necrotic area in the center. A fax was sent to the physician on 8/27/03 with a request for a treatment order. No orders were noted until 9/02/03 when the physician ordered a Santyl dressing to the wound. Review of the clinical record and interview with the assistant director of nursing on 9/29/03 failed to provide evidence that the physician had been notified of the open area or that a treatment order had been obtained from 8/25/03 through 9/2/03.
- f. Resident #12's assessment dated 4/23/03 identified the resident as cognitively impaired, having difficulty communicating needs, and required maximum assistance with all activities of daily living. On 6/04/03 the resident was readmitted to the facility after a surgical repair of a fracture of the left hip. On 6/09/03 at 2 AM, the resident was observed with the left leg externally rotated and flexed with the resident exhibiting facial grimacing when attempts were made to reposition the leg. The resident was assessed by the supervisor at the time and requested that the charge nurse administer pain medication to the resident. Review of the nurse's notes dated 6/09/03 at 10 AM, revealed that the resident's left lower extremity was externally rotated and the resident appeared to be experiencing pain as evidenced by facial grimacing. The notes further documented that the physician was notified and the resident was sent to the hospital for evaluation where she was admitted for a peri-prosthesis fracture of the left hip. During an interview with the supervisor on 9/24/03, she reported that she had not called the physician sooner because she did not think anything was wrong.

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- g. Resident #9's diagnoses included pneumonia, congestive heart failure and syncope. A quarterly assessment dated 2/26/03 identified that the resident was not cognitively impaired, required assistance with activities of daily living and did not have any vascular or pressure ulcers. Nursing notes dated 4/1/03 identified that the resident complained of discomfort to the right foot and that the inner malleolus was noted to have a scabbed area with a slight green tinge at the center and redness surrounding the scab. A nurse's note dated 4/3/03 identified that the right ankle was noted to have green drainage. The physician was notified at this time and ordered a treatment to the area. Interview and review of the clinical record on 9/24/03 with the charge nurse failed to provide evidence that the attending physician was notified on 4/1/03 when the right ankle area was noted to be green in color with a scab. The nurse stated that he did not call the physician but had informed the supervisor.
- h. Resident #19's assessment dated 1/15/03 identified the resident as moderately cognitively impaired and independent for activities of daily living including ambulating. Nursing narrative notes dated 4/3/03 at 8 AM revealed that the resident stated to a nursing assistant that he had fallen in the bathroom. X-rays of the pelvis and hips were taken and were negative for a fracture. Nursing narrative notes dated 4/4/03 at 3 PM noted that the resident required the assistance of two staff to get out of bed and had difficulty bearing weight on the left leg. On 4/7/03, nursing narrative notes revealed that the resident was staying in bed and "not calling out like he usually does". On 4/10/03, nursing narrative notes on the 7-3 shift identified that the resident required the assistance of two staff with ambulation, and extensive assistance with transfers, dressing, and toilet use. On 4/11/03, the physician was notified of the resident's decline. A bone scan was performed and identified that the resident had a fractured pelvis. Review of the clinical record with licensed staff on 9/25/03 failed to provide evidence that the physician was notified when the resident's decline and inability to ambulate were identified.
- i. Resident #24's diagnoses included cellulitis of the leg with a chronic ulcer, diabetes and congestive heart failure. Nurse's notes dated 9/8/03 identified that the resident's right heel was discolored. Review of the clinical record with the assistant director of nursing on 9/29/03 at 10 AM failed to provide evidence that the resident's physician was notified of the new pressure sore from 9/8/03 until 9/12/03 at which time the facility faxed a notice to the physician with orders then received to apply a protective dressing to both heels and apply heel protectors while in bed.
- j. Resident #18's diagnoses included insulin dependent diabetes. An assessment dated 4/23/03 identified the resident as severely cognitively impaired and totally dependent on staff for all activities of daily living. Physician monthly orders dated May 2003 included Novolin Lrsulin 13 units every morning and 7 units every

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- afternoon. The resident also received regular insulin coverage for blood sugars over 251. Review of the nurse's notes revealed that on 5/18/03 the resident vomited the evening meal. At 9:00 PM the residents blood sugar was 82 mg and the resident was given Glucogan Gel 2 tubes. The resident's blood sugar was rechecked and noted to be 92 mg, which was considered low for this resident per nurse's notes. At 10:15 PM the Glucogan Emergency Kit was administered to the resident and the resident's blood sugar was rechecked at 10:30 PM and found to be 161 mg. At 6:00 AM and 7:00 AM the resident again vomited and had a temperature of 102.8. Review of the clinical record with the assistant director of nursing on 10/1/03 at 2 PM failed to provide evidence that the physician was notified of the resident's blood sugars, vomiting and fever until 10:25 AM on 5/19/03. The physician ordered antibiotic therapy.
- k. Resident #35's clinical record identified that a gastroenterology consult on 9/24/03 recommended that the resident receive Nexium and Mylanta as needed and that a HIDA scan be scheduled. Review of nurse's notes identified that faxes were sent to the attending physician on 9/24 and 9/27/03 requesting the changes without a reply or acknowledgement from the physician. On 9/30/03, the medical director approved of the consultant's recommendations. Review of the clinical record on 10/2/03 with the assistant director of nursing failed to provide evidence that the attending physician was called and/or medical director asked to intervene prior to 9/30/03.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t  
(i) Director of Nurses (2)(L).

2. Based on clinical record review and interview for one of three sampled residents who utilized restraints (R#14), the facility failed to assess the resident prior to placing a sock over the resident's hands to prevent the resident from scratching. The findings include:
- a. Resident #14's diagnoses included a stroke with left side hemiparesis. The quarterly assessment dated 4/14/03 identified that the resident was cognitively impaired and totally dependent on staff for hygiene. The resident care plan dated 4/3/03 identified a problem with skin integrity related to fragile skin/scratching/picking at the skin. Review of facility documentation dated 5/1/03 identified that a nurse aide had put a sock over the resident's hand to prevent the resident from scratching. The resident attempted to pull off the sock with her teeth resulting in the loss of three lower teeth. During an interview with the nurse aide on 9/25/03, she stated that she put the sock on the resident's hand for less than five minutes to prevent her from scratching while she provided care. Review of the

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record with the charge nurse failed to provide evidence that the resident had been assessed for the need for a sock as a preventive measure for scratching.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (i) Director of Nurses (2) and/or (c) Medical Records (2)(H).

- 3. Based on clinical record reviews, review of facility reportable event documentation and interviews for two of two residents with injuries of unknown origin (R#6, 12), the facility failed to thoroughly investigate the injuries to attempt to determine their origin. The findings include:
  - a. Resident #6's assessment dated 1/16/03 identified the resident as severely cognitively impaired and totally dependent on staff for activities of daily living. Facility documentation dated 7/7/03 identified that the resident had ecchymotic areas noted on the right foot and 2<sup>nd</sup> toe. Further review of facility documentation with the Director of Nursing (DNS) on 9/23/03 at 11 AM failed to provide evidence that the bruises had been investigated to attempt to determine their origin.
  - b. Resident #12's assessment dated 4/23/03 identified the resident as cognitively impaired, rarely understands or is understood, and required maximum assistance for all activities of daily living. The resident care plan dated 4/23/03 identified falls as a problem with interventions that included utilizing two persons and extensive assistance with a gait belt for transfers. On 5/26/03 nurse's notes identified that the resident was diagnosed with a fracture of the left hip. The subsequent investigation revealed that on 5/22/03 the resident had experienced an incident during a transfer when only one nurse aide was in attendance. During interviews on 9/24/03 with the two nurse aides who were attending to the resident's roommate on 5/22/03, they reported that they heard a thump/crash behind R#12's privacy curtain and upon entering, they observed Nurse Aide #3 holding the resident up off the floor. Although the incident was reported to the charge nurse at the time, no report or investigation was initiated. In addition, on 6/04/03 the resident was readmitted to the facility after an open reduction internal fixation of a fracture of the left hip. On 6/09/03 the resident was diagnosed with a peri-prosthesis fracture of the recently repaired left hip fracture. The resident's left leg was externally rotated, flexed and the resident demonstrated facial grimacing/pain with attempted repositioning of the leg. Review of the incident with the director of nursing failed to provide evidence that the facility had initiated the required report or investigation into the injury of unknown origin.

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8f (f) Administrator (3) and/or (g) Reportable Events (6).

- 4. Observation of resident lunch on 9/23 and 9/24/03 and breakfast on 9/24/03 noted the use of plastic disposable cold cups for all beverages during meals. During an interview with the food service supervisor on 9/24/03 she stated that there were no permanent dinnerware containers available and therefore they used disposable cups.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8f (f) Administrator (3).

- 5. Based on clinical record reviews, review of reportable events and interviews for three sampled residents (R#12, 19, 26), the facility failed to provide care in accordance with standards of practice related to medication administration and assessment of residents who complain of pain or who suffered a fall. The findings include:
  - a. Resident #12's diagnoses included dementia and stroke. An assessment dated 4/23/03 identified that the resident was cognitively impaired, and required maximum assistance for all activities of daily living. On 5/22/03 the resident experienced an incident while being transferred by a nurse aide. Although the nurse aide reported the incident to the charge nurse (LPN), the charge nurse did not report the incident to the supervisor and the resident was not assessed for injury. During an interview with the charge nurse on 9/24/03, he reported that he had checked the resident and did not think anything was wrong. Subsequently he did not report the incident to the supervisor. On 5/26/03 the resident was diagnosed with a fractured hip. According to Expert Rapid Response by Mosby 1999, if you find the patient on the floor perform a rapid head to toe assessment no matter how insignificant the accident seems. Once the patient is stabilized help the patient back to bed or chair unless you suspect a fracture.
  - b. Resident #19's assessment dated 1/15/03 identified the resident as moderately cognitively impaired and independent in ADL's. The assessment further identified that the resident had no functional limitation in range of motion. Nursing narrative notes dated 4/3/03 on the 7 AM-3 PM shift revealed that the resident stated that he had fallen in the bathroom. The resident further stated "it hurts down my leg and in through here, motioning to the left inguinal and around the back". The narrative notes further identified that the left hip area was tender to touch with limited range of motion secondary to pain. An x-ray was negative for fracture. From 4/3 to 4/23/03 the resident required the assistance of two staff for ambulation. A bone scan dated 4/23/03 identified a pelvic fracture. Interview with the ADNS on

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9/25/03 at 11:30 AM noted that the facility failed to perform an assessment of the resident following the resident's fall and subsequent decline in function. According to Clinical Nursing Skills, Fifth Edition, 2000, assessment requires skilled observation, reasoning, and a theoretical knowledge base to gather and differentiate, verify, and organize data, and document the findings. Assessment is a critical phase because all the other steps in the process depend on the accuracy and reliability of the assessment.

- c. On 9/24/03 at 8:29 AM, the licensed nurse on A wing was observed administering medications to Resident #36. After pouring ten medications for the resident, the nurse left the medications on the resident's over bed table next to the resident's breakfast tray and left the room. When the nurse was interviewed at 8:35 AM, the nurse reported that the resident was good and always took her medications after she ate breakfast. According to Pharmacology, A Nursing Practice, Second Edition, 1997, guidelines for administration of medications state to stay with the client until the medications are taken.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t  
(i) Director of Nurses (2).

6. Based on clinical record reviews, observations, review of facility policy and procedures, and interviews for twelve of sixteen sampled residents with pressure sores (R#2, 4, 6, 8, 20, 21, 22, 24, 25, 28, 31, 32), the facility failed to provide wound care in accordance with standards of pressure sore treatment and/or failed to monitor/assess the pressure sores at least weekly and/or failed to initiate interventions to aide in healing/prevent new sores from developing. The findings include:
- a. Resident #22 was admitted to the facility on 8/26/03 with diagnoses that included a fractured hip with an open reduction of the fracture. The hospital discharge summary noted the presence of a 2.5 cm open area on the resident's coccyx that was being treated with a Tegaderm dressing. The nursing admission assessment dated 8/26/03 identified that the resident had a 2-3 cm stage two pressure sore of the coccyx, but the resident would not allow the nurse to assess the wound. Review of physician orders identified that the first treatment order for the coccyx pressure sore was entered on 9/2/03 for a chemical debriding agent, Santyl. No prior orders were noted. The treatment kardex for August identified that no treatments were provided to the coccyx wound from 8/26/03 until 8/29/03 at which time EPC cream (a barrier ointment used for protection from incontinence) was applied to the wound. A nurse's note dated 8/30/03 identified that the wound was now 7 x 6 cm and necrotic in the center with redness surrounding the wound. No treatment orders/physician

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- notification was noted in the record until 9/2/03. A nurse's note dated 9/11/03 identified a 2 x 1 cm dark area on the left heel. On 9/14/03 notes identify foul smelling drainage from the coccyx wound. On 9/15/03 notes identify that heel protectors were provided to the resident and that the coccyx wound had a green center. On 9/16/03 the physician was notified and changed the treatment order to the coccyx. On 9/24/03 the physician was called and facility staff requested a surgical consult. During observation of the resident on 9/25/03 from 11:50 AM till 12:15 PM it was noted that the resident was sitting in a upright gerichair in the area near the nurses desk. Slipper socks were the only footwear and covered only the distal end of each foot. The heels were bare and were resting on the floor. Several staff were observed to pass by resident and did not notice the bare heels resting on the floor and/or fix the socks. On 9/26/03 the resident was transferred to the hospital for treatment and evaluation of a stage IV pressure sore of the coccyx and admitted. Review of the clinical record with the wound nurse on 10/1/03 failed to provide evidence that the physician had been notified/treatment orders obtained for the coccyx wound from admission on 8/26/03 through 9/2/03 or from 9/14-9/16/03 when the wound was noted to have foul smelling and/or green drainage. The review also noted that EPC cream had been applied to the necrotic wound by nursing staff without a physician's order beginning on 8/29/03 through 9/2/03 when a physician's order for treatment was obtained. The review further failed to provide evidence that any interventions were put in place to prevent heel breakdown or that interventions were timely when the resident's left heel was noted to be dark on 9/11/03. Review of the acute care record on 10/2/03 noted that the resident was admitted to the hospital on 9/26/03 for treatment of a stage four pressure sore of the sacrum that was infected. On 10/2/03 the resident was noted to be in the operating room undergoing a debridement and skin graft for a stage four pressure sore of the coccyx.
- b. Resident #21's diagnoses included cancer of the prostate. An assessment dated 7/02/03 identified that the resident required maximum assistance for all activities of daily living and was without pressure ulcers. The care plan dated 7/08/03 included skin integrity with interventions that included to monitor for signs and symptoms of breakdown, document and notify the supervisor. Review of the nurses notes dated 8/25/03 revealed the resident had a 3.5cm x 5.5cm dark area on the left heel. A Xeroform gauze dressing was applied. On 8/27/03 the wound was documented as a 6 cm x 5 cm white, macerated area with a 4 cm x 3 cm necrotic area in the center. A fax was sent to the physician on 8/27/03 with a request for a treatment order. No orders were noted until 9/02/03 when the physician ordered a Santyl dressing to the wound. Although nurse's notes documented daily wound dressing changes, weekly

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wound assessments that included measurements/descriptions had not been done. In addition, on 8/26/03 nurse's notes further documented a 1cm-x1cm superficial open area on the resident's mid back. The ADNS assessed the wound and recommended the application of Extra Protection Cream (EPC). On 9/24/03 during observation of care, the resident was observed to have a 1cm x 1cm open area on the coccyx. EPC was applied to the open wound without a dressing. Review of the clinical record and interview with the assistant director of nursing on 9/29/03 failed to provide evidence that a treatment order for the heel wound had been obtained from 8/25/03 through 9/2/03, that the wound had been assessed at least weekly or that proper dressings had been applied to the open area of the coccyx to protect the area from urine and stool. The resident was transferred to the hospital on 9/24/03 at the request of family for assessment of the heel wound. A review of the hospital record on 10/2/03 noted that a culture of the heel obtained on admission to the hospital identified an infection of the heel wound with methicillin resistant staph aureus (MRSA) requiring intravenous Vancomycin treatment. The resident underwent surgical debridement of the heel down to the bone on 9/29/03 and a physician's note identified that the resident will require a skin graft.

- c. Resident #32's diagnoses included Parkinson's disease, cancer and hypertension. An assessment dated 8/5/03 identified that the resident was cognitively impaired, unable to ambulate and had a stage two pressure sore. The care plan dated 8/19/03 identified the risk for impaired skin integrity with interventions that included to assist with repositioning and incontinence according to facility policy. Observation on 10/1/03 from 8:10 AM through 12:20 PM (4 hours and 20 minutes) noted the resident seated in a wheelchair without the benefit of repositioning or checking for incontinence. At 12:10 PM, the resident was returned to bed and was noted to have been incontinent of bowel. The left buttock was noted to have three small open areas with redness surrounding them. During an interview on 10/1/03 at 2:30 PM, the ADNS stated that the resident should have been repositioned and checked for incontinence every two to three hours.
- d. Resident #28's diagnoses included Alzheimer's dementia. An assessment dated 8/14/03 identified that the resident was cognitively impaired, incontinent of bowel and bladder and required assistance for all ADL's. The care plan dated 8/21/03 identified that the resident was at risk for skin breakdown with interventions that included to reposition and provide incontinent care per policy. Nurse's notes dated 8/24/03 identified the presence of a superficial open area of the coccyx measuring 0.7 cm. The area was cleaned and EPC cream applied. Review of the nursing notes identified that EPC cream was continued until 9/26/03 when the physician and family were notified of the open area and a new treatment ordered.

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- Observation of the resident on 10/1/03 with the unit manager noted a pressure sore of the coccyx that now measured 1 x 1.5 cm. Review of the clinical record with the unit manager on 10/1/03 failed to provide evidence that the physician had been notified of the pressure sore from 8/24/03 through 9/26/03 or that dressings had been applied to protect the area/aid in healing from 8/24/03 through 9/26/03.
- e. Resident #2 was readmitted to the facility on 8/13/03 with diagnoses that included aspiration pneumonia and dementia. A nursing admission assessment dated 8/13/03 identified pressure sores on the left and right buttocks. A physician order dated 8/14/03 directed to apply EPC cream (a barrier cream for incontinent care) to the open areas. A nursing note dated 8/20/03 identified blackened and/or darkened areas on the left and right buttock with open areas. The wound record identified that on 9/8/03 the resident was seen by a wound nurse and recommendations for treatment orders were received. Review of physician orders identified that the change in treatment orders did not occur until 9/16/03. Observation of the wound on 9/25/03 noted that the wounds were not covered upon start of the treatment or after the treatment. Interview with the assistant director of nursing on 9/29/03 at 10 AM noted that she must have misunderstood the salesman for the wound product company when she directed that pressure sores would be left open and treated with only a barrier ointment (EPC). Further review with the ADNS failed to provide evidence that the resident's treatment orders were changed as recommended by the wound specialist when the wound declined from 9/8/03 until 9/16/03.
- f. Resident #4's diagnoses included dementia, urine outlet obstruction and a sacral decubitus. An assessment dated 2/5/03 identified that the resident was cognitively impaired, incontinent of bowel with an indwelling bladder catheter, required total assistance with all activities of daily living and had a stage II pressure sore. The wound assessment, tracking and care plan identified that on 2/16/03 the resident developed a stage one pressure sore of the left buttock measuring 1 x 1 cm and on 3/13/03 developed a stage two pressure sore of the coccyx that measured 8.5 by 3.5 cm. Physician orders directed the application of EPC cream to the open areas. On 3/18/03 physician orders directed the use of a chemical debriding agent, Santyl, to the slough covered area of the coccyx. The resident was also noted to have developed a third area on the right buttock that was documented as a stage two measuring 2 x 1 cm. Review of the weekly wound tracking forms noted that the pressure sores were not monitored/assessed weekly in accordance with facility policy and that the areas had merged into one large area on 4/25/03 and now had a depth of 1 cm. Current physician orders directed that zinc oxide be applied to affected area and A&D be applied topically to the sacral ulcer two times per day. During observation of incontinent care on 9/24/03 at 11:30 AM, the resident was

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- noted to have an open area on the coccyx and a dry, scabbed area on the mid left buttocks. There was no dressing on either area. The charge nurse was then observed to put zinc oxide ointment directly on the open area on the coccyx followed by A&D to the surrounding reddened /scabbed area. No dressing was put on the wound and the nurse aides were directed to finish dressing the resident and continue to get the resident up in a reclining chair. During an interview with the nurse on 9/24/03 at 12:00 noon, she stated that she had been directed by the infection control nurse not to put a dressing on a Stage II open area. Interview with the assistant director of nursing/wound care nurse on 9/29/03 at 10 AM noted that she must have misunderstood the salesman for the wound product company when she directed that pressure sores would be left open and treated with only a barrier ointment (EPC) and that all pressure sores on the buttocks/coccyx would now be covered to protect them from urine/stool.
- g. Resident #6's assessment dated 1/16/03 identified the resident as severely cognitively impaired and totally dependent on staff for ADL including requiring extensive assistance for bed mobility. A Braden scale dated 1/16/03 noted the resident to be at high risk for skin breakdown. On 2/10/03, nursing notes identify that a small dark area was noted on the outer aspect of the left heel. Nursing notes dated 2/16/03 noted the area on the left heel to be 2cm x 1cm with a 1cm blister. On 2/24/03, nursing narrative notes identified that the left heel had blackened. Interview with the staff development coordinator and review of the clinical record on 9/25/03 at 11 AM noted that there was no care plan in place to address the need for protection of the heels and/or evidence in the nursing narrative notes or treatment kardex that interventions were in place. Review of facility policy for prevention of skin breakdown indicated the need for heel protectors for residents at high risk.
- h. Resident #8 was admitted to the facility on 8/20/03 with diagnoses that included peripheral vascular disease and a pressure sore. The admission nursing assessment dated 8/20/03 identified a 5 cm red area across the coccyx with a 2 cm open area and a 1/2 cm black area. Review of the clinical record identified that no treatment orders were obtained for the open/black pressure sore until 8/22/03. Review of the clinical record on 9/25/03 with the charge nurse failed to provide evidence that any treatments were applied to the coccyx from admission on 8/20/03 through 8/22/03.
- i. Resident #25 was admitted to the facility on 9/15/03 with diagnoses that included dementia and diabetes. An admission assessment dated 9/15/03 identified that the buttocks and coccyx had 1 cm and 4 x 3 cm red areas, respectively. Review of the clinical record between 9/15/03 and 9/20/03 identified that the red areas lacked treatment orders. The treatment kardex identified that on 9/20/03, EPC cream was

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- applied. A nurse's note dated 9/24/03 identified that the coccyx area had become blackened in color. Interview with the charge nurse who assessed the resident's skin on admission identified that although she hadn't documented it, the areas on the buttocks and coccyx were open upon admission and were actually Stage II pressure sores.
- j. Resident #20's diagnoses included Alzheimer's disease, dysphagia and diabetes. An assessment dated 6/18/03 identified that the resident was severely cognitively impaired and totally dependent on staff for all ADL's. A care plan dated 6/25/03 identified the resident to be at risk for skin breakdown with interventions that included monitoring for impaired skin integrity. Physician orders dated 9/10/03 directed that Solosite and EPC cream be applied to an open area on the right gluteal fold covered by a Tegaderm dressing. On 9/25/03 during morning care at 10:30 AM, a large open area was noted on the right gluteal fold. It was not covered with a dressing. Interview with the nurse aide who had provided the resident incontinent care at 7:30 AM on 9/25/03 noted that there was no dressing on the gluteal fold at that time. Upon surveyor inquiry, the open area was measured and noted to be 7cm X 4.5cm. Interview with the ADNS at 11 AM on 9/25/03 noted that there was no wound tracking sheet or evidence that the area had been assessed. She further stated that she was unaware that the resident had an open area.
- k. Resident #24's diagnoses included cellulitis of the leg with a chronic ulcer, diabetes and congestive heart failure. An admission assessment dated 8/27/03 identified that both the resident's heels were slightly reddened. Nurse's notes dated 9/8/03 identified that the resident's right heel was discolored. On 9/12/03 the resident's left heel was noted to have a 4 x 2 cm brownish color blister with a 3 x 2 cm intact blister of the right heel. On 9/25/03, a nurse's note identified that the resident had three open areas on the coccyx and that the facility requested an order from the physician for EPC cream. Review of physician orders failed to note any treatment orders for 9/25/03. On 9/28/03, a nurse's note identified that there were three areas on the coccyx measuring 2.5x1.25 cm, 1.0 x 0.5 cm, 0.5 x 1.0 cm with yellow or brownish centers. The note identified that the medical director was consulted and ordered a treatment to the coccyx of Replicare. Review of the clinical record with the ADNS on 9/29/03 failed to provide evidence that the resident received appropriate treatment to the open areas of the coccyx from 9/25-9/28/03 until she asked the medical director to intervene.
- l. Resident #31 was re-admitted to the facility on 6/13/03. The nursing admission assessment dated 6/13/03 identified that the resident's heels were reddened, soft, "mushy" and the right heel had a 1 cm blister. The resident's buttocks were noted to be red with intact skin. The care plan dated 6/13/03 identified the risk for impaired

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skin integrity with interventions that included to initiate a wound tracking form. On 8/9/03, nursing notes identify an open area on the buttock and noted that EPC cream was applied. On 8/16/03, nursing notes identify a 1.5 x 1.5 cm open area on the left buttock. On 8/17/03 nursing notes document an open area 3 cm round on the right buttock. Review of the clinical record with the ADNS on 10/1/03 failed to provide evidence that the pressure sores were monitored/assessed at least weekly from re-admission on 6/13/03 through 9/19/03 when the resident expired or that appropriate treatments to aid in healing/prevent new pressure sores were initiated.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8: (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

7. Based on clinical record reviews, review of reportable event documentation and interviews for two of four residents who experienced injuries (R#12, 14), the facility failed to transfer the residents appropriately to prevent injury and/or failed to apply restraints (hand socks) appropriately to prevent injury. The findings include:
  - a. Resident #14's diagnoses included a stroke with left side hemiparesis. The quarterly assessment dated 4/14/03 identified that the resident was cognitively impaired and totally dependent on staff for hygiene. The resident care plan dated 4/3/03 identified a problem with skin integrity related to fragile skin/scratching/picking at the skin. Review of facility documentation dated 5/1/03 identified that a nurse aide had put a sock over the resident's hand to prevent the resident from scratching. The resident attempted to pull off the sock with her teeth resulting in the loss of three lower teeth. During an interview with the nurse aide on 9/25/03, she stated that she put the sock on the resident's hand for less than five minutes to prevent her from scratching while she provided care.
  - b. Resident #14's diagnoses included a stroke with left side hemiparesis. The significant change assessment dated 1/28/03 identified that the resident was cognitively impaired and totally dependent on staff for transfers utilizing a mechanical lift. The care plan dated 1/24/03 identified the use of a mechanical lift for transfers. A nursing note dated 3/26/03 identified that the resident slid from the shower chair during a shower sustaining a blood blister and skin tear that required treatment, to the left lower leg. Interview with the nurse aide on 9/25/03 at 10 AM noted that the resident was incontinent while seated on a lift pad. The nurse aide then attempted to remove the lift pad by herself and while leaning the resident forward, the resident slipped to the floor.
  - c. Resident #12's diagnoses included dementia and stroke. An assessment dated 4/23/03 identified that the resident was cognitively impaired, rarely understood or

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understands, and required maximum assistance with all activities of daily living. The care plan dated 12/12/01 thru 4/20/03 identified falls as a problem with interventions that included transferring with the extensive assistance of two staff. Facility documentation dated 5/26/03 identified that on 5/22/03 one nurse aide transferred the resident out of bed alone. During an interview with the nurse aide on 9/24/03, she acknowledged that she had transferred the resident out of bed without assistance on 5/22/03. She also reported that she had inadvertently failed to lock the wheelchair brakes and during the transfer, the wheelchair rolled away. She reported that the resident started to fall and she held her up with one arm around the residents waist and the other arm under the residents left leg until two other nurse aides arrived to lift the resident into the wheelchair. On 5/26/03 the resident was diagnosed with a fracture of the left hip.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8:  
(i) Director of Nurses (2) and/or (m) Nursing Staff (2)(C).

- 8. Based on clinical record review and interview for one of three sampled residents with dehydration (R#2), the facility failed to assess the resident for signs and symptoms of dehydration and/or initiate interventions to prevent dehydration when the resident's intake did not meet their needs. The findings include:
  - a. Resident #2 had a history of aspiration pneumonia and dehydration. The assessment dated 7/16/03 identified that the resident was cognitively impaired, non-ambulatory, totally dependent on staff for all activities of daily living and without swallowing problems. The care plan dated 8/13/03 identified the risk for dehydration related to a history of dehydration in February 2003 with interventions that included to monitor for signs and symptoms of dehydration, monitor intake and output and to ensure a fluid intake not less than 1,700-2,100 cc per day. Review of nurse's notes identified that on 7/31/03 the resident vomited and was noted to have poor intake and coughing with meals. Review of intake and output records from 7/31/03-8/3/03 identified a fluid intake range from 750 cc - 1,100 cc per day. On 8/3/03, the resident was noted to have a temperature of 101.2 and oxygen saturation of 84%. The resident was transferred to the hospital and admitted with diagnoses that included aspiration pneumonia and dehydration (BUN of 45). Review of the clinical record with licensed staff on 9/25/03 failed to provide evidence that the resident was assessed for signs/symptoms of dehydration or that interventions to prevent dehydration were put in place when the resident's intake declined from 7/31/03 through 8/3/03.

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The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t  
(i) Director of Nurses (2).

9. Based on clinical record reviews, observations and interviews for one of three sampled residents with gastrostomy tubes (R#18), the facility failed to ensure that placement of the tube was verified prior to instilling fluids/medications and/or failed to ensure that the resident was positioned to prevent aspiration. The findings include:
  - a. Resident #18's assessment dated 8/17/03 identified the resident as cognitively impaired, requiring maximum assistance for activities of daily living and was fed via a gastrostomy tube (GT). Physician orders dated 8/8/03 included to check the GT for residual and for placement on every shift. On 9/24/03 at 8:45 AM the medication nurse was observed administering medications to the resident via the GT. Three medications (Glipizide, Calcium and ASA) were crushed, mixed in water and administered through the GT with water flushes before and after the medications. After administering the medication and the flushes, the nurse was observed to check the GT placement and residual. The nurse aspirated the stomach contents, re-inserted the aspirate and then injected air while auscultating the epigastrium with a stethoscope. During interview with the nurse at 9:00 AM, he reported that he had not checked the GT for placement prior to the administration of the medications. The nurse also reported that it didn't matter if the tube was checked before or after the medications were given. During an interview with the assistant director of nursing on 9/25/03, she reported that all GT should be checked for placement prior to the administration of medications or water fluids.
  - b. Resident #18's dietary progress notes dated 5/30/03 noted that the resident had returned from the hospital with a feeding tube in place. Physician orders dated 5/30/03 directed that the head of the bed be elevated to 45 degrees at all times. Observation of the resident on 9/26/03 at 9:15 AM noted the resident receiving the enteral feeding with the head of the bed elevated to only 20 degrees. The resident was observed to begin to cough. The charge nurse was summoned to the room and immediately elevated the head of the bed to 45 degrees.

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

10. Based on clinical record reviews and interviews for two of thirty-six sampled residents (R#35, 26), the facility failed to ensure that the residents were visited by their attending physicians at least once every thirty days for the first ninety days and/or every sixty days thereafter. The findings include:

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- a. Resident #35 was admitted to the facility on 9/13/03. Review of the clinical record with the assistant director of nursing on 10/2/03 failed to provide evidence that the resident's physician or alternate had visited the resident since admission.
- b. Resident #26 stated during an interview that he had not seen his physician. Review of the clinical record on 10/2/03 with the director of nursing failed to provide evidence that the resident had been visited by his attending physician since May 14, 2003.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t  
(n) Medical and Professional Services (5)(A).

11. Based on clinical record review, observation and interview, the facility failed to ensure that an infection control program was maintained in accordance with infection control standards/principals. The findings include:
  - a. Review of facility infection control logs on 10/1/03 with the infection control nurse/assistant director of nursing noted that the logs were incomplete and were lacking start/stop dates of infections, the organism responsible, treatments, and nosocomial versus community acquired. Updated, ongoing logs of resistant bacterial infections/colonizations with methicillin resistant staph aureus (MRSA) or vancomycin resistant enterococcus (VRE) were not available.
  - b. Observation of a nurse performing a treatment to an open area on Resident #20's right gluteal fold on 9/25/03 at 10:30 AM, noted that she took several 4x4 gauze pads and placed them directly on a soiled overbed table. She then proceeded to place saline on the gauze pads and clean the open area. Interview with the ADNS on 9/29/03 at 1 PM noted that clean dressings should not be placed on overbed tables.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t  
(j) Director of Nurses (2) and/or (c) Infection Control (3).

12. Based on review of clinical records, observations and interviews, the medical director failed to intervene on behalf of the residents when the resident's attending physicians did not respond to facility calls and/or faxes and/or initiated orders not conducive to standards of practice. The findings include:
  - a. The survey findings noted that attending physicians failed to respond promptly to faxed requests for treatment orders and/or failed to order appropriate treatments for pressure sores and/or swallowing problems. Refer to deficiencies F157 and F314. Interview with the Administrator and DNS on 9/29/03, noted that facility policy is

FACILITY: Candlewood Valley Health & Rehabilitation Center

DATE(S) OF VISIT: September 23, 24, 25, 26, 29, 30 and October 1, 2, 2003

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

to refer resident issues that are not responded to by the attending physician to the medical director. Review of the findings failed to provide evidence that the medical director had intervened on behalf of the residents.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (h) Medical Director (2)(B).

- 13. Based on clinical record review and interview for one sampled resident (R#25), the facility failed to maintain accurate clinical records. The findings include:
  - a. Resident #25's diagnoses included diabetes. The resident was admitted to the facility on 9/15/03. The admission assessment dated 9/15/03 identified that the buttock/coccyx area had 1 cm and 4 x 3 cm red areas. Interview and review of the clinical record on 9/25/03 with the nurse who admitted the resident noted that the nurse failed to document on the assessment that the red areas were actually Stage II open pressure areas.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (o) Medical Records (1).

- 14. A tour of the facility on September 25, 2003 revealed the following:
  - a. Documentation was not provided to indicate that the kitchen hood extinguishment system had been inspected within the past six (6) months. Last inspection date was 9/9/02.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).