

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

IN RE: Haven Health Center-Soundview, LLC of West Haven, CT - Licensee  
Haven Health Center-Soundview  
One Care Lane  
West Haven, CT 06516

CONSENT ORDER

WHEREAS, Haven Health Center-Soundview, LLC of West Haven, CT (hereinafter the "Licensee") has been issued License No. 2255 to operate a Chronic and Convalescent Nursing Home known as Haven Health Center-Soundview (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 April 12, 2004 up to and including April 22, 2004 for the purpose of conducting a certification inspection; and

WHEREAS, the Department during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in the violation letter dated August 26, 2004 (Exhibit A- copy attached); and

WHEREAS, an informal conference with respect to the May 25, 2004 violation letter was conducted on June 14, 2004 at the office of the Department; and

WHEREAS, the original violation letter was revised from the original date of May 25, 2004 and re-dated August 26, 2004.

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 Raymond Termini, its Managing Partner, hereby stipulate and agree as follows:

1. The Facility shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order.
2. The INC shall serve for a minimum of six (6) months unless the Department identifies through inspections that the continued presence of the INC 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 INC shall be at the Facility twenty-four (24) hours per week. The Department may, in its discretion, at any time, reduce the hours of the INC and/or responsibilities, if, in the Department's view, the reduction is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.

In addition, the Department may consider a reduction and/or elimination of the hours of the INC upon consultation between the INC and the Department to determine if the facility is in substantial compliance with all pertinent federal/state laws and regulations. The INC shall function in accordance with DHSR's INC Guidelines (Exhibit B – copy attached).

3. The INC shall conduct and submit to the Department an initial assessment of the Facility's regulatory compliance and identify areas requiring remediation within two (2) weeks of assumption of the position. The INC shall submit a weekly written report to the Department identifying the Facility's initiatives to comply with applicable federal and state statutes and regulations and the INC's assessment of the care and services provided to patients, subsequent recommendations made by the INC 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.

4. The INC's position shall be occupied and the duties of said INC shall be performed by a single individual unless otherwise approved by the Department. The INC 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. The Consultant shall confer with the Facility's Administrator, Director of Nursing Services and other staff as the Consultant deems appropriate concerning the assessment of nursing services and the Facility's compliance with federal and state statutes and regulations. The INC 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 INC shall have a fiduciary responsibility to the Department. If the INC and the Facility are unable to reach an agreement regarding the INC'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.
5. The INC 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 INC's monitoring hours if unable to fulfill the responsibilities within the stipulated twenty-four (24) hours per week;
  - iii. Review of all patient care policies and procedures relative to preventing the spread of infection, standard precautions, monitoring of residents with methicillin resistant staph aureus (MRSA) and/or Vancomycin resistant enterococcus (VRE), monitoring and assessing patients, prevention and treatment of pressure sores; 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.
6. The INC, 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 INC. Said meetings shall include discussions of issues related to the care and services provided in the Facility and compliance with applicable federal and state statutes and regulations.
7. 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, upon request.
8. 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 INC and the Department, upon their request.
9. The Department shall retain the authority to extend the period the INC 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.
10. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.

11. 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. The Administrator shall provide the Department with weekly reports pertaining to recruitment efforts for any of the previously identified positions.
12. 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 shall appoint a free floating Nurse Supervisor on each shift whose primary responsibility is the assessment of patients and the care provided by nursing staff. Such Nurse Supervisors shall maintain a record of any patient related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Said records shall be made available to the Department upon request and shall be retained for a three (3) year period of time.
13. Within fourteen (14) days of the execution of this Consent Order the Licensee shall provide to such Nurse Supervisors the following:
  - i. A job description which clearly identifies the supervisors day-to-day duties and responsibilities;
  - ii. An inservice training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;
  - iii. Nurse Supervisors shall be supervised and monitored by a representative of the Facility Administrative Staff (e.g. Director of Nursing Service, Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Supervision by Administrative Staff shall be random and inclusive of evenings, nights, weekends and holidays. Records of such administrative visits and supervision shall be retained for the Department's review;
  - iv. Nurse Supervisors shall be responsible for ensuring that all care is provided to

patients by all caregivers in accordance with individual comprehensive care plans.

- v. Nurse Supervisors shall not have administrative office duties.
14. Within fourteen (14) days of the execution of this Consent Order the Director of Nurses shall develop and/or review and revise as necessary, policies and procedures related to physical assessment of residents, physician notification of change in condition, pressure ulcer prevention and treatment, assessment of patients after a fall or incident, transferring of residents, assessments for dehydration, intake and output monitoring, evaluation of patients with the potential of aspiration, and infection control protocols.
15. Within twenty-one (21) days of the effect of this Consent Order all Facility nursing staff shall be inserviced related to the policies and procedures listed in paragraph number 14.
16. The Administrator and Director of Nursing shall investigate and report to proper authorities all injuries of unknown origin.
17. The Facility shall appoint a credentialed Infection Control Nurse to serve a minimum of twenty-four (24) 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.
18. 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 assessment patients at risk for pressure sores.
19. The Facility shall establish a Quality Assurance Program to review patient care issues inclusive of those identified in the August 26, 2004, 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.

20. 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.
21. The Licensee shall pay a monetary fine to the Department in the amount of five thousand dollars (\$5,000.00), 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:

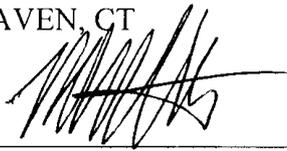
Karen Gworek, R.N., SNC  
Division of Health Systems Regulation  
Department of Public Health  
410 Capitol Avenue, P.O. Box 340308  
MS #12HSR  
Hartford, CT 06134-0308

22. All parties agree that this Consent Order is an Order of the Department with all of the 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.
23. 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.
24. 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.
25. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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.

HAVEN HEALTH CARE-SOUNDVIEW, LLC OF WEST HAVEN, CT

12/17/04  
Date

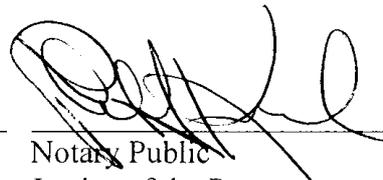
By:   
Raymond Termini, its Manager Member

STATE OF Connecticut

County of Middlesex ) ss 12-17 2004

Personally appeared the above named Raymond S. Termini and made oath to the truth of the statements contained herein.

My Commission Expires: \_\_\_\_\_  
(If Notary Public)



- Notary Public
- Justice of the Peace
- Town Clerk
- Commissioner of the Superior Court

**PHILIP F. KARPEL**  
**NOTARY PUBLIC**  
COMMISSION EXPIRES OCT. 31, 2007

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

December 23, 2004  
Date

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

RECEIVED  
DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF HEALTH SYSTEMS REGULATION  
DEC 23 2004



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

August 26, 2004

Joel Carmichael, Administrator  
Haven Health Care Center - Soundview  
1 Care Lane  
West Haven, CT 06516

Dear Administrator:

This is an amended edition of the violation letter dated May <sup>25</sup>26, 2004.

Unannounced visits were made to Haven Health Care Center - Soundview on April 12, 13, 14 and 15, 2004 by representatives of the Division of Health Systems Regulation for the purpose of conducting a certification inspection and with additional information obtained on April 15 thru April 22, 2004.

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 June 14, 2004 at 10:00 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, repairs, 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,

*Karen Gworek RN SNC*

Karen Gworek, RN  
Supervising Nurse Consultant  
Division of Health Systems Regulation

KEG/DCW:jf

c: Director of Nurses  
Medical Director



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

DATE(S) OF VISIT: April 12, 13, 14 and 15, 2004 with additional information obtained April 15 thru 22, 2004

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

President

DATE(S) OF VISIT: April 12, 13, 14 and 15, 2004 with additional information obtained April 15 thru 22, 2004

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT  
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1. Based on clinical record review, and interviews for one sampled resident (R#9), the facility failed to immediately notify the resident's physician when subsequent to being lowered to the floor onto her knees, the resident complained of pain. The findings include:
  - a. Resident #9's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, renal failure, diabetes and dementia with delusions and depression. A quarterly assessment dated 9/4/03 identified that the resident was moderately cognitively impaired, and required limited assistance from staff for activities of daily living. The resident care plan (RCP) dated 9/9/03 identified the problem with the potential for falls due to the high-risk score on the fall risk assessment. Interventions included to transfer with the assist of one, and ambulation with supervision of one with a rolling walker. Review of physician orders dated 10/22/03 directed that the resident was to ambulate with a rolling walker and supervision with a minimum assistance of one. Review of facility documentation dated 11/20/03 identified that on 11/19/03 at 9:00 PM, the resident was ambulating with a walker from the bathroom to her room when her legs weakened and she was lowered to the floor on her knees by family members. Nurse's notes dated 11/19/03 identified that when lowered to the floor at 9 PM, the resident was unable to get up and needed to be lifted off the floor with the Hoyer lift. The note further identified that the resident complained of knee pain and was provided with Tylenol and ice packs. At 5 AM on 11/20/03, nurse's notes identify that the resident requested Tylenol for leg discomfort and complained of nausea. At 8:30 AM the resident was very anxious and complained of pain in both lower extremities. The left leg was noted to be ecchymotic and the resident was unable to perform range of motion to either leg without pain. The physician was notified, and the resident was transferred to the hospital, where she was diagnosed with bilateral tibia/fibula fractures. During an interview on 4/17/04 at 11:50 AM with the licensed nurse who was on duty at the time the resident was lowered to the floor, identified that he was not required to notify the physician. He further stated that his supervisor had told him he did not need to fill out an incident report, secondary to the resident being lowered to the floor, therefore no physician notification was required. The nurse stated that he did not complete a range of motion assessment. Interview and review of facility documentation including the resident's clinical record and twenty four hour reports with licensed staff on 4/20/04 at 8 AM failed to provide evidence that the resident's physician had been notified of the resident's complaint of pain

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and/or change in condition from 9 PM 11/19/03 until 8:30 AM on 11/20/03, and/or documentation that a range of motion assessment had been completed on 11/20/03.

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

2. Based on observation and interviews, the facility failed to maintain posted banking hours for the residents. The findings include:
  - a. Observation on 4/12/04 at 10:30 AM, noted that two residents had been sitting in their wheelchairs outside of the bookkeeping office for over 20 minutes. Subsequent to surveyor inquiry, the residents stated that they were waiting for the bank to open. A notice posted on the door identified that banking hours were from 10 AM until 2 PM. Interview with the Administrator on 4/22/04 at 11:30 A.M, noted that the bookkeeper was off that day, and that no alternate person was designated to assist the residents in obtaining their funds. He further noted that the residents should have been notified of the change and/or arrangements made for a staff person to be available.

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

3. Based on clinical record reviews, observations and interviews for two of twenty one sampled residents (R#5, 8), the facility failed to ensure the resident's privacy during personal care. The findings include;
  - a. Resident #8's diagnoses included vascular dementia with behavior disturbances. A quarterly assessment dated 3/22/04 identified that the resident was severely cognitively impaired, incontinent of bowel and bladder, and totally dependent on staff for all activities of daily living, including mobility. During observation of two nurse aides (NA) providing incontinent care on 4/13/04 at 2:30 PM, the resident was noted to have been incontinent of bowel and bladder with one NA leaving and re-entering the resident's room on two occasions to get additional supplies. The NA left the door open leaving the resident in full view of passersby. Further observation noted that the resident's privacy curtain had not been pulled closed. During interview with the staff development nurse on 4/13/04 at 3:10 PM, she

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stated that when residents are receiving personal care, the privacy curtains should be pulled closed.

- b. On 4/13/04 at 6 AM, a nurse aide (NA) was observed providing incontinent care to Resident #5. The resident's roommate was in a bed directly across from the resident. The privacy curtain was not drawn so that the resident's roommate had full visual access while care was being provided by the NA. Interview with the NA on 4/13/04 at 7:30 AM, noted that the privacy curtain should always be drawn when providing care. The facility policy for providing incontinent care directs the staff to provide privacy.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or (j) Director of Nurses (2)(L).

4. Based on observations and interviews with staff and residents, the facility failed to ensure that the residents needs were accommodated related to the failure to repair a handicapped bathroom and/or the failure to maintain acceptable/comfortable water temperatures. The findings include:
  - a. Observations during tour on 4/15/04 between 10:05 AM and 10:07 AM, identified water temperatures to be between 79.2 and 84.2 degrees Fahrenheit. Interview with Resident #1 and Resident #3 identified that the water used during morning care was cold, thus they were uncomfortable during care. The water temperatures were rechecked between 10:30 AM and 10:32 AM with Environmental Services personnel and temperatures were found to be between 74.2 and 84.0 degrees Fahrenheit. Review of the Resident Council minutes dated 3/04 identified concerns voiced by the residents regarding the lack of hot water. An interview with the Maintenance Director on 4/15/04, at 10:40 AM, identified that he obtained low water temperatures on 4/14/04, however he adjusted the circulator. In addition, the maintenance logs did not reflect the initial low temperatures. Further review of the temperature logs identified that water temperatures had not been checked subsequent to adjusting the circulator.
  - b. Review of the Resident Council minutes dated 3/10/04 identified old business which included concerns that the resident's bathroom in the recreation room had been out of order for a year and had not been repaired. During the group interview on 4/12/04 at 2:15 P.M., the residents present identified that the handicapped bathroom in their recreation/dining room had been broken for over a year. The

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residents noted that they had complained about having to go back to their rooms to use the bathroom to facility staff on multiple occasions. Observation on 4/20/04 at 9:30 AM noted the bathroom in the dining area was not functioning and a plant stand was noted blocking the door. Interview with the administrator on 4/20/04 at 1:15 PM noted that the bathroom had not been in working order for about a year.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (v) Physical Plant (16)(D)(ii).

5. Based on tour of the facility and interview, the facility failed to prevent objectionable odors. The findings include:
  - a. During tour of the facility on 4/13/04 at 5:30 A.M., three surveyors noted an extremely strong odor of urine and feces throughout the facility. Several residents were observed to be heavily saturated with urine, as well as incontinent of feces. In addition, linen that was heavily soiled was noted thrown on the floor and not bagged in plastic bags as per policy. During observation of incontinent care, several residents were noted with dried urine rings on their sheets.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (m) Nursing Staff (2)(B).

6. Based on observation and interview, the facility failed to ensure that lighting in resident rooms was adequate to complete necessary tasks related to resident care and treatment. The findings include:
  - a. Resident #5, with multiple pressure sores, had a physician order dated 4/9/04 directing the staff to treat the areas with normal saline and Duoderm dressings that were to be changed every third day and whenever necessary. Observation of the treatment by the infection control nurse on 4/19/04 identified that it was difficult to provide an assessment of the pressure sores secondary to the lighting in the room being so poor. The surveyors were unable to adequately visualize wounds and incontinent care in many rooms due to the poor lighting.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (v) Physical Plant (17)(C).

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7. Based on clinical record reviews and interviews for two sampled residents (R #9 and #20), the facility failed to ensure that the Minimum Data Sets (MDS's) were accurate. The findings include:
  - a. Resident #9's diagnosis included congested heart failure and dementia. A significant change of status assessment dated 1/15/04, identified that the resident was moderately, cognitively impaired and totally dependent on staff for ADL. Facility documentation (24 hour report sheet) identified that the resident sustained a fall and subsequently a diagnosis of bilateral tibia/fibula fracture. Review of the assessment dated 1/15/04, failed to identify that a fall/fracture had occurred.
  - b. Resident #20's diagnoses included osteoporosis, macular degeneration and bladder neoplasm. A quarterly assessment dated 8/16/03 identified that the resident had not experienced any falls in the previous 180 days. Review of the clinical record noted that on 7/17/03 at 4:30 AM, 7/18/03 at 5:45 AM and on 7/22/03 at 3:15 AM, the resident was found on the floor. Review of the assessment and clinical record on 4/19/04 at 11:30 AM with the Assistant Director of Nursing failed to provide evidence that the resident's falls had been accurately reflected on the quarterly assessment of 8/16/03.

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

8. Based on clinical record review, review of twenty four hour reports and interviews for the only sampled resident who was lowered to the floor and complained of pain (R#9), the facility failed to ensure that a thorough assessment had been conducted after the incident and/or when the resident complained of pain. The findings include:
  - a. Resident #9's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, renal failure, diabetes and dementia with delusions and depression. A quarterly assessment dated 9/4/03 identified that the resident was moderately cognitively impaired, and required limited assistance from staff for activities of daily living. Review of facility documentation dated 11/20/03, identified that on 11/19/03 at 9:00 PM, the resident was ambulating with a walker from the bathroom to her room, when her legs weakened and she was lowered to the floor on her knees by family members. Nurse's notes dated 11/19/03 identified that when lowered to the floor at 9 PM, the resident was unable to get up and needed to be lifted off the floor with the Hoyer lift. The note further identified that

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the resident complained of knee pain and was provided with Tylenol and ice packs. At 5 AM on 11/20/03, nurse's notes identify that the resident requested Tylenol for leg discomfort and complained of nausea. At 8:30 AM, the resident was noted to be very anxious, and complained of pain in both lower extremities. The left leg was noted to be ecchymotic and the resident was unable to perform range of motion to either leg without pain. The physician was notified, and the resident was transferred to the hospital, where she was diagnosed with bilateral tibia/fibula fractures. Review of written statements obtained by the facility, dated 11/20/03 from the Licensed Practical Nurse (LPN) on duty at the time of the incident, identified that he and two staff persons had attempted, (but were unable) to get the resident up off the floor. The LPN then directed a nurse aide to Hoyer (mechanical) lift the resident off the floor and place her back to bed. During an interview with the LPN on 4/17/04 at 11:50 AM, he indicated that although he had looked at the resident's knees and inquired whether she had pain, he could not recall if he had taken vital signs. He further stated that he had not performed a range of motion assessment on the resident's lower extremities before and/or after transferring the resident from the floor to her bed. Interview and review of facility documentation relating to the incident (including resident clinical record and twenty four hour reports with licensed staff on 4/20/04 at 8 AM), failed to provide evidence that the resident had been physically assessed after the incident on 11/19/03, or throughout the 11 PM-7 AM shift on 11/20/03. 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.

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

9. Based on review of the clinical records, observations and interviews for three of twenty sampled residents with incontinence (R#2, #24 and #25), the facility failed to ensure that barrier cream was applied after incontinent episodes in accordance with the resident's plan of care. The findings include:
  - a. Resident #2's admission assessment dated 3/14/04 identified that the resident was cognitively impaired, totally dependent on staff for assistance with activities of

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- daily living, was incontinent of bowel and bladder and had three stage one pressure ulcers. The plan of care dated 3/09/04 identified the problem of incontinence. The interventions included incontinent care every two hours and the utilization of barrier cream. Observation on 4/13/04 at 6:30 AM, identified the resident was provided with incontinent care however barrier cream was not applied. Interview with the nurse aide on 4/14/04 at 6:45AM identified that the cream was not available.
- b. Resident #24's assessment dated 4/10/04 identified that the resident was moderately, cognitively impaired, and totally dependent on staff for all activities of daily living (ADL). A care plan dated 4/12/04 identified that the resident was incontinent of bowel and bladder. Interventions included the application of barrier cream after incontinent episodes. Observation of the resident on 4/13/04 at 6:15 AM identified that the resident's brief was saturated with urine. The resident's buttocks were noted to be reddened and excoriated. Observation of care noted that the nurse aide (NA) failed to apply the barrier cream. Interview with the NA on 4/13/04 at 7:30 AM noted that she was aware that barrier cream should have been applied, but failed to apply it.
  - c. Resident #25's assessment dated 1/5/04 identified that the resident was without cognitive impairment and totally dependent on staff for all ADL. A care plan dated 1/5/04 identified that the resident was incontinent of bowel and bladder. Interventions included the use of a barrier cream after incontinent episodes. Observation of the resident on 4/13/04 at 6:25 AM, noted the resident's brief to be saturated with urine. The resident was observed to have a reddened, excoriated area around the buttocks fold. Upon completion of incontinent care, the NA failed to apply the barrier cream. Interview with the NA on 4/13/04 at 7:30 AM, identified that the NA was aware that barrier cream should have been applied, but failed to do so.
10. Based on clinical record review, observation and interview for one of ten sampled residents with dysphagia (R#8), the facility failed to provide the resident with thickened liquids as ordered by the attending physician. The findings include:
- a. Resident #8's diagnoses included vascular dementia with behavioral disturbances. A quarterly assessment dated 3/22/04 identified that the resident was severely cognitively impaired, incontinent of bowel and bladder, and totally dependent on staff for all activities of daily living including mobility. The care plan dated 3/23/04

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identified a problem with weight loss related to aspiration risk. Interventions included feeding the resident all meals, follow speech therapy recommendations, and provide a puree diet, with liquids thickened to nectar consistency. Physician orders dated 3/24/04 directed the consistency of diet as puree and to thicken all liquids to nectar consistency. Review of speech therapy notes dated 11/12/03 identified that the resident had difficulty swallowing and required nectar thickened liquids and aspiration precautions. During observation of the serving of snacks and drinks on 4/13/04 at 10:50 AM, it was noted that two nurse aides (NA) provided diet ginger ale through a straw to the resident without the benefit of thickening. The resident was further noted to cough multiple times while the NA continued to give the drink to the resident. During interview with the NA and the assistant director of nursing on 4/14/04 at 9:55 AM, the NA stated that when she gave the resident ginger ale the previous day, she was not aware of any special interventions that the resident required. She further stated that although the NA who was with her at that time told her that this resident might require thickened liquids, she followed what the nutrition kardex had indicated. Review of the of nutrition kardex with the ADNS on 4/14/04, failed to provide evidence that aspiration precautions and/or nectar thickening of liquids had been entered on the kardex.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

11. Based on clinical record reviews, observations and interviews for 5 of 20 sampled residents with incontinence (R# 8, 22, 23, 27, 58), and 1 of 15 sampled residents in the facility dependent on staff to provide oral hygiene(R#5), the facility failed to provide incontinent care and/or mouth care in an appropriate manner in accordance with the resident care plans. The findings include:
  - a. Resident #8's diagnoses included vascular dementia with behavior disturbances. A quarterly assessment dated 3/22/04 identified that the resident was severely cognitively impaired, incontinent of bowel and bladder and totally dependent on staff for all activities of daily living (ADL), including mobility. The care plan dated 3/23/04 identified a problem with incontinence of bowel and bladder. Interventions included providing incontinent care every two hours and application of a barrier cream. During observation of incontinent care on 4/13/04 at 2:30 PM, the resident was noted to have been incontinent of bowel and bladder with the feces noted

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between and/or throughout the resident's genital area. Further observation of incontinent care noted one NA holding the resident on her right side while the other NA poured peri-wash liquid on paper towelettes. Approaching from left side of bed (resident's back), the second NA wiped feces off of the resident's buttocks and folding the paper pad in half continued wiping through her legs from behind. Upon completion of care, the NA failed to wash and/or clean the resident's perineum area. During interview with the NA on 4/13/04 at 3:00 PM she stated that although she had wiped from front to back she was not aware that she had not cleaned the resident's perineum area. During interview with the infection control nurse on 4/13/04 at 3:10 PM she stated that appropriate incontinent care of a resident who had been incontinent of bowel and bladder should include utilization of soap and water and/or peri-wash. She further stated that incontinent care should include the resident's genital (front) area as well as the buttocks.

- b. Resident #22's assessment dated 12/26/03 identified that the resident was severely cognitively impaired and totally dependent on staff for ADL. A care plan dated 12/28/03, identified that the resident was incontinent of bowel and bladder with interventions that included incontinent care every two hours. Observation of the resident while incontinent care was being performed on 4/13/04 at 5:45 AM. by a nurse aide (NA), noted the resident had been incontinent of a moderate amount of urine. The NA was noted to apply periwash to a washcloth and wash the peri area. The NA was observed to turn the resident on her side and cleanse the fold of the buttocks, but failed to wash the buttocks. Interview with the NA on 4/13/04 at 7:30 AM identified that incontinent care should include washing the buttocks.
- c. Resident #58's assessment dated 2/23/04, identified that the resident was severely cognitively impaired and totally dependent on staff for all ADL. A care plan dated 3/10/04, identified a problem with bowel and bladder incontinence with a potential for alteration in skin integrity. Interventions included providing incontinent care every two hours and utilizing barrier cream. Observation of the resident on 4/13/04 at 7:20 AM noted the resident to be lying in the bed. The nurse aide (NA) proceeded to remove the resident's brief that was noted to be heavily saturated with urine. The NA proceeded to cover the resident and leave the room without the benefit of providing incontinent care and/or applying barrier cream. Interview with the NA on 4/13/04 at 7:30 AM, identified that she was going home and was unable to provide the care.

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- d. Resident #27's assessment dated 3/16/04 identified that the resident was moderately cognitively impaired and totally dependent on staff for all ADL's. A care plan dated 4/4/04 identified that the resident was incontinent of bowel and bladder with interventions which included providing incontinent care every two hours. Observation of the resident on 4/13/04 at 6:40 AM during incontinent care, noted the resident's brief to be heavily saturated with urine with a strong urine odor noted. The resident's perineal area and buttocks were noted to be reddened. The NA was observed placing the towel into the sink and allowing the water to run onto it. The NA then placed pink liquid soap on the towel and washed the perineal and buttocks areas without the benefit of rinsing the soap. Interview with the NA on 4/13/04 at 7:30 AM identified that the incontinent care should have included rinsing the soap.
- e. Resident #23's assessment dated 2/27/04 identified that the resident was moderately cognitively impaired and totally dependent on staff for all ADL's. A care plan dated 2/28/04 identified that the resident was incontinent of bowel and bladder, with interventions that included providing incontinent care every two hours and as needed. Observation of the resident on 4/13/04 at 6:15 AM, during incontinent care, noted the resident's brief to be heavily saturated with urine. The sheet under the resident was noted to have visible, dried urine rings. The NA was observed washing the perineal area and applying a disposable brief without the benefit of cleansing the buttocks or applying barrier cream. Interview with the NA on 4/17/04 at 7:30 AM identified that incontinent care should include washing the buttocks and applying barrier cream.
- f. Resident #5 had an assessment dated 3/9/04 which identified that the resident was moderately, cognitively impaired and totally dependent on staff for ADL including oral hygiene. The resident received nourishment through a feeding tube and had a physician order that she not receive anything by mouth. On 4/19/04 at 8:45 A.M., the resident was observed in bed. Her lips, tongue and mucous membranes in her mouth, were noted to be dry, with several small crust-like formations observed in the oral cavity. Upon surveyor inquiry, the nurse swabbed the oral cavity and lips with a disposable swab. Small crusts were noted on the swabs. Interview with the nurse at that time, identified that the resident should receive mouth care at least one time every shift and whenever necessary as per care plan.

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

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12. Based on clinical record reviews, observations and interviews for nine of fourteen sampled residents with pressure sores (Residents #1, 5, 6, 7, 8, 14, 15, 16, 28), the facility failed to ensure that the residents were provided with incontinent care and/or repositioning at least every two hours to aid in healing and/or prevention of new pressure sores and/or failed to provide appropriate treatments as ordered by the attending physician and/or failed to implement interventions as directed by physician orders. The findings include:
  - a. Resident #1's quarterly assessment dated 3/16/04 identified that the resident was without cognitive impairment, was totally dependent on staff for all activities of daily living (ADL's) and had a stage two pressure sore. The care plan dated 3/18/04 indicated a problem with impaired bed mobility. The interventions included turning and repositioning the resident every two hours. Clinical record review identified a wound tracking record dated 4/7/04 that noted a pressure ulcer on Resident #1's right buttock had healed. Observations on 4/13/04 from 6:00 AM through 9:35 AM identified that R #1 remained on his back without the benefit of repositioning (three hours and thirty-five minutes). Although observations identified that Resident #1 lifted herself in bed with the assistance of a trapeze, observations from 6:50 AM through 9:35 AM failed to identify that the resident was reminded and/or encouraged to reposition herself. Further observation on 4/13/04 at 10:02 AM during the morning care identified an open area measuring 1 by 1 centimeter (cm) with a 3 by 3 cm reddened area on the resident's left buttocks. Interview with the nurse aide on 4/14/04 at 10:15 AM identified that the area on the left buttocks was new.
  - b. Resident #8's diagnoses included vascular dementia with behavior disturbances. A quarterly assessment dated 3/22/04 identified that the resident was severely cognitively impaired, incontinent of bowel and bladder and totally dependent on staff for all ADLs, including mobility. The care plan dated 3/23 /04 identified a problem with alteration of skin integrity related to a decline in bed mobility, incontinence of bowel and bladder and fragile skin. Interventions included to assess and document the condition of skin for changes, reposition and provide incontinent care every two hours and application of a Duoderm dressing to the coccyx for protection. Physician orders dated 3/24/04 directed to cleanse the coccyx with normal saline followed by Xenaderm every shift for fourteen days and then re-evaluate. Review of facility wound tracking documentation dated 4/7/04 identified

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a stage two pressure sore located on the resident's coccyx. It further identified the stage two measurement as "pin point" and excoriated. Observation of the resident on 4/12/04 from 9:30 AM to 2:10 PM (four hours and forty minutes) identified that she remained on her buttocks without the benefit of repositioning. Continuous observation on 4/13/04 from 9:15 AM to 2:30 PM (five hours and fifteen minutes) noted that the resident had been seated in a wheelchair at fifteen degrees without the benefit of incontinent care and/or repositioning during this time. During observation of incontinent care at that time (2:30 PM), the resident was noted to have been incontinent of bowel and bladder with the feces noted between and/or throughout the resident's genital area. The resident was further noted to have deep lines of demarcation imbedded into her skin through out her buttock area and around her thighs. During interview with the NA on 4/13/04 at 3:00 PM she was unable to identify when the resident had last received incontinent care and/or had been repositioned. During observation and assessment of the resident's skin with the infection control nurse (ICN) on 4/13/04 at 3:30 PM she identified a new stage two pressure sore measuring 0.75 by 0.75 cm on the resident's coccyx. She further stated that the last time she had seen the resident's coccyx area it had been healing. The ICN noted that it was facility policy to provide incontinent care/check for incontinence and repositioning every two hours.

- c. Resident #15's diagnoses included mental status changes, Parkinson's disease, diabetes and right below the knee amputation. A quarterly assessment dated 2/26/04 identified that the resident was moderately cognitively impaired, incontinent of bowel and bladder, totally dependent on staff for all ADL's, including mobility and had one stage two and one stage three pressure sore. The care plan dated 4/13/04 identified a problem with impaired skin integrity secondary to a pressure ulcer. Interventions included to reposition and provide incontinent care every two hours, application of a Duoderm dressing as ordered, and application of barrier cream. Review of facility wound tracking documentation dated 4/7/04, identified two stage three pressure sores located on the resident's coccyx which measured 1.5 by 0.5 cm and 0.5 by 0.5 cm. Observation of the resident on 4/13/04 at 6:45 AM noted the resident to have a reddened buttocks, and the disposable brief was noted to be saturated with urine, as well as the draw sheet which was under the resident. In addition, the Duoderm on the coccyx was observed to be partially off and there was an area around the circumference of where the DuoDerm had been placed, which was bright red in color. Linear

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demarcations were observed on the right hip. Upon completion of incontinent care, the NA failed to rinse the soap off, which she had applied to the perineal and buttocks area. In addition, she did not apply barrier cream. The NA was further noted applying a clean draw sheet and two disposable pads, underneath the resident who was lying on an anti-pressure mattress. Interview with the NA at 7:30 AM on 4/13/04, noted that she was aware that the soap should have been rinsed off and barrier cream applied. Observation on 4/14/04 from 11:45 AM to 1:10 PM noted that that the resident had been seated in her motorized wheel chair. Interview with the nurse aide on 4/14/04 at 1:10 PM noted that the resident had last been provided with incontinent care and repositioning when she was taken out of bed at 10:00 AM. (three hours and ten minutes). During observation and assessment of the resident with the infection control nurse (ICN) on 4/14/04 at 1:20 PM, the resident was noted to now have three stage three pressure sores; one located on resident's left buttock measuring 2.0 by 0.75 by 0.20 cm deep, one on the coccyx measuring 3.0 by 2.0 cm and one on the coccyx measuring 5.0 by 5.0 cm. During an interview with the ICN at that time, she stated that the area had deteriorated since she saw it last week.

- d. Resident #7's diagnoses included dementia, and urinary tract infections. A quarterly assessment dated 3/25/04 identified that the resident was severely cognitively impaired, incontinent of bowel and bladder, totally dependent on staff for all ADL's, including mobility and had a stage one pressure sore. The care plan dated 3/30/04 identified a problem with impaired skin integrity. Interventions included treatment as ordered, reposition and provide incontinent care every two hours and avoid positioning on bony prominence. Review of facility wound tracking documentation dated 3/31/04 identified the resident's coccyx as "fragile" and having a history of a healed stage two pressure sore. On 4/12/04, the resident was observed out of bed in a wheelchair from 8:50 AM until after 1:05 PM (four hours and fifteen minutes) without the benefit of repositioning. On 4/14/04 the resident was noted seated in a wheel chair from 11:45 until 2:50 PM (three hours and five minutes). Observation of incontinent care at that time noted a red area of the coccyx that did not blanch. The resident was noted to have been incontinent of urine and a large amount soft stool. The nurse aide stated during interview at that time that she had provided incontinent care at approximately 1:20 PM and put the resident immediately back in the wheelchair. On 4/15/04 the resident was observed from 6:30 AM to 9:45 AM seated in the wheelchair without the benefit of repositioning.

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Observation of incontinent care at 9:45 AM noted a large circular non-blanchable reddened area of the right ischial tuberosity and a quarter sized area of the coccyx that was deep red, non-blanchable and appeared to be open in the center. The nurse present at the time denied that the area was open. At 9:50 AM, the resident was transferred back into the wheelchair where she remained until 1 PM. Subsequent to surveyor inquiry, observation with the ICN at 1:05 PM on 4/15/04 noted that the resident now had two non blanchable red areas identified as stage one pressure sores located on the resident's ischial areas and a stage two pressure sore located on the resident's coccyx measuring 2.0 by 0.5 cm.

- e. Resident #16's annual assessment dated 3/12/04 identified the resident was moderately cognitively impaired, totally dependent on staff for all activities of daily living, incontinent of bladder, and had a stage four pressure sore. Clinical record review indicated R#16 had a stage four pressure sore on the right hip. The care plan dated 3/14/04 identified a problem of alteration in elimination related to incontinence of bowel and bladder. The interventions included incontinent care and repositioning every two hours. Review of the physician order dated 4/7/04 directed to cleanse the coccyx with Normal Saline followed by Curgeal and a 4x4 dressing with no tape. Observation on 4/14/04 noted the resident seated in a wheelchair from noon through 1:50 PM. Review of the positioning tracking form in the resident's room indicated the resident had last been repositioned at 9 AM. Observation on 4/15/04 at 10 AM identified R#16 lying in bed. The blue chux pad was saturated with urine, and the resident's coccyx was not covered with the 4X4 dressing as ordered by the physician. On 4/15/04 at 10:15 AM, the nurse aide caring for the resident stated during an interview, that on 4/14/04 the resident had last received care at 9:00 AM when she was transferred out of bed (four hours and fifty minutes in the wheelchair without repositioning and/or checks for incontinence). The NA further identified that on 4/15/04 the resident had last been checked at 7 AM when she was set up for breakfast (three hours without incontinence checks and/or repositioning). Observation of the resident on 4/19/04 at 7:30 A.M. noted the resident to be lying in bed, incontinent of urine, and there was a strong urine odor identified. The resident was further observed to be on an anti-pressure mattress and over the mattress were noted to be multiple layers of linen (a quarter-folded sheet and three disposable pads). A large reddened, excoriated area was observed on the coccyx. Interview with the infection control nurse at that time, identified that the resident should not be on more than one pad to render the anti-

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- pressure mattress effective. In addition, although the physician's order directed a 4x4 dressing to the coccyx with no tape, review of the clinical record failed to identify any interventions to ensure that the dressing remained on the coccyx.
- f. Resident #14's diagnoses included aphasia, stroke, cardiomyopathy, renal transplant, gastrostomy tube placement, neuropathy, and clostridium difficile colitis. The admission assessment dated 3/22/04 identified that the resident was cognitively impaired, required assistance from staff for all activities of daily living, was incontinent of bowel and bladder, and had one stage two pressure sore. The care plan dated 3/25/04 identified impaired skin integrity with interventions that included to reposition and provide incontinent care every two hours and as needed. Facility wound tracking documentation identified that the resident had two stage two pressure sores of the coccyx on 4/7/04. Constant observation on 4/15/04 from 6 AM until 10:05 AM (four hours and five minutes) noted the resident to be without the benefit of a check for incontinence or repositioning. Observation on 4/19/04 at approximately 9 AM with the infection control nurse noted the resident lying on multiple layers of underpads and sheets over a pressure reducing mattress.
- g. Resident #28's diagnoses included osteomyelitis of the coccyx, neurogenic bladder, renal insufficiency and multiple sclerosis. The significant change assessment dated 1/14/04 identified that the resident was without cognitive impairment, totally dependent on staff for all ADL's, incontinent of bowel and had one stage two pressure sore on the buttocks measuring 0.5 by 0.5 cm, and one stage four pressure sore on the buttocks measuring 10x4cm/2.5x2. The care plan dated 1/14/04 identified that the resident was incontinent of bowel, with interventions that included to turn and reposition the resident every two hours. Constant observation on 4/15/04 from 6 AM until 9 AM (three hours) noted the resident in bed on his back without the benefit of repositioning or checking for incontinence. Observation of the treatments on 4/15/04 at 2 PM noted a stage four pressure sore of the right buttock and a stage two of the coccyx.
- h. Resident #5's assessment dated 3/9/04 identified that the resident was moderately cognitively impaired, incontinent of bowel and bladder, totally dependent on staff for ADL's, and had one stage two pressure sore. A care plan dated 3/9/04 identified a potential alteration in skin integrity related to inability to reposition herself and bowel and bladder incontinence. Interventions included turning and repositioning the resident every two hours. A skin assessment dated 4/9/04 identified that the resident had multiple areas of impaired skin integrity, which included a scabbed

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area on the coccyx. A Braden scale dated 4/9/04 identified that the resident was at high risk for skin breakdown. Observation on 4/12/04, at 11:40 AM, noted the resident to have a stage 1 pressure area of the outer right foot which was noted to be very red. The resident had been observed positioned on her right side with the outer aspect of the right foot resting on the mattress without the benefit of foot protection and/or elevation. Subsequent to surveyor inquiry, a physician order dated 4/12/04, directed that booties be worn on both feet at all times. Observation of the resident in bed on 4/13/04 from 9 AM to 10:40 AM, noted that the resident's feet were without the booties. Further observation of the resident in bed on 4/19/04 noted the resident to be without the booties to both feet. Observation with the infection control nurse at that time, noted the right heel to have a new stage one pressure area measuring 7.5 cm. x 4 cm with a darkened center which measured 1.5 cm. x 1cm. A new stage one pressure area on the outer right foot measured 6 cm. x 4 cm. There were two new stage one areas observed on the left outer foot which measured 8 cm. x 4 cm and 6 cm x 4 cm. Interview with the infection control nurse noted that the resident should have had booties on but that they were probably in the laundry. Observation of Resident #5 on 4/12/04, noted the resident to be without the benefit of repositioning from 9 AM until 10:40 AM. Further observation of the resident noted that the resident had a new stage two pressure sore on the coccyx measuring 1 cm x 0.5 cm. Interview with the nurse aide at 10:45 AM, noted that she had not repositioned the resident since 7 AM (three hours and forty minutes). Further observation of the resident on 4/13/04 at 6:15 AM, noted the resident to be lying on three layers of incontinent pads and the pressure sore on the coccyx was not covered by a dressing. The resident was noted to have been incontinent of feces. The NA was observed providing incontinent care utilizing a washcloth and "pink" soap, wiping the buttocks including the pressure sore. Further observations noted that the NA failed to rinse the soap off. Interview with the infection control nurse on 4/13/04 at 10:00 A.M., identified that the soap should have been rinsed off and the pressure sore covered with a dressing. Further observation of R#5 on 4/12/04 at 10:40 AM, noted that the knee gatch of the bed was rolled up, creating a large bubble in the mid mattress which caused her feet to press into the mattress. A stage one pressure area was identified on a bunion on the right foot which measured 2.5 cm

- i. Resident #6's assessment dated 3/1/04 identified that the resident was moderately cognitively impaired and totally dependent on staff for ADL's. A wound tracking

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record dated 2/24/04 identified a stage four pressure sore on the left elbow which measured 1.5 x 0.5 cm. A physician order dated 3/24/04 directed that the left elbow be cleansed with normal saline followed by Panafil and a dry clean dressing. Observations on 4/19/04 at 9 AM noted that the dressing on the elbow was loosened and the pressure sore was exposed. Further observation of the pressure sore with the infection control nurse, noted the area to measure 0.75 cm x 0.8 cm. Interview with the infection control nurse noted that the wound has been slow to heal and that the dressing frequently falls off. Interview failed to provide evidence of any interventions was attempted to secure the bandage to prevent it from falling off and/or other methods to alleviate pressure to the area.

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

13. Based on clinical record reviews, observations and interviews for one of fifteen sampled residents who required assistance for transfers (R #19), the facility failed to ensure that the residents received adequate supervision or assistance to prevent incidents. The findings include:
  - a. Resident #19's diagnoses included Parkinson's disease and a fractured pelvis and sacrum with a history of multiple falls at home. An admission assessment dated 11/13/02 identified that the resident was cognitively impaired, required assistance with transfers and ambulation and had a history of falls. The care plan last updated on 11/15/02 identified the risk for falls with interventions that included to keep the call bell in reach, ambulate with the assistance of one staff and a walker and two side rails up. Nursing notes dated 2/4/03 identified that the resident was found on the floor. Nursing notes dated 2/28/03 identified that at 6:15 AM the resident was found on the floor with a laceration of the right frontal area of the head and bruises of the right shoulder, right elbow and right hip. The resident was transferred to the hospital and facility documentation identified that the resident was admitted with a fracture of the right hip and subarachnoid hemorrhage. The resident expired at the hospital. Review of the clinical record with the Assistant Director of Nursing on 4/19/04 at 10:45 AM failed to provide evidence that a re-assessment was completed and/or specific interventions were initiated to prevent further falls/ensure the resident's safety after the fall of 2/4/03.

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14. Based on review of the clinical record, observations and staff interviews for the only sampled resident with a gastric tube feeding (R#5), the facility failed to ensure that the resident was administered the feeding in a manner consistent with safe practice and/or that prevented aspiration. The findings include:
  - a. Resident #5's history included aspiration pneumonia, with a recent hospitalization for pneumonia. An assessment dated 3/9/04, identified that the resident was moderately cognitively impaired, had a feeding tube in place and was totally dependent on staff for all activities of daily living. A care plan dated 2/28/04 identified that the resident's nourishment was provided via gastric tube, with interventions that included maintaining elevation of the head of the bed. Observation of the resident on 4/12/04 at 10:40 AM while in bed, noted the head of the bed to be lowered flat by the nurse aide (NA) prior to beginning morning care with the enteral feeding running via the feeding pump. Further observations on 4/13/04 at 6 a.m. noted an NA lowering the head of the bed to a flat position while the enteral feeding was running, just prior to providing incontinent care. Interview with the NA on 4/13/04 at 6:05 a.m. identified that the NA was unaware of any interventions (i.e. turning off feeding) prior to caring for a resident with a feeding tube. Subsequent to surveyor inquiry, the nurse shut off the feeding prior to care. Interview with the infection control nurse on 4/22/04 at 9:34 AM identified that the head of the bed should always be elevated 30-45 degrees. She further stated that the NA's responsibility is to inform the nurse prior to providing care, and the nurse needs to stop the feeding.

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

15. Based on observation and interview, the facility failed to ensure that the medication administration error rate was less than 5%. The findings include:
  - a. Observation of the morning medication pass on 4/14/04 between 7:45 AM and 10:35 AM noted four medication administration errors as follows resulting in an error rate of 5.6%:

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- b. Resident #13 was provided with Hydralazine 25 mg without a physician order. Subsequent to surveyor inquiry, an order was obtained to administer the medication. Resident #13's physician order directed the administration of Vitamin C 500 mg which was not administered.
- c. Resident #50 received Combivent inhaler two puffs in rapid succession although the pharmacy policy directs waiting one minute between puffs.
- d. Interview with the nurse on 4/14/04 at 9:40 AM noted that the Hydralazine must have been a prescription error, the Vitamin C was overlooked and he was unaware that he should wait one minute between puffs of an inhaler.

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

16. Based on clinical record reviews, observations, interviews, review of the Vancomycin Resistant Enterococcus (VRE) and/or Methicillin Resistant Staph Aureus (MRSA) infection control logs, review of nurse aide assignments and review of the facility infection control program, the facility failed to have an infection control program in place that identified on resident admissions for the presence with colonization and/or active infections of MRSA and/or VRE, that identified a facility protocol/mechanism for identification/communication for residents known to be colonized and/or infected with MRSA and/or VRE, that addressed the staffs implementation of infection control standards and necessary precautions, that provided personal protective equipment (PPE) in convenient locations for staff use, and/or failed to store PPE supplies in an appropriate manner. The findings include:
  - a. Review of clinical records, and hospital discharge records on 4/19/04 with the infection control nurse, noted that Resident #9 developed nosocomial VRE in the urine on 2/6/04 which was treated with antibiotic therapy. Review of the clinical record identified that the resident had been hospitalized from 12/26/03 though 1/9/04. A urine culture dated 12/26/03 was noted to be negative for VRE. A urine culture done at the facility on 2/6/04 was reported to be positive for VRE. Interview with the infection control nurse on 4/19/04 at 3 PM noted that although the resident may have been treated with antibiotics while hospitalized, the facility definition of nosocomial is any infection that occurs more than 48 hours after admission.

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- b. During the initial tour of the facility on 4/12/04, the infection control nurse identified that a resident was difficult to place at Hospice (R#33) because he had VRE and MRSA. Observation of the resident's doorway failed to identify a system to communicate with others the presence of the colonization of MRSA and/or VRE. Subsequent to surveyor inquiry, a list of residents known to have a history of VRE and MRSA was provided to the surveyors. It was noted that of the 20 residents with MRSA and 9 residents with VRE, a mechanism was lacking for alerting the staff to the presence of an infection. On the second day of the survey (4/13/04), Residents # 2, 9, 13, 31, 36, 45, 46, 47, and 48 were still lacking a mechanism to indicate to staff the presence of colonization with either MRSA and/or VRE. Although facility documentation identified that the residents with MRSA and VRE are identified in the Infection Control Office, Admissions Office, and inconsistently documented on the Medication Administration Record, the facility lacked a consistent system to communicate the presence of MRSA and VRE to visitors and/or disciplines other than nursing to include in part, housekeeping and dietary. In addition during the initial tour on 4/12/04 at 8:30 AM when it was noted that a mechanism was lacking to identify residents with MRSA and VRE, the practices and principles were reviewed with the Infection Control Nurse. The Infection Control Nurse stated when asked how MRSA and VRE colonization/infections were communicated to the nursing staff, that the diagnoses were contained on the nurses aide assignments. Review of the nurse assignments noted that VRE and/or MRSA colonization were lacking on the assignments for Residents #2, 9, 14, 33, 38, 43, 44, 45, 46, 47, and 56.
- c. Review of the line listings for MRSA and VRE and comparison of those with twenty four hour reports, nurse aide assignments and clinical record reviews, noted the following:
  - i. Resident #47, who was treated in March 2004 with intravenous Vancomycin for active MRSA infections, was not on the line listing.
  - ii. Residents #13, 40 and 56 who were known to have a history of MRSA colonizations, were not on the line listings.
  - iii. Residents #31 and 40 who were known to have a history of VRE were not on the line listings.
- d. Review of the clinical records on 4/13/04 identified that Residents #1, 2, 9, 10, 13, 16, 17, 30, 32, 35, 37, 38, 39, 42, and 43 had care plans that inconsistently identified their histories of VRE and/or MRSA. Further review identified that the

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- care plans for Residents #1, 2, 9, 10, 13, 16, 17, 30, 32, 35, 37, 38, 39, 42, and 43 inconsistently identified the histories of MRSA and VRE to include location and/or specific organisms and/or monitoring relative to the histories and/or risk of infection. On 4/14/04 at 3:50 PM during an interview with the director of nursing and review of the above noted residents care plans with the surveyor, the DNS stated that the residents were colonized and did not need care plans to address VRE or MRSA. Subsequent to surveyor inquiry, the infection control nurse stated that she updated all of the care plans to include those residents colonized with MRSA and/or VRE.
- e. Review of the monthly infection control report on 4/14/04 at 2:25 PM noted that for January 2004, the report inaccurately identified the number of residents with nosocomial infections of the lower respiratory tract, the urinary tract and catheter associated infections. The report was incomplete and did not provide the calculations of the total rate of infection. The report for February 2004 was completed, however the calculation of the total rate of infection was not done.
  - f. During review of clinical records, it was noted that the list of diagnoses for Residents #2, 9, 17, 25, 30, 32, 35, 36, 38, 42, 43, 44, 45, and 46 failed to identify a consistent location to identify that the resident had a history of MRSA and/or VRE colonization and/or infections. Interview with the ICN noted that diagnoses should be included in the list maintained on the current physician orders.
  - g. See observations cited under F444 and F445 related to infection control procedures.
  - h. Review of the monthly infection reports/statistics for 2004 noted an increase in urinary tract infections for the month of March from 2% in February to 8% in March. Interview with the infection control nurse on 4/12/04 at 2 PM failed to provide evidence that investigations into the origin of the increase had been conducted or that a plan had been put in place to address the increase.
17. Based on clinical record reviews, observations and interviews, the facility failed to ensure that staff donned gloves appropriately and/or washed their hands appropriately in accordance with standard precautions. The findings include:
- a. Observations during tour on 4/13/04 at 5:50 AM identified that a nurse aide (NA) provided incontinent care to Resident # 41 who had diagnoses that included VRE in the stool. After providing the resident with care for urinary incontinence, the nurse aide went to the clean linen cart and proceeded to handle the linen, without the benefit of washing her hands.

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- b. Resident #8's diagnoses included vascular dementia with behavior disturbances. A quarterly assessment dated 3/22/04 identified that the resident was severely cognitively impaired, incontinent of bowel and bladder and totally dependent on staff for all activities of daily living (ADLs), including mobility. During observation of incontinent care on 4/13/04 at 2:30 PM, the resident was noted to have been incontinent of bowel and bladder. The nurse aide (NA) directly providing the incontinent care was observed to remove her gloves, open the bed room door, walk down the hallway, enter a supply closet, return to the resident's room opening the door, and re-enter without washing her hands. Upon completion of providing incontinent care, the NA was observed to have placed all soiled items into a plastic bag. Removing her gloves, she proceeded to the soiled utility room, disposed of the bag and then was noted to enter the resident's bathing area touching the door handle, and immediately passed through, out the other door and into another resident's bathroom where she washed her hands. During interview with infection control nurse on 4/13/04 at 3:10PM she stated that after removing gloves staff should wash their hands and that it was facility policy to do so.
- c. Observations on Saturday April 17, 2004 at 8 AM noted a housekeeper enter Resident #9's room (Resident colonized with Vancomycin resistant enterococcus (VRE)) with gloves on. The housekeeper was observed to empty the trash in the room into the cart in the hallway, and then proceed into Resident #33's room (resident colonized with VRE in the stool and MRSA in the urine). She was observed to empty the trash in R#33's room and then empty the trash in the common bathroom in the hallway with the same gloves on. She was then observed to proceed into the staff bathroom where she again emptied the trash and replaced the toilet paper with the same pair of gloves on. Subsequent to surveyor inquiry, the housekeeper removed the gloves and washed her hands. During interview at the time, the housekeeper stated that she was not educated about the "stop" signs on the door and did not know that she should remove her gloves and wash her hands prior to going to the next room.
- d. Observation on Saturday, April 17, 2004 at 8:28 AM noted a nurse aide enter Resident #18's room without gloves on. A "stop" sign was noted on the resident's door and the resident was known to have had a recent urinary tract infection with VRE. The NA was observed to remove the resident's covers and handle items on the overbed table and on the bed looking for a missing item. The NA left the resident's room, walked down the hallway and began to feed Resident #6 without

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- the benefit of washing her hands. Subsequent to surveyor inquiry, she stopped feeding the resident and washed her hands. The NA stated during an interview at the time, that she was not aware of what the "stop" sign meant, and that she only worked on weekends, but stated that she had worked there for 20 years and should have known better.
- e. Observations on Saturday, April 17, 2004 from 8:15 AM to 9 AM noted a nurse aide enter and exit eight rooms on B Wing of which four rooms contained residents colonized with either MRSA or VRE, intermittently providing care such as entering the bathroom to bring a resident a towel, collecting multiple breakfast trays, fixing residents shoes, handling equipment in rooms such as overbed tables and wheelchairs, without donning gloves or washing her hands.
  - f. On 4/13/04 at 5:45 AM, a nurse aide (NA) was observed providing incontinent care to Resident #22. Further observations noted the NA providing incontinent care to Residents #5 and R#58 before washing her hands.
  - g. Facility policy identified the need to wash hands after removing gloves, and between care of the residents. In addition, facility policy identified that an infection control program would be in place, and provide education to all staff regarding policies and procedures relating to maintaining a clean and sanitary environment.
18. Based on observation and staff interview, the facility failed to ensure that linen was handled in a manner that prevents the spread of infection. The findings include:
- a. On 4/13/04 at 5:45 AM, a nurse aide (NA) was observed providing care to Resident #22 who had been incontinent of a large amount of urine and stool. The NA was observed placing the soiled pads and towel that she had utilized to provide incontinent care, onto the floor. Interview with the NA on 4/13/04 at 7:30 AM, noted that the policy of the facility is to place soiled linen into a plastic bag. The NA further identified that she should have brought a plastic bag into the room with her.
  - b. On 4/13/04 at 6:45 AM, a NA was observed performing incontinent care for R#15. The brief was observed to be saturated with urine and stool, which the NA was noted to place on the floor. Interview with the NA on 4/13/04, who had provided the care, identified that linen should never be placed on the floor.
  - c. On 4/13/04 at 7:20 AM, a NA was observed performing incontinent care for R#58. The resident's brief was noted to be soaked with urine. The NA was noted removing the brief and placing it on the floor.

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- d. On 4/13/04 at 6:40 AM, a NA was noted to be providing incontinent care to R#27. The resident's brief was noted to be saturated with urine. The NA was observed providing incontinent care with a wet towel. Upon completion of incontinent care, the NA was observed placing the same towel on the overbed table.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (t) Infection Control (2).

19. During tours of the facility's enclosed and attached patio (back porch) area on all days of survey and with ADNS on 4/15/04 at 5:35 PM the following was noted:
  - a. Numerous cigarette butts were noted strewn around and in close proximity of a gas grill adjacent to the facility.
  - b. Many cigarette butts were noted scattered throughout the enclosed patio floor and in two large suspended flower planters.
  - c. A large amount of cigarette butts were noted in an open five gallon plastic container filled with cardboard and paper debris adjacent to the facility doorway.
  - d. Interview and observation of patio area with the ADNS at that time, failed to identify any cigarette smoking receptacles. She further stated that the patio area was not the designated smoking area for residents.

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

20. Based on review of the emergency preparedness plan and interview, the facility failed to ensure that all staff were trained in emergency procedures. The findings include:
  - a. During review of the emergency plan on 4/13/04 it was identified that a nurse aide on the 11-7 shift was unable to describe what would be done in the event of a fire in a resident's room. When asked what would you do if there was a fire in a resident's room during care rounds, the nurse aide indicated that she would notify the supervisor. The aide also indicated that all the in-services that she attended regarding fires were in the hallway.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (u) Emergency Preparedness Plan (5).

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21. A tour of the facility on April 12, 2004 revealed the following:
  - a. It was observed that the fire doors in the corridor near Resident Room A6, had cracks in the core and laminate that was peeling.
  - b. It was observed that the fire doors in the corridor near Resident Room #21, had cracks in the core and laminate that was peeling.
  - c. It was observed that the closet which houses the soiled linen chute in Nurse Station A had voids which were sealed with a flammable spray in foam. Documentation was not provided that the foam had a listed fire retardency and rating at least equivalent to the barrier it was applied to.
  - d. It was observed that the electrical closet doors in Nursing Station A & B which open into the corridor were not provided with an automatic closing device as required by the referenced LSC for an opening to a hazardous area.
  - e. It was observed that the Chemical Storage Room door in the Dietary Department was not provided with an automatic closing device and the room lacked a source of mechanical ventilation as required for a hazardous area.
  - f. It was observed that the housekeeping Chemical Storage Room in the basement was not provided with an automatic closing device on the door in order to maintain the fire resistive rating to an opening of a hazardous area.
  - g. It was observed that the emergency lights in the basement corridor by the boiler room and at Nurse Station B, were not working when tested at the time of inspection.
  
22. During a tour of the facility on 04/12/04, the following was observed:
  - a. Resident room #A8 had a window which was observed to be fogged with moisture between the glass panes.
  - b. There were ceiling tiles throughout the facility, which appeared to be stained and/or water damaged.
  - c. The nurse call button on the wall of Resident Room #25, appeared to be broken and not operable.
  - d. The corridor carpet, which borders the carpet to the administrative area, was missing a threshold.
  - e. The wall in the Dietary Department near the office was heavily marred.
  - f. The stove and oven in the Dietary Department was observed to be very old, dirty and rusting.

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- g. The exit door between Resident Rooms #23 and #24, was rusted and had excessive rot on the bottom (this was previously cited without any corrective action).
- h. The loading dock and the ramp outside of the Physical Therapy Department was observed to be deteriorated and posing a hazard to the area (this was previously cited without any corrective action).
- i. The front entrance and handicap ramp was observed to be heavily damaged and deteriorated and did not appear to be ADA compliant at the time of inspection (this was previously cited without any corrective action).
- j. Resident room furniture throughout the facility was observed to be missing, broken, and/or worn and appeared to no longer operate safely.

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

- 23. During a tour of the Dietary Department on April 12, 2004, it was observed that the designated hand wash sink lacked wrist blade type faucet handles.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (v) Physical Plant (16)(D)(i).